STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495330	A. BUILDING _____ B. WING _____	07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE OF CHESAPEAKE	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 7/25/17 through 7/28/17. Four complaints were investigated. Significant corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 120 bed facility was 105 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #19, and #34, #35). The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.	F 000	F000 This plan of correction constitutes our Credible Allegation of Compliance. Preparation/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-140 (D)(15.d) Dignity and Respect Please Cross-Reference to F-241 12 VAC 5-371-270A. Social Services Please Cross Reference to F250. 12 VAC 5-371-300 (A,B) Pharmacy Services Please Cross Reference to F425 and F431 12 VAC 5-371-250 (A, F, I,G). Resident Assessment and Care Planning Please Cross-Reference to F-278 and F280. 12 VAC 5-371-370 (A, E). Maintenance and Housekeeping	F 001	F001 Plan of Correction includes cross references to state licensure requirements: 12 VAC 5-371-140(D) (15.d) Dignity and Respect F241 12 VAC 5-371-270A. Social Services F250 12 VAC 5-371-300 (A, B) Pharmacy Services F425 and F431 12 VAC 5-371-250 (A, F, I, G). Resident Assessment and Care Planning F278 and F280. 12 VAC 5-371-370 (A, E). Maintenance and Housekeeping F323 and F469. 12 VAC 5-371-220 (B, C, I). Nursing Services F314 and F309. 12 VAC 5-371-360 (E.4). Clinical Records F514.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Exe. Dir	8/21/17

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F 001	Continued From Page 1 Please Cross-Reference to F323 and F-469. 12 VAC 5-371-220 (B,C.1) Nursing Services Please Cross Reference to F314 and F309 12 VAC 5-371-360 (E.4). Clinical Records Please Cross-Reference to F514	F 001		

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/25/17 through 7/27/17. Four complaints were investigated. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 35 residents, 21 current Resident reviews (Resident #1 through #19, and #34, #35) and 14 closed record reviews (Resident #20 through #33).	F 000	F000 This plan of correction constitutes our Credible Allegation of Compliance. Preparation/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws.	
F 159 SS=D	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) ...If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account,	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Exe Dir | (X6) DATE: 8/21/17

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F 159	Continued From page 1 interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and	F 159		

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F 159	Continued From page 2 (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure Residents had access to funds available during posted hours for 1 Resident (Resident #34) of 35 Residents in the survey sample. The findings included: Resident #34 was admitted to the facility on 11/16/16. Diagnoses for Resident #34 included but are not limited to Heart Failure (1), Benign Prostatic Hyperplasia (2) (BPH), Manic Depression (Bipolar Disease) (3), Chronic Obstructive Pulmonary Disease (COPD) (4), Difficulty in Walking, Patient Non-Compliance with Medical Treatment, Diabetes Type II (5), Presence of Automatic Implantable Cardiac Defibrillator (6) and Cellulitis (7) of Lower Legs. Resident #34's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 7/21/17 coded Resident #34 with a BIMS score of 15 of 15 indicating no cognitive impairment. In addition the Quarterly MDS scored Resident #34 to require extensive assistance with two staff person assistance in bed mobility and transfer. Resident #34 was coded to require limited assistance with one staff person assistance for	F 159	F159 1. Resident #34 received funds requested from resident fund account. 2. Residents who have active resident account funds have the potential to be affected. 3. Staff who are assigned to receptionist duty will be in-serviced on notifying residents when banking hours change. 4. The BOM/designee will monitor resident funds availability 3xs a week for 30days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17	

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F 159	Continued From page 3	F 159		

dressing and personal hygiene. Resident #34 was coded to require extensive assistance with one staff person assistance for toilet use and bathing.

The Surveyor interviewed Resident #34 on 7/26/17 at approximately 5:27 p.m.. One concern verbalized by Resident #34 was that on 7/23/17 (Sunday) at approximately 6:00 p.m. he went to obtain money from his account. Resident #34 stated that he asked the Receptionist sitting at the Front Lobby Desk and was told that the person with the key to the safe left earlier. Resident #34 stated that he pointed to the posted hours at the Business Office Door of 8:00 a.m. to 8:00 p.m. and asked for his money. The ADON (Assistant Director of Nursing) #3 was called to assist. Resident #34 stated that the ADON said that she could not get the code or key to the safe and that he would have to wait until Monday 7/24/17. Resident #34 stated that he wanted the money to order take out food as he was not satisfied with the facility food.

The ADON was interviewed on 7/27/17 at approximately 10:30 a.m. She stated when asked about Resident #34's attempts to obtain his money on 7/23/17, that his statement is correct. He was not able to obtain his money as the person with the key had left the facility early.

A sign was observed posted at the Business Office door that listed times available: 8 a.m. to 8 p.m.

The facility administration was informed of the findings during a briefing on 7/27/17 at approximately 5:15 p.m. The facility did not present any further information about the findings.

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DEFINITIONS

(1) Heart Failure: Medline plus documented: Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs.

(2) Benign Prostatic Hyperplasia: Medline plus documented: The prostate is a gland in men. It helps make semen, the fluid that contains sperm. The prostate surrounds the tube that carries urine out of the body. As men age, their prostate grows bigger. If it gets too large, it can cause problems.

(3) Manic Depression/Bipolar: Medline plus documented: Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression.

(4) Chronic Obstructive Pulmonary Disease: Medline Plus documented: COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it.

(5) Diabetes Type II: Medline Plus documented: your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood.

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F 159	Continued From page 5 (6) Cardiac Defibrillator: An arrhythmia is any disorder of your heart rate or rhythm. It means that your heart beats too quickly, too slowly, or with an irregular pattern. Most arrhythmias result from problems in the electrical system of the heart. (7) Cellulitis: Cellulitis is an infection of the skin and deep underlying tissues. Group A strep (streptococcal) bacteria are the most common cause. The bacteria enter your body when you get an injury such as a bruise, burn, surgical cut, or wound.	F 159		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to maintain dignity during a wound dressing change for 1 of 35 residents in the survey sample, Resident #6. The facility staff failed to maintain dignity for Resident #6 by labeling the wound dressing while on the resident with date and initials. The findings included: Resident #6 was admitted to the facility on 9/21/09 with a readmission date of 4/14/17.	F 241	F241 1. Resident #6 treatments were administered appropriately with respect and dignity honored. 2. Residents with pressure injuries and require treatment administration have the potential to be affected. 3. Facility licensed nurses will be in-serviced on the policy and procedure of appropriate dressing change. 4. The DON/designee will audit dressing changes by licensed nurses 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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F 241	Continued From page 6 Diagnoses for Resident #6 included but not limited to, Type arthritis, high blood pressure and depression. The most recent Minimum Data Set with an assessment reference date of 7/18/17, coded Resident #6 with a score of 15 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #6's cognitive abilities for daily decision making are intact. On 7/26/17 at 2:15 PM, the surveyor observed LPN (Licensed Practical Nurse) #2 perform a wound dressing change on Resident #6's wounds on the right heel and left heel. LPN #2 performed the procedure for the left heel wound as follows: Washed hands; Prepared supplies; Assessed Resident #6 for pain; Cleaned and disinfected overbed table; Placed barrier on the overbed table; Washed hands; Applied clean pair of gloves; Removed soiled wound dressing and discarded; Assessed the wound; Removed soiled gloves; Washed hands; Applied a clean pair of gloves; Cleansed the wound; Removed soiled gloves; Washed hands; Applied clean pair gloves; Applied (Brand name) dressing on the wound; Placed adhesive tape on the dressing; Labeled the adhesive tape with date and initials on the resident. Washed hands. LPN #2 repeated the same procedure for the	F 241		

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right heel wound but this time she dated the adhesive tape prior to application; she placed the labeled adhesive tape on the right heel wound dressing. LPN #2 missed labeling the adhesive tape with her initials, so she took a marker and wrote her initials on the dressing that had been applied on Resident #6's wound. She missed the proper procedure twice for labeling the wound dressing prior to application. When LPN #2 was asked what the proper procedure was for labeling the wound dressing, she stated, "Label before applying the dressing."

On 7/27/17 at 9:50 am, the DON (Director of Nursing) was asked regarding the proper procedure for wound dressing change and labeling dressing, in particular, and she replied, "Label the dressing before you apply; do not label on the resident." When asked why this was the proper procedure, she stated, "It may cause injury to a resident's sensitive skin...It is a dignity issue".

On 7/27/17, the most current "Wound Care Specialist Evaluation" record dated 7/6/17 provided by the facility was reviewed. It stated that Resident #6 had a Stage 3 pressure wound of the left heel and a Stage 3 pressure wound of the right heel, both had improved.

On 7/26/27 at approximately 12:30 PM, the facility policy and procedure titled, "Dressing, Dry/Clean" was reviewed. The policy stated, in part, as follows, "Purpose: The purpose of this procedure is to provide guidelines for the application of dry, clean, dressings...Steps in the Procedure: 1. Clean bedside stand. Establish a clean field...10. Label tape or dressing with date, time and initials. Place on clean field..."

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F 241	Continued From page 8 The Administrator, DON and Corporate VP were made aware of these findings on 7/27/17 at approximately 5:15 PM. No further information was provided.	F 241		
F 250 SS=E	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, staff and resident interview, and facility documentation review, the facility staff failed to provide medically-related social services to attain or maintain the highest practical mental and psychosocial well-being for 1 of 35 residents (Resident #17) in the survey sample. The facility failed to develop a plan to meet the needs of Resident #17's related to the potential for supportive outside services to include Day support services and or integration into the community. The findings include: 1. Resident #17 was admitted on 3/12/15 with diagnosis that included but not limited to Mild Intellectual Disability (ID). Review of the most recent Minimum Data Set (MDS) assessment dated 7/21/17 was a quarterly which did not assess Resident #17 with the diagnosis of ID, thus subsequent prompted sections were not completed, A1510 and A1550 .	F 250	F250 1. Resident #17 plan was developed to address supportive community services available for resident. Resident was presented with options and accepted exercise Zumba classes. 2. Residents who have a diagnosis of MR/ID that reside in the facility have the potential to be affected. 3. Facility DON, social worker and MDS coordinators in-serviced on PASRR significance and facility responsibility to resident who are assessed at level 2. 4. The SS director/designee will monitor PASRR assessments, recommendations and follow up needed 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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F 250	Continued From page 9 Also, the previous MDS assessments (Admissions, Annuals and Quarterlies) from the resident's initial admission to the current one, did not assess the resident with the diagnosis of ID. The resident was coded with a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS). The resident had no behavioral or mood problems, nor did he refuse care. The most recently revised care plan dated 7/21/17 identified the resident was verbally and mentally challenged but did not identify any additional suggested services to be provided based on the Level II screening 8/24/16. On 7/26/17 at 2:00 p.m., when asked of the Administrator for all PASRR (Preadmission Screening and Resident Review) Level I, and if applicable Level II screenings based on Resident #17's diagnosis of ID, he stated he was not aware of what this surveyor was asking for or the significance of such screenings. Further inquiry of the request for the PASRR documents led to the Medical Records Coordinator and Director of Social Work (DSW) on 7/27/17 at 12:30 p.m. who presented all level I and level II screenings. All of them were obtained from the residents' purged chart. The Level II PASRR identified the resident had mild ID and cerebral palsy as a related condition. The recommendations dated 8/24/16 indicated the resident could benefit services in the community of lesser intensity, referring to just nursing home care and services. The recommendations indicated the following: "Targeted case management is recommended to connect with supportive services and explore the potential for discharge to the community, should he and his	F 250		

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family desire for him to do so. Collaboration with the local Community Services Board may be helpful in identifying services that may allow (Resident #17's name) needs to be met in a less restrictive environment. A resident review is recommended in 180 days to assess his status at that time and identify any additional supports needed." Further discussion with the DSW stated she had been the DSW a little over a year and dropped the ball on following through with the Level II recommendations. She stated until surveyor inquiry, she had not seen or reviewed the August 24,2016, Level I of Level II screening and she was not told anything by the previous DSW, nor was it discussed by Administration. She stated she did not complete A1500, A1510 or A1550 of the MDS, but she was well familiar with what to do because she worked with the ID population in the past. The DSW stated she would do a preliminary search to see what would be available for the resident in the community and talk to the resident. She returned with two possible day classes and an appointment with the Community Service Board. The DSW stated the resident was not on any psychotropic medications and there were no Psychiatric evaluations. She stated it was a part of her job description to explore resident needs and acquire input from outside resources to meet the needs of ID residents.

On 7/27/17 at 1:30 p.m., an interview was conducted with the Minimum Data Assessment (MDS) Coordinator. She stated she did not complete the section of A1500, A1510 and A1550 and thought the Social Worker completed those sections. A closer examination of the aforementioned sections revealed the MDS department completed them. The MDS

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Coordinator stated she did not know what PASRR referred to and needed to gain education on the subject and how to further assess and code the section. She said it would have had some bearing on further care planning and addressing his special needs, but they did not coordinate any of the assessment sections for ID. She stated she would refer to the Resident Assessment Instrument (RAI) manual to help her understand how to complete the sections that refer to PASRR.

On 7/27/17 at 5:16 p.m., an interview was conducted with the Administrator, Director of Nursing (DON), Corporate Administrator and Corporate Nurse. The Administrator and the DON stated they were not familiar with PASRR and would have to research the topic. They stated they had not seen the level I or Level II screening evaluation and did not know what it was or that they needed to review it. The Corporate nurse stated, "The purpose of the PASRR is to identify residents with mental illness or Intellectual Disability (ID) from the Level I screening leading to the Level II screening and provide any services outside of the nursing home that even may lead to integration into the community or day support services." They further stated they would start from keeping Level I and Level II assessments on the chart, making sure social services would assess the A1500, A1510 and A1550 that would trigger evaluation and seeking out additional outside services. They stated there had not been any arrangements to collaborate with the local Community Service Board (CSB), nor had they invited this entity to participate in care planning.

On 7/26/17 at approximately 3:00 p.m., the resident was observed in a wheelchair. The right

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arm was in a splint and contracted in a 90 degree angle. The resident was able to actively initiate and sustain conversation.

On 7/27/17 at approximately 3:45 p.m., the resident was observed in bed. He was an accurate historian of how he use to work and fold clothes and where he participated in other day programing before he was in the hospital and was admitted to the nursing home, even the street name. He was able to remember past CSB case worker names and stated if he had their phone numbers he would call them. He further accurately stated where he lived before the hospitalization and his Resident Representative (RR). The resident called out the names of nurses, aides, social worker and read the name off the badge of the aide that came to check on him during the interview with this surveyor. He spoke about the reason he was in the hospital due to breaking his right leg in 2015, that required a rod and physical therapy. He stated, "I would love to go out of the building and do other things, but did not know I could do anything but be here. No one here came to talk about that. I had a care plan meeting yesterday and they didn't tell me I had a chance to maybe go back to the place I was at before or another place. I won't turn down anything they think I am ready for."

The facility's policy and procedures titled "Social Services" dated 2016 indicated the following: "...Medically related social services are provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental and psychosocial needs. Services to meet resident's needs may include making referrals and obtaining services from outside entities seeking ways to support

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F 250	Continued From page 13 resident's individual needs...The resident's care plan will reflect ongoing social service needs and how these needs are being addressed."	F 250		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278		

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F 278	Continued From page 14 material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation review, the facility staff failed to ensure 2 out of 35 residents (Resident #17 and #10) Minimum Data Set (MDS) assessments accurately reflected their status. 1. The facility staff failed to code Resident #17 in A1500 Preadmission Screening and Resident Review (PASRR) which would prompt additional assessment areas that were not completed, A1510 and A1550. 2. The facility staff failed to accurately code Resident #10's 7/11/17 Significant Change MDS assessment to include Hypertension and Glaucoma in section "I" Active Diagnoses. The findings included: 1. Resident #17 was admitted on 3/12/15 with diagnosis that included but not limited to Mild Intellectual Disability (ID). Review of the most recent Minimum Data Set (MDS) assessment dated 7/21/17 was a quarterly which did not assess Resident #17 with the diagnosis of ID, thus subsequent prompted sections were not completed, A1510 and A1550 . Also, the previous MDS assessments (Admissions, Annuals and Quarterlies) from the resident's initial admission to the current one, did not assess the resident with the diagnosis of ID. The resident was coded with a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS). The resident had no behavioral or mood problems, nor did he refuse care.	F 278	F278 1. Resident #17 MDS modification completed to include coding for PASRR and additional assessments. Resident #10 MDS modification completed to include hypertension and Glaucoma active diagnosis. 2. Residents in facility who have PASRR assessments and active diagnosis of hypertension and glaucoma have the potential to be affected. 3. Facility MDS/Social workers in-serviced on completion of MDS section A1500 accurately and including all of residents active diagnosis. 4. MDS coordinator will audit MDS accuracy for section A1500 ad active diagnosis coding 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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The most recently revised care plan dated 7/21/17 identified the resident was verbally and mentally challenged but did not identify any additional suggested services to be provided based on the Level II screening 8/24/16.

On 7/26/17 at 2:00 p.m., when asked of the Administrator for all PASRR (Preadmission Screening and Resident Review) Level I and if applicable Level II screenings, based on Resident #17's diagnosis of ID, he stated he was not aware of what this surveyor was asking for or the significance of such screenings.

Further inquiry of the request for the PASRR documents led to the Medical Records Coordinator and Director of Social Work (DSW) on 7/27/17 at 12:30 p.m. who presented all level I and level II screenings. All of them were obtained from the residents purged chart. The Level II PASRR recommendations dated 8/24/16 indicated the resident could benefit services in the community of lesser intensity, referring to just nursing home care and services. The recommendations indicated the following: "Targeted case management is recommended to connect with supportive services and explore the potential for discharge to the community, should he and his family desire for him to do so. Collaboration with the local Community Services Board may be helpful in identifying services that may allow (Resident #17's name) needs to be met in a less restrictive environment. A resident review is recommended in 180 days to assess his status at that time and identify any additional supports needed." Further discussion with the DSW stated she had been the DSW a little over a year and dropped the ball on following through

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with the Level II recommendations. She stated until surveyor inquiry, she had not seen or reviewed the August 24, 2016, Level I of Level II screening and she was not told anything by the previous DSW, nor was it discussed by Administration. She stated she did not complete A1500, A1510 or A1550 of the MDS, but she was well familiar with what to do because she worked with the ID population in the past.

On 7/27/17 at 1:30 p.m., an interview was conducted with the Minimum Data Assessment (MDS) Coordinator. She stated she did not complete the section of A1500, A1510 and A1550 and thought the Social Worker completed those sections. A closer examination of the aforementioned sections revealed MDS department completed them. The MDS Coordinator stated she did not know what PASRR referred to and needed to gain education on the subject and how to further assess and code the section. She said it would have had some bearing on further care planning and addressing his special needs, but they did not coordinate any of the assessment sections for ID. She stated she would refer to the Resident Assessment Instrument (RAI) manual to help her understand how to complete the sections that refer to PASRR.

On 7/27/17 at 5:16 p.m., an interview was conducted with the Administrator, Director of Nursing (DON), Corporate Administrator and Corporate Nurse. The Administrator and the DON stated they were not familiar with PASRR and would have to research the topic. The Corporate nurse stated, "The purpose of the PASRR is to identify residents with mental illness or Intellectual Disability (ID) from the Level I screening leading

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to the Level II screening and provide any services outside of the nursing home that even may lead to integration into the community or day support services." They further stated they would start keeping Level I and Level II assessments on the chart, making sure social services would assess the A1500, A1510 and A1550 that would trigger evaluation and seeking out additional outside services.

The facility's policy entitled "Resident Assessment Instrument" dated 2010 indicated "The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment team conduct timely and accurate resident assessments..."

The Resident Assessment Instrument (RAI) indicated the A1500 section refers to coding for ID or MI (mental illness). Residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State. A1510 further coded for whether the resident has a diagnosis of ID or MI with a Level II PASRR condition. A1550 identifies the specific condition present (i.e., congenital conditions, cerebral palsy, hydrocephalus {increased ventricular fluid in the brain}...)

2. Resident #10 was originally admitted to the facility 6/6/16 and readmitted 8/16/16 after an acute hospitalization. The current diagnoses included high blood pressure and glaucoma.

The Significant Change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/11/17 coded the

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resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #10 cognitive abilities for daily decision making were intact.

Review of the 7/11/17 MDS assessment revealed hypertension was not coded at "I0700" and neither was glaucoma coded at " I6500".

The Resident Assessment Instrument dated October 2016 stated, "Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period". (page I-4)

Review of the July 2017 physician order summary included an order for Labetalol 100 milligrams (a medication indicated used to manage hypertension). Administer 1/2 tablet every 12 hours for hypertension. The July physician's order summary also revealed an order for Travatan Z drops 0.004% (an ophthalmic solution is indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension) every evening.

Review of Resident #10's active care plan dated 7/18/17 revealed a care plan problem for hypertension with a risk for complications. The goal read; "Resident will not have signs/symptoms related to hypertension such as but not limited to blurred vision, dizziness,

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F 278	Continued From page 19 headache, and fatigue through review." One of the approaches was; Administer medication as ordered. There was no care plan to address the diagnosis of glaucoma. An interview was conducted with the MDS Coordinator on 7/26/17 at approximately 4:40 p.m., the MDS Coordinator stated the MDS should have been coded at section "I" for both hypertension and glaucoma. On 7/27/17 at approximately 6:15 p.m., the above findings were shared during the pre-exit debriefing with the Administrator, Director of Nursing, Corporate Administrator and the Regional Nurse Consultant. The Director of Nursing stated the diagnoses should have been coded on the MDS assessment.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		

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F 280	Continued From page 20 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 280		

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F 280	Continued From page 21 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation, the facility staff failed to revise care plans and/or allow opportunity for participation in his or her person centered plan of care for 4 out of 35 residents (Resident #17, #10, #3 and #18) in the survey sample. 1. The facility staff failed to care plan the Level II PASRR (Preadmission Screening and Resident Review) recommendations for Intellectual Disability (ID) condition and provide approaches to implement those recommendations for Resident #17. 2. The facility staff failed to afford Resident #10 the opportunity to participate in planning and review of his person centered plan of care.	F 280	F280 1. Resident #17, #10, #3 and #18 were offered invites to care plan. Resident #17 care plan was updated to reflect community services offered to resident. Resident #10 was offered the opportunity to attend care plan meetings. Resident #3 care plan was updated to include smoking restrictions. Resident #18 care plan was updated to include smoking. 2. Residents who have MR/ID and has a scheduled care plan meeting or smokes has the potential to be affected. 3. Facility licensed nurses and social services in-serviced on care planning, care plan invites and all inclusive care plans for resdents. 4. MDS/designee will audit care plan invites and care plan updates 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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3. The facility staff failed to review and revise Resident #3's care plan to include smoking restrictions.

4. The facility staff failed to review and revise Resident #18 care plan to include smoking.

The findings include:

1. Resident #17 was admitted on 3/12/15 with diagnosis that included but not limited to Mild Intellectual Disability (ID).

Review of the most recent Minimum Data Set (MDS) assessment dated 7/21/17 was a quarterly assessment which did not assess Resident #17 with the diagnosis of ID, thus subsequent prompted sections were not completed, A1510 and A1550 . Also, the previous MDS assessments (Admissions, Annuals and Quarterlies) from the resident's initial admission to the current one, did not assess the resident with the diagnosis of ID. The resident was coded with a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS). The resident had no behavioral or mood problems, nor did he refuse care.

The most recently revised care plan dated 7/21/17 identified the resident was verbally and mentally challenged but did not identify any additional suggested services to be provided based on the Level II screening conducted on 8/24/16.

On 7/27/17 at 1:30 p.m., an interview was conducted with the Minimum Data Assessment (MDS) Coordinator. She stated the MDS

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department care plans issues, as well as other interdisciplinary team members. The MDS Coordinator stated she did not know what PASRR referred to and needed to gain education on the subject and how to further assess and code the section. She said it would have had some bearing on further care planning and addressing his special needs.

On 7/27/17 at 5:16 p.m., an interview was conducted with the Administrator, Director of Nursing (DON), Corporate Administrator and Corporate Nurse. The Administrator and the DON stated they were not familiar with PASRR and would have to research the topic. The DON stated all conditions and care needs would be addressed on the resident's Person Centered Care Plan.

The facility's policy and procedure titled "Care Plans-Comprehensive" dated 9/2010 indicated "The resident's individualized care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident."

2. Resident #10 was originally admitted to the facility 6/6/16 and readmitted 8/16/16 after an acute hospitalization. The current diagnoses included high blood pressure and glaucoma.

The Significant Change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/11/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a

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F 280	Continued From page 24 possible 15. This indicated Resident #10's cognitive abilities for daily decision making were intact. Review of Resident #10's care plan meeting signature logs for 7/21/16, 10/20/16, 4/20/17 and 7/19/17 reveal the resident did not participate in the meetings. The notes on the 4/20/17 and 7/19/17 care plan meeting signature logs indicated the Resident and family were invited to the care plan meetings but did not choose to attend. The 7/21/16, 10/20/16 care plan meeting logs had no notes. During an interview with Resident #10 on 7/25/17 at 7:20 p.m. The Resident viewed the sample letter and stated he had never seen or received an invitation to any care plan meetings. An interview was conducted with the Social Worker on 7/27/17 at approximately 1:40 p.m. The Social Worker stated normally when a resident does not come to the conference room the interdisciplinary team goes to the resident's room and holds the meeting. She offered no explanation why this did not happen for Resident #10. 3. Resident #3 was originally admitted 7/13/16 and had never been discharged. The current diagnoses included cirrhosis, malnourishment, and chronic obstructive pulmonary disease. The quarterly MDS assessment with an assessment reference date (ARD) of 5/15/17 coded the resident as completing the Brief	F 280		

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F 280	Continued From page 25 Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #3's cognitive abilities for daily decision making was severely impaired. Review of the clinical record revealed a nurse's note dated 4/24/17 at 8:15 a.m.,which stated the certified nursing assistant (CNA) reported the resident was observed smoking a cigarette in his room. The nurse confiscated the smoking materials and notified social services. The social services note dated 4/24/17 at 11:31 a.m., which stated the resident was reminded of the smoking policy, a copy was given to the resident secondary to a CNA observing him smoking in his room and all smoking materials were confiscated. The note further stated the resident apologized and stated it would not happen again. Review of Resident #3 care plan revealed a care plan problem dated 2/7/17 and updated 5/18/17 which read; Smoker has not attempted to smoke in facility at this time. Has a significant documentation of smoking one pack a day prior to hospitalization. The goals read; "Resident will comply with smoking guidelines through the next review. Will maintain oxygen saturation levels." Some of the approaches included; smoking assessment on admission and as needed. instruct resident and responsible party of the facility smoking policy and procedure and remind resident of the smoking policy as needed. An interview was conducted with the Social Worker on 7/27/17 at approximately 1:40 p.m. The Social Worker stated the resident is no	F 280		

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longer allowed to keep his smoking materials. The Social Worker further stated staff stores Resident #3's smoking materials and distributes then to the resident at smoke breaks.

A review of the facility's document titled "Rules for Smoking" dated 7/1/17 revealed 4 rules. Rule #4 read "No smoking in rooms, only in designated areas. A note at the bottom of page one read "If you do not follow the rules, your smoking paraphernalia will be placed in a lock box at the nursing station.

The facility's policy titled "Smoking Policy" dated 12/2011 read at #8; "Any smoking related privileges, restrictions and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues".

On 7/27/17 at approximately 6:15 p.m., during the pre-exit debriefing the Director of Nursing stated the care plan should have been updated to reflect the resident was no longer an independent smoker.

4. Resident #18 was originally admitted to the facility 10/7/16 and has never been discharged from the facility. The current diagnoses included: hypertension, dementia, arthritis, high cholesterol and psychosis.

The quarterly MDS assessment with an assessment reference date (ARD) of 10/7/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #18

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cognitive abilities for daily decision making were intact.

Resident #18 was observed on 7/26/17 at approximately 11:50 a.m., outside on the patio with smoking materials. Resident #18 was smoking and aiding other residents by lighting their cigarettes.

Review of Resident #18's care plan revealed no care plan for smoking. Review of the facility's policy titled "Smoking Policy" dated 12/2011, 12 e read; "Residents with independent smoking privileges may not give smoking materials to other residents with restricted smoking privileges."

On 7/27/17 at approximately 6:15 p.m., the above findings were shared during the pre-exit debriefing with the Administrator, Director of Nursing, Corporate Administrator and the Regional Nurse Consultant. The Director of Nursing stated the Resident should have a care plan addressing smoking.

The facility staff presented a care plan to the surveyor on 7/27/16 at approximately 7:00 p.m., identifying the resident as an independent smoker.

The facility's policy titled "Care Plans - Comprehensive" dated 9/2010 read at #8 that assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes.

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F 280	Continued From page 28 The facility's policy titled "Care Plans - Interdisciplinary" at #3 reads that the resident, the resident's family and or the residents legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review and in the course of a complaint investigation the facility staff failed to follow professional standards of practice for one of 35 residents in the survey sample, Resident #25. The facility staff failed to transcribe the physician order for a sacral wound treatment to include Dakins solution from 10/13/16-10/24/16. The findings included: Resident #25 was originally admitted to the facility on 11/04/03, discharged to a local hospital on 05/23/16 through 05/27/16 after a fall resulting in right femur fracture; returned to facility on 05/27/16 then discharged to a local hospital on 10/24/16. Resident #25 did not return to the	F 281	F281 1. Resident #25 has been discharged from the facility. 2. Residents who have an order for treatment administration has the potential to be affected. 3. Wound Physician in-serviced on writing out physician orders on telephone order forms. Licensed nurses in-serviced on appropriate transcription of physician orders. 4. DON/designee will audit new orders transcription 3xs a week for 30days, then 2xs a week for 30days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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nursing facility. Diagnoses for Resident #25 included but not limited to: Sacral Pressure Ulcer (1), Type II Diabetes (2), Cerebrovascular Accident (CVA) (3), Anorexia (4), and Urinary Tract Infection (UTI) (5).

Resident #25's Quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 08/31/17 was coded 00 out of a possible 15 indicating severe cognitive impairment. Resident #25 was coded as requiring total dependence of one with personal hygiene and bathing, extensive assistance of two with bed mobility, transfer and dressing, extensive assistance of one with eating and toilet use for Activities of Daily Living care. Under section "G" for functional limitation in Range of Motion (ROM) was coded for impairment one side for both upper and lower extremity and under section "H" for bladder and bowel was coded for indwelling Foley (6) catheter always incontinent of bowel.

The MDS with an ARD of 08/31/17 under section "M" (Skin Condition - M0100) was coded: Resident has a stage 1 or greater pressure ulcer. Under section (M0150) at risk for developing pressure ulcers was coded yes, under section (M0210) for unhealed pressure ulcers was coded yes, under section (M0300) for having stage 3 (7) pressure ulcer and unstageable (8) pressure ulcer was coded yes. Under section (M0610) for dimension of unhealed stage 3 or 4 pressure ulcers or eschar was to identify the pressure ulcer with the largest surface area (length x width) was measured (4.5 cm x 3.0 cm x 0 cm). Under section (M0700) most severe tissue type for any pressure ulcer was coded 4 for eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be shorter or

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harder that an surrounding skin) and under section (M1200) for skin and treatments was coded for having pressure reducing device for chair and bed, turning /repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer care, application of nonsurgical dressings and applications of ointments/medications other than feet.

Resident #25's Comprehensive care plan documented resident with potential for further skin breakdown due to (d/t) decreased mobility, incontinent of bowel elimination and cognitive deficits. Resident has use of splints and pressure reductions devices; history of healed pressure ulcers with an unstageable to sacrum and right heel with ongoing treatments to sacrum and heel. The goal: to have no increase in size of pressure ulcer or signs or symptoms (s/s) infection by next review. Some of the intervention/approaches to manage goal included: wound nurse and Wound Physician as needed and treatment as ordered, pressure relief device as needed in bed and chair and assist with turning and positioning to relieve pressure on bony prominences as needed.

According to the nursing documentation on 05/28/16 at approximately 12:48 p.m., Resident #25 re-entered the facility on 05/27/16 with a stage II to sacrum measuring 1.5 cm x 0.5 cm x 0.1 cm; being pale red in color and no drainage but surrounding skin pink, closed but fragile.

On 07/27/17 at approximately 8:05 a.m., an interview was conducted with LPN #6 who stated she remembered (name of Resident #25) having a pressure ulcer to her heel but was not sure which heel and a wound to a sacrum but can't tell you anything else about (name of Resident #25).

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The surveyor asked if she remembered anything about the sacral wound and she replied "No."

An interview was conducted with Assistant Director of Nursing (ADON) on 07/27/17 at approximately 8:30 a.m., who stated "I don't remember anything about 9name of Resident #25); I never laid eyes on her."

A phone call was placed to LPN #13 on 07/27/17 at 9:00 a.m., who cared for Resident #25 on 10/24/16, a message was left, LPN never called back.

A phone call was placed to LPN #14 on 07/27/17 at 9:10 a.m., who cared for Resident #25 on 10/20/16, a message was left, LPN never called back.

An interview was conducted with LPN #8 on 07/27/17 at approximately 8:45 a.m., who stated she remembered that (name of Resident #25) had a wound to her sacrum; about the size of a lime. The LPN also stated she remembered the wound had a smelly odor and was on a low air loss mattress (9). She proceeded to say the Resident needed help with bed mobility and repositioning and wore boots to both feet, she believed they were the blue ones, Prevalon boots (10). The surveyor reviewed with LPN #8 nurse's notes written by her on 12/22/16 at approximately 1:46 p.m., who documented the following, "Alert and verbally responsive, antibiotics for sacral wound day 9, no reactions, Foley catheter intact draining clear yellow urine, turned/repositioned every 2 hours and temp 97.6." The surveyor stated, "I didn't see from your nurse's notes that Resident #25's sacral wound presented with an odor as previously mentioned, she replied "I only

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work here labor pool, I guess I just forgot to chart it but I do remember, her sacral wound definitely had an odor."

Resident #25's sacral wound was being assessed and monitored by the wound care specialist weekly starting on 06/02/16 through 10/20/16:

On 06/02/16 the wound care specialist documented the sacral pressure ulcer as a stage 3 measuring 2.5 cm x 2 cm x 0.1 cm with a surface area of 5.00 cm2 and having light serous exudate with 100% granulation tissue.

On 06/09/16 the wound care specialist documented the sacral pressure ulcer is now an unstageable with necrosis measuring 5 cm x 5 cm x 0.1 cm with a surface area of 25.00 cm2 and having light serous exudate with 90% yellow necrotic and 10% granulation tissue. The wound progress had deteriorated due to generalized decline of patient. Recommendation to Off-Load wound and reposition per facility policy and Pre-Albumin (14) level.

The wound care specialist documented Resident's sacral wound pressure ulcer had improved on the following days: 06/16/16, 06/23/16, 06/30/16, 07/14/16, 07/21/16, 07/28/17, 08/05/16, 08/11/16, and 08/18/16.

On 08/25/16 the wound specialist documented the sacral wound pressure ulcer as stage 3 measuring 0.6 cm x 0.5 cm x 0.1 cm. The wound progress with no change but now has hyper-granulation (15) tissue present within the wound margins. The sacral wound had a surfaced area of 0.30 cm2 with light serous exudate and 100% granulation tissue. The

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procedure performed by the wound doctor is as follows: Chemical Cauterization (16) of hyper-granulation tissue performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding.

On 09/1/16 the wound specialist documented the sacral pressure ulcer as stage III measuring 0.2 cm x 0.2 cm x 0.1 cm. The wound progress indicated improvement by decreased surface area 0.04 cm2 with light serous exudate, 100% granulation tissue with epiboly (rolled wound edges) present within the wound margins. The procedure performed by the wound doctor is as follows: Chemical Cauterization of epiboly performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding. Treatment remains unchanged.

On 09/08/16 the wound specialist documented the sacral wound pressure ulcer remains at a stage 3 measuring 0.1 cm x 0.1 cm x 0.1 cm. The wound progress indicated improvement by decreased surface area at 0.01 cm2 with light serous exudate and 100% granulation tissue with epiboly present within the wound margins. The procedure performed by the wound doctor is as follows: Chemical Cauterization of epiboly performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding. Treatment remains unchanged.

On 09/15/16 the wound specialist documented the sacral wound pressure ulcer remains at a stage III measuring 0.1 cm x 0.1 cm x 0.1 cm. The surface area is 0.01 cm2 with light serous exudate and 100% granulation tissue but now with abnormal granulation present within the wound margins. New treatment to sacral wound

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as follows: skin prep periwound, apply Silver Hydrogel (17) and cover with dry protective dressing daily. Chemical Cauterization of abnormal granulation performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding.

On 09/22/16 the wound specialist documented the sacral wound pressure ulcer as stage 3. The wound progress has decreased due to generalized decline of patient measuring 3 cm x 4 cm x 0.1 cm with a surface area of 12.00 cm2, maceration to periwound, without any exudate, 30% yellow necrotic tissue, 30% of granulation tissue and 40% skin. Additional information indicated Resident #25 noted to have recent frequent loose stools, which may have contributed to wound deterioration. Wound debrided via surgical excision and subcutaneous tissue removed along with necrotic disuse. New treatment to sacral wound as follows: skin prep to peri-wound, apply Hydrocolloid (18) every three days and as needed.

On 09/29/16 the wound specialist documented the sacral wound pressure ulcer as stage III. The wound progress has decreased due to increased surface area measuring 3.5 cm x 4 cm x 0.1 cm with a surface area of 14.00 cm2 with maceration to periwound radius, light serous exudate, 40 yellow necrotic tissue, 10% granulation and 50% skin. New treatment to sacral wound as follows: skin prep periwound, apply Santyl and cover with dry protective dressing daily. The recommendation is as follow: continue off load wound, reposition per facility's policy, and suspect deterioration secondary to Urinary Tract Infection (UTI). The procedure performed by the wound doctor is as follows: wound debrided via surgical

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F 281	Continued From page 35 excision and subcutaneous tissue removed along with necrotic disuse. On 10/06/16 the wound specialist documented the sacral wound pressure ulcer as stage 3. The wound progress had improved due to decreased surface area. The wound measured 3 cm x 4 cm x 0.1 cm with a surface area of 12.00 cm2, light serous exudate with 40% of yellow necrotic tissue, 10% granulation tissue and 50% skin. The sacral wound was surgically debrided removing necrotic tissue and establish the margins of the viable tissue. The dressing treatment to sacral wound included the following: Skin Prep to periwound, apply Santyl, cover with dry protective dressing daily. On 10/13/16 the wound specialist documented the sacral wound pressure ulcer as stage 3. The wound had deteriorated due to infection. The wound measured 4 cm x 5 cm x 0.1 cm with a surface area of 20.00 cm2, light purulent exudate with 100% yellow necrotic tissue with red periwound radius. The sacral wound was surgically debrided removing necrotic tissue and establish the margins of the viable tissue. The dressing to sacral wound changed to the following: skin prep to peri-wound, apply Santyl, apply Dakins (21) moistened gauze and cover with dry protective dressing. The recommendation was to use Group 2 Mattress (Low Air Loss Mattress), and start antibiotics: Doxycycline (22) 100 mg by mouth twice daily x 14 days for infection. On 10/20/16 the wound specialist documented the sacral wound pressure ulcer as unstageable with necrosis. The wound had deteriorated due to generalized decline of patient. The wound	F 281		

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measured 7 cm x 6 cm x 0.1 cm with a surface area of 42.00 cm2, moderate serous exudate with 100% yellow necrotic tissue with odor present. The sacral wound was surgically debrided removing necrotic tissue and establish the margins of the viable tissue. The dressing to sacral wound included the following: skin prep to peri-wound, apply Santyl, apply Dakins moistened gauze and cover with dry protective dressing.

According to Resident #25's clinical record review, a stool specimen was obtained on 09/23/17 to rule out (r/o) Clostridium Difficle Infection (C-Diff) (19) related to (r/t) diarrhea. Stool results returned on 09/23/16 with negative results.

New order obtained on 09/29/17 for Cipro (20) 500mg by mouth every 12 hours x 14 days for Urinary Tract Infection.

The clinical record review for October 2016 Treatment Administration Record (TAR) did not indicate the physician order for 10/13/16 was transcribed for the following order: Skin prep to periwound, apply Santly, apply Dakins moistened qauze and covered with protective dressing daily.

An interview was conducted with the wound care specialist on 07/27/17 at approximately 11:25 a.m., to discuss the ongoing treatment of Resident #25's sacral pressure ulcer. During the interview with the wound specialist, the surveyor stated, "I didn't see an evaluation on the sacral wound ulcer for 07/07/16," the wound specialist stated, "I must was gone for a week during that time." Related to sacral wound evaluation on

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10/13/16, she stated, "I felt like the deterioration was due an infection in the sacral wound but not suspicious of osteomyelitis (23) because the wound was superficial and that Resident #25's sacral wound was an unstageable and not a stage 3 on 10/13/16. The surveyor asked what is Dakins solution and why is it used on wounds, the wound care specialist replied, "Dakins is nothing but diluted bleach and the purpose is to decrease bacterial growing in the wound." The surveyor asked how is Dakins solution typically used, she replied, "The gauze is typically moistened with the Dakins solution and placed into the wound on top of the Santyl and covered with a dry dressing. The wound care specialist proceeded to say that Dakins will kill anything left behind in the wound. She stated, "I wanted to continue with the Santyl and Dakins treatment since it had only been one (1) week. The wound specialist proceeded to say she saw a significant change in the progress of the sacral wound which required a more extensive debridement. The surveyor asked the wound care specialist how significant was the Dakins solution in managing the sacral wound, she replied, "Very important, I have seen great results when using Santyl and Dakins together. The Doxycycline is a great systemic antibiotic and Dakins is great topically because it kills bacteria."

The surveyor informed the wound care specialist that after reviewing Resident #25's Treatment Administration Record (TAR) for October 2016, the order written on 06/13/16 to apply skin prep to peri-wound, apply Santyl then apply Dakins moistened gauze and cover with dry protective dressing daily was never transcribed indicating the treatment to add Dakins solution was never started to the sacral wound. The surveyor asked

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the wound care specialist, "How important was the Dakins solution to sacral wound treatment" she replied "Dakins never added, that's an issue unfortunately, Dakins was a significant form of treatment in managing the sacral wound for infection." The surveyor asked, "What is your expectations when you write wound care orders," the wound specialist stated, "I expect for the orders to be transcribed as ordered," the surveyor asked if she was informed the order written on 10/13/16 to add Dakins was never transcribed to the October 2016 TAR, she replied, "No, I had no idea the Resident#25 wasn't receiving the Dakins to her sacral wound." The wound specialist proceeded to say that the nurse making wound rounds is always communicated verbally of all new orders that's going to be written that day, and a copy of the wound progress report that includes all new orders is also emailed to the Director of Nursing (DON) and the wound nurse. The surveyor asked, "When is the wound progress report available for review", she replied, "The same day, everything is completed the same day before I leave the facility." The surveyor informed the wound specialist on 07/27/17 that Resident #25 was sent out to the hospital after a fall on 10/24/16 and her final diagnosis was sepsis from her sacral wound and that Resident #25 expired on 10/31/16. The wound care specialist was informed that the treatment started to the sacral wound at the local hospital was to use Dakins, the same treatment that was initially ordered on 10/13/16 but was never started." The wound care specialist stated, "The Dakins to the sacral wound could have made a difference in her outcome, she then stated: "Oh Wow, 12 days with no Dakins; the Dakins would have been her best chance to fight her wound infection - absolutely but unfortunately."

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The nurse's note dated 10/25/16 at approximately 5:27 a.m., indicated Resident #25 was sent out to local Emergency Room (ER) for evaluation after falling out of bed on 10/24/16.

The local ER/hospital note for 10/24/16 indicated resident #25 arrived to the ER at 6:54 p.m. The ER diagnosis included but not limited to: Sacral decubitus ulcer, fall - initial encounter and hypoglycemia.

The local ER/Hospital information dated on 10/24/16 included but not limited to: Integumentary: Patient has a very large 5 cm round sacral ulcer that is all the way down to the bone, appears to be dark brown or necrotic tissue within that ulcer. There is a smaller shallow ulcer over the left buttock without cellulitis surrounding it, but there is purulent drainage that is expressed. It has a foul odor. Impression and Management Plan included but not limited to: wound culture of the large sacral ulcer.

The local ER/Hospital information dated on 10/24/16 included but not limited to: #1 evaluation after fall: Ct head and C-spine are negative for acute findings. X-ray of the hip does not show a current fracture, #2- a very large foul-smelling stage IV (intravenous) sacral decubitus that when pressed expresses purulent drainage. We have cultured it and ordered IV Vancomycin (24) and Zosyn (25), #3-Hypoglycemia (low blood sugar): Blood sugar 52 given IV D50 and then started on D5 half-normal saline infusion. Recheck blood sugar 82. Patient will need to be admitted for treatment of this very large foul-smelling sacral decubitus.

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On 10/25/16 at 3:13 p.m., the local Hospital Wound Nurse Progress Note documented the following but not limited to:
Situation: Wound Consult
Background: Medical patient with Braden (for predicting pressure sore risk) Score of 12/23. Patient has history of Type 2 Diabetes, Hyperlipidemia, Hypertension and CVA. Patient is a resident of local nursing home. She was admitted with sacral wound.
Assessment: There is a necrotic unstageable pressure wound to the sacrum which measures 6.7 cm x 7.5 cm x 2.4 cm with undermining circumferentially to 0.8 cm. The wound base is essential 100% black with necrotic odor. The periwound is denuded.
Recommendation: Would recommend ¼ strength Dakins damp gauze dressings twice daily to sacral wound for now. Surgical debridement would be preferable.

The infectious disease follow up noted from the local hospital dated 10/28/16 at 1:08 p.m., indicated Resident #25's sepsis was from the infected unstageable sacral decubitus which was Present on Admission (POA).

On 10/28/16 at 4:21 p.m., the local Hospital progress note documented the following: Postoperative Diagnoses included sacral pressure ulcer, stage 4 and sacral osteomyelitis. Following excisional debridement, the wound measured 12 cm x 8 cm x 3 cm with bone at the base of wound. Following irrigation and confirmation of adequate hemostasis, the wound was then packed with Kerlix (wovēn gauze) soaked in ¼ -strength Dakin's.

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The facility administration was informed of the finding during a briefing on 07/27/17 at approximately 5:15 p.m. The Director of Nursing (DON) was asked what is the facility process and procedure for following up on orders written by the wound care specialist, the DON replied, "The wound specialist will send out an email to me and the wound care nurse and also gives a verbal to the nurse making rounds with the wound specialist. The night shift will review all new orders written for that day to make sure they have been transcribed and put on the MAR or TAR." The surveyor asked if the night shift reviews the progress report written by the wound care specialist for new orders, she replied, "No". The DON proceeded to say; moving forward the wound specialist will be writing all new orders and then give them orders the nurse to transcribe to the MAR or TAR.

Definitions:

1. Pressure Injury: A pressure injury is localized damage to the skin and 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 (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)

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

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

4. Anorexia is the lack or loss of appetite, resulting in the inability to eat (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition).

5. UTI is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney (http://www.cdc.gov/HAI/ca_uti/uti.html).

6. Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html).

7. Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)

8. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue

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F 281	Continued From page 43 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 the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) 9. Low air loss mattress is an alternating pressure mattress systems are designed to heal and prevent bed sores (http://www.medicalairmattress.com/deluxe.html). 10. Prevalon boots helps minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals. By off-loading the heel, it delivers total, continuous heel pressure relief (www.hdis.com/prevalon-boot-heel-protector.html). 11. Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/). 12. Hydrogel is ideal for dry-to-moist clean wounds. Helps create a moist wound environment. Balanced formulation Easy irrigation Indications: pressure ulcers, partial and full-thickness wounds, leg ulcers, surgical wounds, lacerations, abrasions and skin tears, and first- and second-degree burns (www.medline.com/product/Skintegrity-Hydrogel/	F 281		

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F 281	Continued From page 44 Gel/Z05-PF00182). 13. Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts. 14. Prealbumin is a protein in the body and can be measured with a blood test. This protein tells about nutritional status (https://www.drugs.com/cg/prealbumin.html). 15. Hyper-granulation (or overgranulation) is an excess of granulation tissue beyond the amount required to replace the tissue deficit incurred as a result of skin injury or wounding (https://www.ncbi.nlm.nih.gov/pubmed/20335928). 16. Cauterization is the process of burning a part of the body cautery. A cautery is a device or agent used in the coagulation of tissue by heat or caustic substances (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition). 17. Silver Hydrogel is a wound dressing for lightly draining wounds that are in need of an antimicrobial barrier. Silvasorb harnesses the power of ionic silver. This wound gel releases silver at a controlled level for broad spectrum antimicrobial action, without harming tissue cells (https://www.exmed.net/p-3251-medline-silvasorb-hydrogel-silver-antimicrobial-wound-gel.aspx).	F 281		

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F 281	Continued From page 45 18. Hydrolloid dressings are occlusive or semi-occlusive dressings consisting of a combination of gel-forming polymers that absorb exudate slowly by swelling into a gel-like mass (http://woundeducators.com/hydrocolloid-dressings). 19. C-Diff is a bacterium that causes diarrhea (https://medlineplus.gov/clostridiumdifficileinfections.html). 20. Cipro is an antibiotic used to treat urinary tract infections (https://medlineplus.gov/druginfo/meds/a682514.html). 21. Dakins solution is used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. It is also used before and after surgery to prevent surgical wound infections. Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation (healthcentral.com/skin-care/medications/dakin-misc-62261/uses) 22. Doxycycline is used to treat bacterial infections; it works by preventing the growth and spread of bacteria (https://medlineplus.gov/druginfo/meds/a682514.html). 23. Osteomylitis is a local or generalized infection of bone and bone marrow. It is usually casued by bacterial introduced by trauma or surgery (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition).	F 281		

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F 281	Continued From page 46 24. Vancomycin is used alone or in combination with other medications to treat certain serious infections such as skin, blood, and bones. It works by killing bacteria that cause infections (https://medlineplus.gov/druginfo/meds/a601167.html). 25. Zosyn is an antibiotic used treat pneumonia and skin and infections caused by bacteria (https://medlineplus.gov/druginfo/meds/a601167.html).	F 281		
F 285 S=E	COMPLAINT DEFICIENCY 483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual	F 285		

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F 285	Continued From page 47 disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 285		

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paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

(k)(4) A nursing facility must notify the state mental health authority or state intellectual

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F 285	Continued From page 49 disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interview and facility documentation review, the facility staff failed to incorporate the recommendations from the PASRR level II determination and evaluation report into a resident's assessment, care planning and transitions of care for 1 of 35 residents (Resident #17) with a diagnosis of Intellectual disability (ID). The findings include: 1. Resident #17 was admitted on 3/12/15 with diagnosis that included but not limited to Mild Intellectual Disability (ID). Review of the most recent Minimum Data Set (MDS) assessment dated 7/21/17 was a quarterly which did not assess Resident #17 with the diagnosis of ID, thus subsequent prompted sections were not completed, A1510 and A1550 . Also, the previous MDS assessments (Admissions, Annuals and Quarterlies) from the resident's initial admission to the current one, did not assess the resident with the diagnosis of ID. The resident was coded with a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS). The resident had no behavioral or mood problems, nor did he refuse care. The most recently revised care plan dated 7/21/17 identified the resident was verbally and mentally challenged but did not identify any additional suggested services to be provided	F 285	F285 1. Resident #17 MDS modification completed, care plan updated and community services available offered to resident. 2. Residents who have PASRR assessment for level 2 has the potential to be affected. 3. Social services/MDS and nursing administration will be in-serviced on PASRR assessment significance, updating care plans, and PASRR recommendation follow up. 4. Social service will monitor PASRR assessments, recommendations, any follow up needed and care plan updating 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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F 285	Continued From page 50 based on the Level II screening 8/24/16. On 7/26/17 at 2:00 p.m., when asked of the Administrator for all PASRR (Preadmission Screening and Resident Review) Level I and if applicable Level II screenings, based on Resident #17's diagnosis of ID, he stated he was not aware of what this surveyor was asking for or the significance of such screenings. Further inquiry of the request for the PASRR documents led to the Medical Records Coordinator and Director of Social Work (DSW) on 7/27/17 at 12:30 p.m. who presented all level I and level II screenings. All of them were obtained from the residents' purged chart. The Level II PASRR identified the resident had mild ID and cerebral palsy as a related condition. The recommendations dated 8/24/16 indicated the resident could benefit services in the community of lesser intensity, referring to just nursing home care and services. The recommendations indicated the following: "Targeted case management is recommended to connect with supportive services and explore the potential for discharge to the community, should he and his family desire for him to do so. Collaboration with the local Community services Board may be helpful in identifying services that may allow (Resident #17's name) needs to be met in a less restrictive environment. A resident review is recommended in 180 days to assess his status at that time and identify any additional supports needed." Further discussion with the DSW stated she had been the DSW a little over a year and dropped the ball on following through with the Level II recommendations. She stated until surveyor inquiry, she had not seen or reviewed the August 24,2016 Level I of Level II screening	F 285		

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F 285	Continued From page 51	F 285		

and she was not told anything by the previous DSW, nor was it discussed by Administration. She stated she did not complete A1500, A1510 or A1550 of the MDS, but she was well familiar with what to do because she worked with the ID population in the past. The DSW stated she would do a preliminary search to see what would be available for the resident in the community and talk to the resident. She returned with two possible day classes and an appointment with the Community Service Board. The DSW stated the resident was not on any psychotropic medications and there were no Psychiatric evaluations.

On 7/27/17 at 1:30 p.m., an interview was conducted with the Minimum Data Assessment (MDS) Coordinator. She stated she did not complete the section of A1500, A1510 and A1550 and thought the Social Worker completed those sections. A closer examination of the aforementioned sections revealed MDS department completed them. The MDS Coordinator stated she did not know what PASRR referred to and needed to gain education on the subject and how to further assess and code the section. She said it would have had some bearing on further care planning and addressing his special needs, but they did not coordinate any of the assessment sections for ID. She stated she would refer to the Resident Assessment Instrument (RAI) manual to help her understand how to complete the sections that refer to PASRR.

On 7/27/17 at 5:16 p.m., an interview was conducted with the Administrator, Director of Nursing (DON), Corporate Administrator and Corporate Nurse. The Administrator and the DON stated they were not familiar with PASRR and

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F 285	Continued From page 52	F 285		

would have to research the topic. They stated they had not seen the level I or Level II screening evaluation and did not know what it was or that they needed to review it. The Corporate nurse stated, "The purpose of the PASRR is to identify residents with mental illness or Intellectual Disability (ID) from the Level I screening leading to the Level II screening and provide any services outside of the nursing home that even may lead to integration into the community or day support services." They further stated they would start from keeping Level I and Level II assessments on the chart, making sure social services would assess the A1500, A1510 and A1550 that would trigger evaluation and seeking out additional outside services. They stated there had not been any arrangements to collaborate with the local Community Service Board (CSB), nor had they invited this entity to participate in care planning.

On 7/26/17 at approximately 3:00 p.m., the resident was observed in a wheelchair. The resident's right arm was in a splint and contracted in a 90 degree angle. The resident was able to actively initiate and sustain conversation.

On 7/27/17 at approximately 3:45 p.m., the resident was observed in bed. He was an accurate historian of how he use to work and fold clothes and where he participated in other day programing before he was in the hospital and was admitted to the nursing home, even the street name. He was able to remember past CSB case worker names and stated if he had their phone numbers he would call them. He further accurately stated where he lived before the hospitalization and his Resident Representative (RR). The resident called out the names of nurses, aides, social worker and read the name

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F 285	Continued From page 53 off the badge of the aide that came to check on him during the interview with this surveyor. He spoke about the reason he was in the hospital due to breaking his right leg in 2015, that required a rod and physical therapy. He stated, "I would love to go out of the building and do other things, but did not know I could do anything but be here. No one here came to talk about that. I had a care plan meeting yesterday and they didn't tell me I had a chance to maybe go back to the place I was at before or another place. I won't turn down anything they think I am ready for." The facility's policy and procedure titled "Coordination with PASRR Program" dated 2016 indicated "This facility coordinates with the Preadmission Screening and Resident Review (PASRR) program under Medicaid to the maximum extent practicable to avoid duplicate testing and effort. All individuals with a mental disorder or intellectual disability (ID) who the State mental health or ID authority has determined as appropriate for admission. Recommendations, such as specialized services from a PASRR Level II determination and/or PASRR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care."	F 285		
F 287 SS=E	483.20(f)(1)-(4) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (f) Automated Data Processing Requirement (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 287		

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F 287	Continued From page 54 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting Data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data Format. The facility must transmit data	F 287		

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F 287	Continued From page 55 in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to assure prompt encoding and transmittal of an MDS (Minimum Data Set) to the Centers for Medicare and Medicaid (CMS) System for 9 of 35 residents in the survey sample, Residents #23, #26, #27, #28, #29, #30, #31, #32 and #33. The facility staff failed to encode (1) and transmit (2) an MDS Discharge assessment according to Federal time frames for nine (9) Residents #23, #26, #27, #28, #29, #30, #31, #32 and #33. The findings included: A review of the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act Assessment) Report was conducted on 7/25/17. Nine discharge residents were identified on the report as missing OBRA Discharge assessments as follows: 1. Resident #23 was admitted on 9/10/15 with a stroke and high blood pressure. The resident was discharged from the nursing facility on 9/28/16 with return not anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Annual with an assessment reference date of 9/19/16. There was no Discharge MDS found in the resident's record.	F 287	F287 1. Residents #23, #26, #27, #28, #29, #30, #31, #32, #33 MDS were encoded and transmitted. 2. Residents who MDS is due for submission has the potential to be affected. 3. MDS coordinators will be in-serviced on encoding and transmitting MDS timely. 4. MDS/Designee will monitor MDS schedule validation report and missing OBRA assessment report 3xs a week for 30 days, then 2xs a week for 30days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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F 287	Continued From page 56 The facility staff failed to encode and electronically transmit any MDS assessments after 9/19/16 to include a discharge MDS to the QIES ASAP System (2) (the National Data Base for the Centers for Medicare and Medicaid-CMS) for Resident #23. 2. Resident #26 was admitted on 11/29/16 with uterine and pelvic inflammation and infection. The resident was discharged from the nursing facility on 12/30/16 with return not anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Admission with an assessment reference date of 12/6/16. There was no Discharge MDS found in the resident's record. The facility staff failed to encode and electronically transmit any MDS assessments after 12/6/16 to include a discharge MDS to the QIES ASAP System for Resident #26. 3. Resident #27 was admitted on 1/24/17 with severe sepsis and shock. The resident was discharged from the nursing facility on 1/25/17 with return not anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Entry with an assessment reference date of 1/24/17. There was no Discharge MDS found in the	F 287		

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F 287	Continued From page 57 resident's record. The facility staff failed to encode and electronically transmit any MDS assessments after 1/24/17 to include a discharge MDS to the QIES ASAP System for Resident #27. 4. Resident #28 was admitted on 1/23/07 with a readmission date of 4/5/16 with diagnosis of unspecified Atrial fibrillation (abnormal heart rhythm). The resident was discharged from the nursing facility on 11/12/16 with return anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was a Quarterly with an assessment reference date of 10/12/16. There was no Discharge MDS found in the resident's record. The facility staff failed to encode and electronically transmit any MDS assessments after 10/12/16 to include a discharge MDS to the QIES ASAP System for Resident #28. 5. Resident #29 was admitted on 11/02/16 with admission diagnosis of altered mental status. The resident was discharged from the nursing facility on 11/26/16 with return not anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Admission with an assessment reference date of 11/09/16 with return not anticipated.	F 287		

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F 287	Continued From page 58 There was no Discharge MDS found in the resident's record. The facility staff failed to encode and electronically transmit any MDS assessments after 11/09/16 to include a discharge MDS to the QIES ASAP System for Resident #29. 6. Resident #30 was admitted on 9/29/08 with a readmission date of 2/23/17 with admitting diagnosis of viral enteritis (inflammation of the intestines). The resident was discharged from the nursing facility on 3/29/17 with return not anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Admission with an assessment reference date of 3/2/17. There was no Discharge MDS found in the resident's record. The facility staff failed to encode and electronically transmit any MDS assessments after 3/2/17 to include a discharge MDS to the QIES ASAP System for Resident #30. 7. Resident #31 was admitted on 8/4/16 with a readmission date of 2/2/17 with diagnosis of urinary tract infection. The resident was discharged from the nursing facility on 3/23/17 with return not anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Admission with an assessment reference date of 2/9/17.	F 287		

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F 287	Continued From page 59 There was no Discharge MDS found in the resident's record. The facility staff failed to encode and electronically transmit any MDS assessments after 2/9/17 to include a discharge MDS to the QIES ASAP System for Resident #31. 8. Resident #32 was admitted on 1/26/17 with diagnosis of a stroke. The resident was discharged from the nursing facility on 3/24/17 with return not anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Admission with an assessment reference date of 2/2/17. There was no Discharge MDS found in the resident's record. The facility staff failed to encode and electronically transmit any MDS assessments after 2/2/17 to include a discharge MDS to the QIES ASAP System for Resident #32. 9. Resident #33 was admitted on 10/7/16 with diagnosis of a stroke. The resident was discharged from the nursing facility on 11/3/16 with return anticipated. According to the MDS 3.0 Missing OBRA Report the resident's last transmitted MDS assessment was an Admission with an assessment reference date of 10/14/16. There was no Discharge MDS found in the resident's record.	F 287		

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F 287	Continued From page 60 The facility staff failed to encode and electronically transmit any MDS assessments after 10/14/16 to include a discharge MDS to the QIES ASAP System for Resident #33. An interview was conducted with the MDS Coordinator on 7/25/17 at 4:15 p.m. The 3.0 Missing OBRA Assessment Report that identified the nine Residents was shared. She stated that today was the first time she had ever pulled a Missing OBRA Report. She further stated that there was a change in personnel in the MDS department and stated, "getting discharge MDS's done in a timely fashion" had been an issue. She stated she would follow up as to why these nine residents were on the Missing OBRA Assessment Report. On 7/26/17 at 5:50 p.m., The MDS Coordinator returned to say that the nine residents (Resident's #23, #26, #27, #28, #29, #30, #31, #32 and #33) were on the Missing OBRA Assessment Report because they did not have a discharge MDS. She stated they have now all been coded and transmitted except for Resident #33. She stated the facility's system was not allowing the transmission and she is awaiting a call back from the State Survey Agency to obtain further assistance. The above findings was shared with the Administrator, the Corporate Administrator, the Director of Nursing and the Regional Director of Clinical Services during a pre-exit meeting conducted on 7/27/17 at 5:15 pm. The CMS RAI 3.0 Manual dated October 2016 chapter 2: Assessment for the RAI (Resident Assessment Instrument) OBRA Discharge	F 287		

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F 287	Continued From page 61 Assessment read, in part: "OBRA Discharge assessment consist of discharge return anticipated and discharge return not anticipated. 09. Discharge Assessment-Return Not Anticipated 1. Must be complete when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. 2. Must be completed within 14 days after the discharge date. 3. Must be submitted within 14 days after the MDS completion date. 10. Discharge Assessment-Return Anticipated 1. Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged. 2. Must be completed within 14 days after the discharge date. 3. Must be submitted within 14 days after the MDS completion date." Definitions obtained from the CMS RAI Version 3.0 Manual 1. Encode-"Encoding" means entering MDS information into a computer. 2. Transmitting data" refers to electronically sending encoded MDS information, from the facility to the QIES ASAP System (Quality Improvement and Evaluation System Assessment Submission and Processing System), using a	F 287		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 287	Continued From page 62 modem and communications software.	F 287		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

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F 309	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on resident interview, observations, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow physician orders for 2 of 35 Residents in the survey sample, Resident #34 and Resident #23 . The findings included: 1. Resident #34 was admitted to the facility on 11/16/16. Diagnoses for Resident #34 included but are not limited to Heart Failure (2), Benign Prostatic Hyperplasia (3) (BPH), Manic Depression (4) (Bipolar Disease), Chronic Obstructive Pulmonary Disease (5) (COPD), Difficulty in Walking, Patient Non-Compliance with Medical Treatment, Diabetes Type II (6), Presence of Automatic Implantable Cardiac Defibrillator (7) and Cellulitis (8) of Lower Legs. Resident #34's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 7/21/17 coded Resident #34 with a BIMS (Brief Interview for Mental Status) score of 15 of 15 indicating no cognitive impairment. In addition the Quarterly MDS scored Resident #34 to require extensive assistance with two staff person assistance in bed mobility and transfer. Resident #34 was coded to require limited assistance with one staff person assistance for dressing and personal hygiene. Resident #34 was coded to require extensive assistance with one staff person assistance for toilet use and bathing.	F 309	F309 1. Resident #34 assessed for shortness of breath and offered PRN Proventil for relief as needed per physician order. Resident #23 has been discharged from facility. 2. Residents who experience shortness of breath and those residents who have physician orders for vital signs every shift and weekly skin assessments have potential to be affected. 3. Facility licensed nurses will be in-serviced on medication administration, including PRN meds, completing skin assessments and following physician orders. 4. DON/designee will audit MAR/TAR, skin assessment completion 3xs a week for 30 days, then 2xs a week for 30days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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Resident #34's Medication Orders documented the following:

4/22/17 Order: Eucerin cream Application topically to dry skin daily.

4/25/17 Order: Aquaphor Apply to dry areas on face and neck twice daily for dry flaky skin.

6/28/17 Order: Spiriva 2 puffs via inhalation daily for COPD.

4/19/17 Order: Proventil 2 puffs by mouth every four hours as needed for wheezing and shortness of breath.

5/20/17 Order: Breo Ellipta Inhalation 100-25 1 puff by mouth daily.

Resident #34's Care Plan documented the following Problem areas and interventions: 3/22/17 Refuses Care then complains staff does not care for him: Interventions: Explain benefits versus risk of refusal, Administer medication as ordered by physician.

3/21/17 Like to pick and choose the medications that I take and sometimes refuses care that is offered by the staff: Interventions: explain implications/possible consequences of continued resistance to care,

On 7/26/17 at approximately 5:27 p.m., the Facility Social Worker (SW) assisted Resident #34 to get his wheel chair to the Restorative Nursing Room, as Resident was complaining of Shortness of Breath. It was observed that no

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PRN Proventil was offered Resident #34 in the next approximate 2 hours.

On 7/27/17 at approximately 11:30 a.m. during a meeting with the Director of Nursing, Resident #34 was observed to stop talking as he was short of breath. After rest the resident resumed talking only to require stopping again due to shortness of breath. The DON (Director of Nurses) did not offer Resident #34 his PRN Proventil. Part of the meeting discussion was that Resident #34 was not getting his inhalers.

Observation of Resident #34's July MAR 2017 (Medication Administrator Record) documented he received his routinely scheduled inhalers of Spireva and Breo. The MAR documented that Resident #34 has received no PRN Proventil. Resident #34 complained that he was not getting the new inhaler the Doctor had prescribed to him during a meeting on 7/26/17 at approximately 5:26 p.m..

Review of the July 2017 Eucerin Cream application topically to dry skin patch daily noted on 7/6/17 and 7/11/17 no documentation as to reasons for this not being done.

Aquaphor ointment apply to dry areas on face and neck twice daily for dry flaky skin was not documented as applied on 7/6/17 morning and 7/7/17 evening with no documentation as reason why not done.

On 7/27/17 at approximately 2:00 p.m., Resident #34 stated, I'm finally getting the treatment done to my legs. Resident #34's TAR for July 2017 documented there had been no gaps for treatments to his legs.

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An interview with the Director of Nursing on 7/27/17 at approximately 3:00 p.m. was done. The DON was asked if she had every observed Resident #34 short of breath in the last month. The DON stated, "Yes". The DON was asked if she offered Resident #34 his PRN Proventil inhaler, and the DON stated she had. The DON was asked if she documented her administration of PRN Proventil inhaler and she stated, "No."

The facility administration was informed of the findings during a briefing on 7/27/17 at approximately 5:15 p.m. The facility did not present any further information about the findings.

COMPLAINT DEFICIENCY

DEFINITIONS

(1) Proventil: Medline Plus documented: Albuterol is used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways). Albuterol is in a class of medications called bronchodilators. It works by relaxing and opening the air passages to the lungs to make breathing easier.

(2) Heart Failure: Medline plus documented: Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs.

(3) Benign Prostatic Hyperplasia: Medline plus documented: The prostate is a gland in men. It helps make semen, the fluid that contains sperm. The prostate surrounds the tube that carries urine

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out of the body. As men age, their prostate grows bigger. If it gets too large, it can cause problems.

(4) Manic Depression/Bipolar: Medline plus documented: Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes.

(5) Chronic Obstructive Pulmonary Disease: Medline Plus documented: COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema.

(6) Diabetes Type II: Medline Plus documented: your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood.

(7) Cardiac Defibrillator: An arrhythmia is any disorder of your heart rate or rhythm. It means that your heart beats too quickly, too slowly, or with an irregular pattern. Most arrhythmias result from problems in the electrical system of the heart. If your arrhythmia is serious, you may need a cardiac pacemaker or an implantable cardioverter defibrillator (ICD).

(8) Cellulitis: Cellulitis is an infection of the skin and deep underlying tissues. Group A strep (streptococcal) bacteria are the most common cause. The bacteria enter your body when you get an injury such as a bruise, burn, surgical cut, or wound.

2. Resident #23 was admitted to the facility on 9/10/15. Diagnoses for Resident #23 included but are not limited to Non Alzheimer's Dementia

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F 309	Continued From page 68 (1), History of CVA (Cerebral Vascular Accident*), and Hypertension (2). Resident #23's Yearly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of coded Resident #23 with a Brief Interview for Mental Status (BIMS) score of 00 of 15 indicating short and long term memory problems affecting resident's daily decision making. In addition the MDS scored Resident #23 as requiring extensive assistance with one staff person assistance for hygiene and toileting and total dependence with one staff person assistance for bathing. Resident #23 was coded as occasionally incontinent of bowel function and frequently incontinent of bladder functioning. Review of Resident #23's clinical Record documented Emergency Room visits on the following dates: 8/13/16 diagnosis weakness and Urinary Tract Infection 9/12/16 diagnosis mild dehydration and scrotal Irritation 9/22/16 diagnosis acute lethargy, delirium superimposed on dementia Resident #23 had a hospitalization on 9/28/17 with diagnoses of recurrent Cerebrovascular Accident, Acute thalamic infarct *and intracranial and left carotid origin stenosis* of 70% to 80%. Resident #23's Care Plan documented the following problems and interventions:	F 309		

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F 309	Continued From page 69 9/24/15 Self Care Deficit: Interventions: Report to MD any significant change in ADL abilities, Meds as ordered, treatments as ordered, Monitor for complaints of difficulty chewing or tolerating his current diet 9/23/15 Risk for decreased cardiac output related to diagnosis Hypertension: Interventions: vital signs per order, alert MD to significant changes in BP (blood pressure). 9/23/15 at risk for impaired skin integrity related to decreased cognition and episodes of incontinence: Interventions: Treatments as ordered, keep skin clean and dry, encourage adequate fluid and food intake 8/11/16 Urinary Tract Infection 9/28/17 Urinary Tract Infection Interventions: antibiotics as ordered, vital signs every shift, encourage fluids unless contraindicated. Review of Resident's Medication Administration Record (MAR) documented the following gaps of MD orders: 8/6/17 Tricor 145 milligrams by mouth every night: this medication was not documented as given on the following dates: 8/11/16, 8/14/16, 8/19/16, 8/22/16, 8/29/16 3/7/16 Dexilant Capsule 30 milligrams give 1 capsule by mouth daily for GERD (gastroesophageal reflux disease): This medication was not given on 8/27/16. 9/10/15 Metoprol 25 milligrams give 1 tablet by mouth twice daily for hypertension: This	F 309		

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F 309	Continued From page 70 medication was not given on 8/14/16. 5/24/16 Magic cup by mouth twice daily at 12 pm and 5 pm: this medication was not given on 8/26/16 for 12 pm and 5 pm 8/10/16 Ferrous Sulfate 325 milligrams t tablet by mouth twice a day. This medication was not given on 8/28/16. 8/10/16 Vitamin C 250 milligrams 1 tab by mouth three times a day. This medication was not given on 8/28/16. 8/16/16 Fish oil 1200 milligrams 1 tab by mouth daily. This medication was not given on 8/24/16, 8/27/16 and 8/28/16. 9/22/16 Magic Mouth wash 5 milliliters by mouth swish and spit three times a day as needed for stomatitis: an as needed medication was ordered for a resident with dementia who had short and long term memory problems. This medication was not given at all on 9/27/16. The September 2016 MAR did show that some nurses did access for the need and others didn't offer. Resident #23's Weekly skin assessment sheet documented 7/5/16 refusal and then not attempted again until 7/19/17 (a 14 day gap) Review of Resident #23's TAR documented the following gaps of MD orders: Vital Signs every shift ordered 8/11/16: This was not done any in August 2016 for day shift (7 a.m. to 3 p.m.) Vital Signs every shift ordered 8/11/16: This was not done on the following dates for evening shift (3 p.m. to 11 p.m.)	F 309		

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F 309	Continued From page 71 8/13/16, 8/14/16, 8/22/16, 8/24/16, 8/26/16 through 8/29/16 Vital Signs every shift ordered 8/11/16: This was not done on the night shift (11 p.m. to 7 a.m.) on the following dates: 8/25/16, 8/27/16, 8/28/16, 8/29/16 An interview with the Director of Nursing on 7/27/17 at approximately 5:15 p.m. was conducted. The DON stated it would be the expectation of the nurse to administer medications as ordered and to follow treatments as ordered by the Physician. When asked if it would be an expectation of the Nurses to attempt skin assessment before waiting 14 days after Resident refused, she stated, "It would be my expectation for the Nurses to try again, before the next weekly which would be due in 7 days." The Facility Policy with a revision of April 2007, titled, "Documentation of Medication Administration" documented the following: "A nurse or Certified Medication aide shall document all medications administered to each resident on the resident's medication administration record. The facility administration was informed of the findings during a briefing on 7/27/17 at approximately 5:15 p.m. The facility did not present any further information about the findings. COMPLAINT DEFICIENCY DEFINITIONS: (1) Non Alzheimer's Dementia: Medline Plus	F 309		

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F 309	Continued From page 72 documented: caused of dementia other than Alzheimer's disease (2) CVA (Cerebrovascular Accident): Medline Plus documented: A stroke is a medical emergency. Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die. There are two kinds of stroke. The more common kind, called ischemic stroke, is caused by a blood clot that blocks or plugs a blood vessel in the brain. The other kind, called hemorrhagic stroke, is caused by a blood vessel that breaks and bleeds into the brain. "Mini-strokes" or transient ischemic attacks (TIAs), occur when the blood supply to the brain is briefly interrupted. Hypertension*: Medline Plus documented; High blood pressure is a common condition and when not treated, can cause damage to the brain, heart, blood vessels, kidneys and other parts of the body. Acute thalmic infarct*: www.ausefulguide.com/health/thalamic_stroke/thalamic_stroke.html documented: A thalamic stroke is so named because it occurs in the lower area of the brain, known as the thalamus. The thalamus serves as a sort of relay and coordination center in the brain, so any damage to it can cause a variety of symptoms and problems Corotid origin stenosis*: Medline Plus documented: Carotid artery disease occurs when the carotid arteries become narrowed or blocked. The carotid arteries provide part of the main blood supply to your brain. They are located on each side of your neck. You can feel their pulse	F 309		

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F 309	Continued From page 73 under your jaw line. Tricor*: Medline Plus Documented: Fenofibrate is used with a low-fat diet, exercise, and sometimes with other medications to reduce the amounts of fatty substances such as cholesterol and triglycerides in the blood and to increase the amount of HDL (high-density lipoprotein; a type of fatty substance that decreases the risk of heart disease) in the blood. Build-up of cholesterol and fats along the walls of the arteries (a process known as atherosclerosis) decreases the blood flow and, therefore, the oxygen supply to the heart, brain, and other parts of the body. This increases the risk of heart disease, angina (chest pain), strokes, and heart attacks. Although fenofibrate decreases the levels of fatty substances in the blood, it has not been shown to decrease the risk of heart attacks or strokes. Fenofibrate is in a class of medications called antilipemic agents. It works by speeding the natural processes that remove cholesterol from the body. Dexilant*: Medline Plus documented: Dexlansoprazole is used to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach). Dexlansoprazole is used to treat the symptoms of GERD, allow the esophagus to heal, and prevent further damage to the esophagus. Dexlansoprazole is in a class of medications called proton pump inhibitors. It works by decreasing the amount of acid made in the stomach. Metoprol*: Medline Plus documented:	F 309		

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Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure.

Magic Cup*: Livestrong.com documented: a creative way to meet the calorie needs of those at nutritional risk. It is a nutritional supplement that can be eaten as a pudding or frozen as an ice cream. Eaten with meals or in between meals as a snack, Magic Cup is a way to boost your nutritional intake. Magic Cup is an alternative to the traditional liquid supplements.

Vitamin C*: Medline Plus documented: Ascorbic acid is used to prevent and treat scurvy, a disease caused by a lack of vitamin C in the body.
This medication is sometimes prescribed for other uses; ask your doctor or pharmacist for more information

Ferrous Sulfate*: Medline Plus documented: Ferrous sulfate provides the iron needed by the body to produce red blood cells. It is used to treat or prevent iron-deficiency anemia, a condition that occurs when the body has too few red blood cells because of pregnancy, poor diet, excess bleeding, or other medical problems.

Fish Oil*: Medline Plus documented: If you

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F 309	Continued From page 75 already have heart disease or high triglycerides, you may benefit from consuming higher amounts of omega-3 fatty acids. It may be hard to get enough omega-3s through food. Ask your doctor if taking fish oil supplements might be a good idea.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review and in the course of a complaint investigation the facility staff failed to follow professional standards of practice for one of 35 residents in the survey sample, Resident #25. The facility staff failed to transcribe the physician order for a sacral wound treatment to include Dakins solution from 10/13/16-10/24/16.	F 314	F314 1. Resident #25 has been discharged from facility. 2. Residents who have physician order for treatment administration to pressure injury has the potential to be affected. 3. Wound Physician in-serviced on writing own physician orders. Facility licensed nurses in-serviced on transcribing physician orders accurately. 4. DON/designee will audit new order transcription accuracy 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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The findings included:

Resident #25 was originally admitted to the facility on 11/04/03, discharged to a local hospital on 05/23/16 through 05/27/16 after a fall resulting in right femur fracture; returned to facility on 05/27/16 then discharged to a local hospital on 10/24/16. Resident #25 did not return to the nursing facility. Diagnoses for Resident #25 included but not limited to: Sacral Pressure Ulcer (1), Type II Diabetes (2), Cerebrovascular Accident (CVA) (3), Anorexia (4), and Urinary Tract Infection (UTI) (5).

Resident #25's Quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 08/31/17 was coded 00 out of a possible 15 indicating severe cognitive impairment. Resident #25 was coded as requiring total dependence of one with personal hygiene and bathing, extensive assistance of two with bed mobility, transfer and dressing, extensive assistance of one with eating and toilet use for Activities of Daily Living care. Under section "G" for functional limitation in Range of Motion (ROM) was coded for impairment one side for both upper and lower extremity and under section "H" for bladder and bowel was coded for indwelling Foley (6) catheter always incontinent of bowel.

The MDS with an ARD of 08/31/17 under section "M" (Skin Condition - M0100) was coded: Resident has a stage 1 or greater pressure ulcer. Under section (M0150) at risk for developing pressure ulcers was coded yes, under section (M0210) for unhealed pressure ulcers was coded yes, under section (M0300) for having stage 3 (7) pressure ulcer and unstageable (8) pressure

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F 314	Continued From page 77 ulcer was coded yes. Under section (M0610) for dimension of unhealed stage 3 or 4 pressure ulcers or eschar was to identify the pressure ulcer with the largest surface area (length x width) was measured (4.5 cm x 3.0 cm x 0 cm). Under section (M0700) most severe tissue type for any pressure ulcer was coded 4 for eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be shorter or harder that an surrounding skin) and under section (M1200) for skin and treatments was coded for having pressure reducing device for chair and bed, turning /repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer care, application of nonsurgical dressings and applications of ointments/medications other than feet. Resident #25's Comprehensive care plan documented resident with potential for further skin breakdown due to (d/t) decreased mobility, incontinent of bowel elimination and cognitive deficits. Resident has use of splints and pressure reductions devices; history of healed pressure ulcers with an unstageable to sacrum and right heel with ongoing treatments to sacrum and heel. The goal: to have no increase in size of pressure ulcer or signs or symptoms (s/s) infection by next review. Some of the intervention/approaches to manage goal included: wound nurse and Wound Physician as needed and treatment as ordered, pressure relief device as needed in bed and chair and assist with turning and positioning to relieve pressure on bony prominences as needed. According to the nursing documentation on 05/28/16 at approximately 12:48 p.m., Resident #25 re-entered the facility on 05/27/16 with a stage II to sacrum measuring 1.5 cm x 0.5 cm x	F 314		

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0.1 cm; being pale red in color and no drainage but surrounding skin pink, closed but fragile.

On 07/27/17 at approximately 8:05 a.m., an interview was conducted with LPN #6 who stated she remembered (name of Resident #25) having a pressure ulcer to her heel but was not sure which heel and a wound to a sacrum but can't tell you anything else about (name of Resident #25). The surveyor asked if she remembered anything about the sacral wound and she replied "No."

An interview was conducted with Assistant Director of Nursing (ADON) on 07/27/17 at approximately 8:30 a.m., who stated "I don't remember anything about 9name of Resident #25); I never laid eyes on her."

A phone call was placed to LPN #13 on 07/27/17 at 9:00 a.m., who cared for Resident #25 on 10/24/16, a message was left, LPN never called back.

A phone call was placed to LPN #14 on 07/27/17 at 9:10 a.m., who cared for Resident #25 on 10/20/16, a message was left, LPN never called back.

An interview was conducted with LPN #8 on 07/27/17 at approximately 8:45 a.m., who stated she remembered that (name of Resident #25) had a wound to her sacrum; about the size of a lime. The LPN also stated she remembered the wound had a smelly odor and was on a low air loss mattress (9). She proceeded to say the Resident needed help with bed mobility and repositioning and wore boots to both feet, she believed they were the blue ones, Prevalon boots (10). The surveyor reviewed with LPN #8 nurse's

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notes written by her on 12/22/16 at approximately 1:46 p.m., who documented the following, "Alert and verbally responsive, antibiotics for sacral wound day 9, no reactions, Foley catheter intact draining clear yellow urine, turned/repositioned every 2 hours and temp 97.6." The surveyor stated, "I didn't see from your nurse's notes that Resident #25's sacral wound presented with an odor as previously mentioned, she replied "I only work here labor pool, I guess I just forgot to chart it but I do remember, her sacral wound definitely had an odor."

Resident #25's sacral wound was being assessed and monitored by the wound care specialist weekly starting on 06/02/16 through 10/20/16:

On 06/02/16 the wound care specialist documented the sacral pressure ulcer as a stage 3 measuring 2.5 cm x 2 cm x 0.1 cm with a surface area of 5.00 cm2 and having light serous exudate with 100% granulation tissue. The new sacral wound treatment was to apply skin prep (11) to periwound then apply Hydrogel (12) and cover with foam dressing daily.

On 06/09/16 the wound care specialist documented the sacral pressure ulcer is now an unstageable with necrosis measuring 5 cm x 5 cm x 0.1 cm with a surface area of 25.00 cm2 and having light serous exudate with 90% yellow necrotic and 10% granulation tissue. The wound progress had deteriorated due to generalized decline of patient. The sacral wound treatment was changed to the following: apply skin prep to periwound, apply Santyl (13) and cover with foam daily. Recommendation to Off-Load wound and reposition per facility policy and Pre-Albumin (14) level.

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The wound care specialist documented Resident's sacral wound pressure ulcer had improved on the following days: 06/16/16, 06/23/16, 06/30/16, 07/14/16, 07/21/16, 07/28/17, 08/05/16, 08/11/16, and 08/18/16.

On 08/25/16 the wound specialist documented the sacral wound pressure ulcer as stage 3 measuring 0.6 cm x 0.5 cm x 0.1 cm. The wound progress with no change but now has hyper-granulation (15) tissue present within the wound margins. The sacral wound had a surfaced area of 0.30 cm2 with light serous exudate and 100% granulation tissue. The procedure performed by the wound doctor is as follows: Chemical Cauterization (16) of hyper-granulation tissue performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding.

On 09/1/16 the wound specialist documented the sacral pressure ulcer as stage III measuring 0.2 cm x 0.2 cm x 0.1 cm. The wound progress indicated improvement by decreased surface area 0.04 cm2 with light serous exudate, 100% granulation tissue with epiboly (rolled wound edges) present within the wound margins. The procedure performed by the wound doctor is as follows: Chemical Cauterization of epiboly performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding. Treatment remains unchanged.

On 09/08/16 the wound specialist documented the sacral wound pressure ulcer remains at a stage 3 measuring 0.1 cm x 0.1 cm x 0.1 cm. The wound progress indicated improvement by decreased surface area at 0.01 cm2 with light

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F 314	Continued From page 81 serous exudate and 100% granulation tissue with epiboly present within the wound margins. The procedure performed by the wound doctor is as follows: Chemical Cauterization of epiboly performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding. Treatment remains unchanged. On 09/15/16 the wound specialist documented the sacral wound pressure ulcer remains at a stage III measuring 0.1 cm x 0.1 cm x 0.1 cm. The surface area is 0.01 cm2 with light serous exudate and 100% granulation tissue but now with abnormal granulation present within the wound margins. New treatment to sacral wound as follows: skin prep periwound, apply Silver Hydrogel (17) and cover with dry protective dressing daily. Chemical Cauterization of abnormal granulation performed on sacrum wound with topical anesthetic to facilitate healing. No complications or bleeding. On 09/22/16 the wound specialist documented the sacral wound pressure ulcer as stage 3. The wound progress has decreased due to generalized decline of patient measuring 3 cm x 4 cm x 0.1 cm with a surface area of 12.00 cm2, maceration to periwound, without any exudate, 30% yellow necrotic tissue, 30% of granulation tissue and 40% skin. Additional information indicated Resident #25 noted to have recent frequent loose stools, which may have contributed to wound deterioration. Wound debrided via surgical excision and subcutaneous tissue removed along with necrotic disuse. New treatment to sacral wound as follows: skin prep to peri-wound, apply Hydrocolloid (18) every three days and as needed.	F 314		

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F 314	Continued From page 82 On 09/29/16 the wound specialist documented the sacral wound pressure ulcer as stage III. The wound progress has decreased due to increased surface area measuring 3.5 cm x 4 cm x 0.1 cm with a surface area of 14.00 cm2 with maceration to periwound radius, light serous exudate, 40 yellow necrotic tissue, 10% granulation and 50% skin. New treatment to sacral wound as follows: skin prep periwound, apply Santyl and cover with dry protective dressing daily. The recommendation is as follow: continue off load wound, reposition per facility's policy, and suspect deterioration secondary to Urinary Tract Infection (UTI). The procedure performed by the wound doctor is as follows: wound debrided via surgical excision and subcutaneous tissue removed along with necrotic disuse. On 10/06/16 the wound specialist documented the sacral wound pressure ulcer as stage 3. The wound progress had improved due to decreased surface area. The wound measured 3 cm x 4 cm x 0.1 cm with a surface area of 12.00 cm2, light serous exudate with 40% of yellow necrotic tissue, 10% granulation tissue and 50% skin. The sacral wound was surgically debrided removing necrotic tissue and establish the margins of the viable tissue. The dressing treatment to sacral wound included the following: Skin Prep to periwound, apply Santyl, cover with dry protective dressing daily. On 10/13/16 the wound specialist documented the sacral wound pressure ulcer as stage 3. The wound had deteriorated due to infection. The wound measured 4 cm x 5 cm x 0.1 cm with a surface area of 20.00 cm2, light purulent exudate with 100% yellow necrotic tissue with red periwound radius. The sacral wound was	F 314		

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F 314	Continued From page 83 surgically debrided removing necrotic tissue and establish the margins of the viable tissue. The dressing to sacral wound changed to the following: skin prep to peri-wound, apply Santyl, apply Dakins (21) moistened gauze and cover with dry protective dressing. The recommendation was to use Group 2 Mattress (Low Air Loss Mattress), and start antibiotics: Doxycycline (22) 100 mg by mouth twice daily x 14 days for infection. On 10/20/16 the wound specialist documented the sacral wound pressure ulcer as unstageable with necrosis. The wound had deteriorated due to generalized decline of patient. The wound measured 7 cm x 6 cm x 0.1 cm with a surface area of 42.00 cm2, moderate serous exudate with 100% yellow necrotic tissue with odor present. The sacral wound was surgically debrided removing necrotic tissue and establish the margins of the viable tissue. The dressing to sacral wound included the following: skin prep to peri-wound, apply Santyl, apply Dakins moistened gauze and cover with dry protective dressing. According to Resident #25's clinical record review, a stool specimen was obtained on 09/23/17 to rule out (r/o) Clostridium Difficile Infection (C-Diff) (19) related to (r/t) diarrhea. Stool results returned on 09/23/16 with negative results. New order obtained on 09/29/17 for Cipro (20) 500mg by mouth every 12 hours x 14 days for Urinary Tract Infection. The clinical record review for October 2016	F 314		

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Treatment Administration Record (TAR) did not indicate the physician order for 10/13/16 was transcribed for the following order: Skin prep to periwound, apply Santly, apply Dakins moistened qauze and covered with protective dressing daily.

An interview was conducted with the wound care specialist on 07/27/17 at approximately 11:25 a.m., to discuss the ongoing treatment of Resident #25's sacral pressure ulcer. During the interview with the wound specialist, the surveyor stated, "I didn't see an evaluation on the sacral wound ulcer for 07/07/16," the wound specialist stated, "I must was gone for a week during that time." Related to sacral wound evaluation on 10/13/16, she stated, "I felt like the deterioration was due an infection in the sacral wound but not suspicious of osteomyelitis (23) because the wound was superficial and that Resident #25's sacral wound was an unstageable and not a stage 3 on 10/13/16. The surveyor asked what is Dakins solution and why is it used on wounds, the wound care specialist replied, "Dakins is nothing but diluted bleach and the purpose is to decrease bacterial growing in the wound." The surveyor asked how is Dakins solution typically used, she replied, "The gauze is typically moistened with the Dakins solution and placed into the wound on top of the Santyl and covered with a dry dressing. The wound care specialist proceeded to say that Dakins will kill anything left behind in the wound. She stated, "I wanted to continue with the Santyl and Dakins treatment since it had only been one (1) week. The wound specialist proceeded to say she saw a significant change in the progress of the sacral wound which required a more extensive debridement. The surveyor asked the wound care specialist how significant was the Dakins solution in managing

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the sacral wound, she replied, "Very important, I have seen great results when using Santyl and Dakins together. The Doxycycline is a great systemic antibiotic and Dakins is great topically because it kills bacteria."

The surveyor informed the wound care specialist that after reviewing Resident #25's Treatment Administration Record (TAR) for October 2016, the order written on 06/13/16 to apply skin prep to peri-wound, apply Santyl then apply Dakins moistened gauze and cover with dry protective dressing daily was never transcribed indicating the treatment to add Dakins solution was never started to the sacral wound. The surveyor asked the wound care specialist, "How important was the Dakins solution to sacral wound treatment" she replied "Dakins never added, that's an issue unfortunately, Dakins was a significant form of treatment in managing the sacral wound for infection." The surveyor asked, "What is your expectations when you write wound care orders," the wound specialist stated, "I expect for the orders to be transcribed as ordered," the surveyor asked if she was informed the order written on 10/13/16 to add Dakins was never transcribed to the October 2016 TAR, she replied, "No, I had no idea the Resident#25 wasn't receiving the Dakins to her sacral wound." The wound specialist proceeded to say that the nurse making wound rounds is always communicated verbally of all new orders that's going to be written that day, and a copy of the wound progress report that includes all new orders is also emailed to the Director of Nursing (DON) and the wound nurse. The surveyor asked, "When is the wound progress report available for review", she replied, "The same day, everything is completed the same day before I leave the facility." The surveyor informed

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the wound specialist on 07/27/17 that Resident #25 was sent out to the hospital after a fall on 10/24/16 and her final diagnosis was sepsis from her sacral wound and that Resident #25 expired on 10/31/16. The wound care specialist was informed that the treatment started to the sacral wound at the local hospital was to use Dakins, the same treatment that was initially ordered on 10/13/16 but was never started." The wound care specialist stated, "The Dakins to the sacral wound could have made a difference in her outcome, she then stated: "Oh Wow, 12 days with no Dakins; the Dakins would have been her best chance to fight her wound infection - absolutely but unfortunately."

The nurse's note dated 10/25/16 at approximately 5:27 a.m., indicated Resident #25 was sent out to local Emergency Room (ER) for evaluation after falling out of bed on 10/24/16.

The local ER/hospital note for 10/24/16 indicated resident #25 arrived to the ER at 6:54 p.m. The ER diagnosis included but not limited to: Sacral decubitus ulcer, fall - initial encounter and hypoglycemia.

The local ER/Hospital information dated on 10/24/16 included but not limited to: Integumentary: Patient has a very large 5 cm round sacral ulcer that is all the way down to the bone, appears to be dark brown or necrotic tissue within that ulcer. There is a smaller shallow ulcer over the left buttock without cellulitis surrounding it, but there is purulent drainage that is expressed. It has a foul odor. Impression and Management Plan included but not limited to: wound culture of the large sacral ulcer.

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The local ER/Hospital information dated on 10/24/16 included but not limited to: #1 evaluation after fall: Ct head and C-spine are negative for acute findings. X-ray of the hip does not show a current fracture, #2- a very large foul-smelling stage IV (intravenous) sacral decubitus that when pressed expresses purulent drainage. We have cultured it and ordered IV Vancomycin (24) and Zosyn (25), #3-Hypoglycemia (low blood sugar): Blood sugar 52 given IV D50 and then started on D5 half-normal saline infusion. Recheck blood sugar 82. Patient will need to be admitted for treatment of this very large foul-smelling sacral decubitus.

On 10/25/16 at 3:13 p.m., the local Hospital Wound Nurse Progress Note documented the following but not limited to:
Situation: Wound Consult
Background: Medical patient with Braden (for predicting pressure sore risk) Score of 12/23. Patient has history of Type 2 Diabetes, Hyperlipidemia, Hypertension and CVA. Patient is a resident of local nursing home. She was admitted with sacral wound.
Assessment: There is a necrotic unstageable pressure wound to the sacrum which measures 6.7 cm x 7.5 cm x 2.4 cm with undermining circumferentially to 0.8 cm. The wound base is essential 100% black with necrotic odor. The periwound is denuded.
Recommendation: Would recommend ¼ strength Dakins damp gauze dressings twice daily to sacral wound for now. Surgical debridement would be preferable.

The infectious disease follow up noted from the local hospital dated 10/28/16 at 1:08 p.m., indicated Resident #25's sepsis was from the

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F 314	Continued From page 88 infected unstageable sacral decubitus which was Present on Admission (POA). On 10/28/16 at 2:12 p.m., local Hospital progress note documented the following: Patient noted to have decreased mentation today; noted to have fevers today as well. Reexamined patient and sacral wound with continued necrotic tissue and odor but not drainage and with concerned that the source of fever and mental status change is due to sacral wound. I have discussed that patient is high risk of procedure with possible respiratory failure, cardiac event, bleeding complications, etc. Alternatively, I have discussed that the risk of not debriding would result in further decline of medical status and possible death of patient. The patient's daughter states that she understands the situation and the risks of surgery and alternative of no surgery. She states that she wishes to proceed with surgery due to possible poor outcome and possible death of patient if debridement not performed and the sacral wound continues to be a source of sepsis for the resident. On 10/28/16 at 4:21 p.m., the local Hospital progress note documented the following: Postoperative Diagnoses included sacral pressure ulcer, stage 4 and sacral osteomyelitis. Following excisional debridement, the wound measured 12 cm x 8 cm x 3 cm with bone at the base of wound. Following irrigation and confirmation of adequate hemostasis, the wound was then packed with Kerlix (woven gauze) soaked in ¼ -strength Dakin's. On 10/28/16 at 2:12 p.m., local Hospital progress note documented the following: Patient noted to have decreased mentation today; noted to have	F 314		

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F 314	Continued From page 89 fevers today as well. Reexamined patient and sacral wound with continued necrotic tissue and odor but not drainage and with concerned that the source of fever and mental status change is due to sacral wound. I have discussed that patient is high risk of procedure with possible respiratory failure, cardiac event, bleeding complications, etc. Alternatively, I have discussed that the risk of not debriding would result in further decline of medical status and possible death of patient. The patient's daughter states that she understands the situation and the risks of surgery and alternative of no surgery. She states that she wishes to proceed with surgery due to possible poor outcome and possible death of patient if debridement not performed and the sacral wound continues to be a source of sepsis for the resident. On the morning of 10/31/16, Resident #25's condition worsened, she was sent to Intensive Care Unit (ICU) where she later went into cardiac arrest and was coded. The family ultimately made a Do Not Resuscitate (DNR); Resident #25 expired on 10/31/16 at approximately 6:48 a.m. The facility administration was informed of the finding during a briefing on 07/27/17 at approximately 5:15 p.m. The Director of Nursing (DON) was asked what is the facility process and procedure for following up on orders written by the wound care specialist, the DON replied, "The wound specialist will send out an email to me and the wound care nurse and also gives a verbal to the nurse making rounds with the wound specialist. The night shift will review all new orders written for that day to make sure they have been transcribed and put on the MAR or TAR." The surveyor asked if the night shift reviews the	F 314		

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progress report written by the wound care specialist for new orders, she replied, "No". The DON proceeded to say; moving forward the wound specialist will be writing all new orders and then give them orders the nurse to transcribe to the MAR or TAR.

Definitions:

1. Pressure Injury: A pressure injury is localized damage to the skin and 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 (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)

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

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

4. Anorexia is the lack or loss of appetite, resulting in the inability to eat (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition).

5. UTI is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney

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F 314	Continued From page 91 (http://www.cdc.gov/HAI/ca_uti/uti.html). 6. Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html). 7. Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/). 8. 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 the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/). 9. Low air loss mattress is an alternating pressure mattress systems are designed to heal and prevent bed sores	F 314		

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(http://www.medicalairmattress.com/deluxe.html).

10. Prevalon boots helps minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals. By off-loading the heel, it delivers total, continuous heel pressure relief (www.hdis.com/prevalon-boot-heel-protector.html).

11. Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/).

12. Hydrogel is ideal for dry-to-moist clean wounds. Helps create a moist wound environment. Balanced formulation Easy irrigation Indications: pressure ulcers, partial and full-thickness wounds, leg ulcers, surgical wounds, lacerations, abrasions and skin tears, and first- and second-degree burns (www.medline.com/product/Skintegrity-Hydrogel/Gel/Z05-PF00182).

13. Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.

14. Prealbumin is a protein in the body and can be measured with a blood test. This protein tells about nutritional status

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F 314	Continued From page 93 (https://www.drugs.com/cg/prealbumin.html). 15. Hyper-granulation (or overgranulation) is an excess of granulation tissue beyond the amount required to replace the tissue deficit incurred as a result of skin injury or wounding (https://www.ncbi.nlm.nih.gov/pubmed/20335928) 16. Cauterization is the process of burning a part of the body cautery. A cautery is a device or agent used in the coagulation of tissue by heat or caustic substances (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition). 17. Silver Hydrogel is a wound dressing for lightly draining wounds that are in need of an antimicrobial barrier. Silvasorb harnesses the power of ionic silver. This wound gel releases silver at a controlled level for broad spectrum antimicrobial action, without harming tissue cells (https://www.exmed.net/p-3251-medline-silvasorb-hydrogel-silver-antimicrobial-wound-gel.aspx). 18. Hydrolloid dressings are occlusive or semi-occlusive dressings consisting of a combination of gel-forming polymers that absorb exudate slowly by swelling into a gel-like mass (http://woundeducators.com/hydrocolloid-dressings). 19. C-Diff is a bacterium that causes diarrhea (https://medlineplus.gov/clostridiumdifficileinfections.html). 20. Cipro is an antibiotic used to treat urinary tract infections (https://medlineplus.gov/druginfo/meds/a682514.	F 314		

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F 314	Continued From page 94 html). 21. Dakins solution is used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. It is also used before and after surgery to prevent surgical wound infections. Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation (healthcentral.com/skin-care/medications/dakin-misc-62261/uses) 22. Doxycycline is used to treat bacterial infections; it works by preventing the growth and spread of bacteria (https://medlineplus.gov/druginfo/meds/a682514.html). 23. Osteomylitis is a local or generalized infection of bone and bone marrow. It is usually casued by bacterial introduced by trauma or surgery (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition). 24. Vancomycin is used alone or in combination with other medications to treat certain serious infections such as skin, blood, and bones. It works by killing bacteria that cause infections (https://medlineplus.gov/druginfo/meds/a601167.html). 25. Zosyn is an antibiotic used treat pneumonia and skin and infections caused by bacteria (https://medlineplus.gov/druginfo/meds/a601167.html).	F 314		
F 323	COMPLAINT DEFICIENCY 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 95 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to obtain and record daily temperatures on the hydrocollator to prevent avoidable accidents. The findings included: On 7/27/17 during general observations the hydrocollator was observed in a storage room in the rehabilitation gym. The staff stated the unit	F 323	F323 1. Facility hydrocollator temperature has been documented daily. 2. Residents receiving heat pack has the potential to be affected. 3. Therapy staff will be in-serviced on documenting hydrocollator temperature daily. 4. Director of Therapy will monitor temperature log 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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was there because it had not used for a while. The unit was unplugged but very warm to touch and the water was clear with multiple hot packs submerged. The physical Therapy Assistant (PTA) obtained a temperature reading of 123 degrees. The surveyor asked to view the temperature log for the unit but the PTA stated there was no log for the unit was not in use and there were no residents currently with orders for hot packs.

An interview was conducted with the Rehabilitation Director on 7/27/17 at approximately 1:30 p.m., the Rehabilitation Director stated the PTA was mistaken as the hydrocollator was currently in use but they had failed to obtain the daily temperatures as required. The Rehabilitation Director stated the hydrocollator had been calibrated last month and she was unable to provide the temperature log because it had been misplaced during the rehabilitation gym's renovations and they had not started another but they would begin another temperature log today (7/27/17). The Rehabilitation Director stated hydrocollator temperatures should be obtained daily minimally.

The facility's policy provided by the facility staff did not address obtaining hydrocollator temperatures. The manufacturers user manual read, "Precautions: The recommended operating temperature is 160 degrees F (Fahrenheit) to 165 F. The temperature of the water should be checked with a thermometer after every adjustment, and before using the hot pack."

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F 323	Continued From page 97 On 7/27/17 at approximately 6:15 p.m., the above findings were shared during the pre-exit debriefing with the Administrator, Director of Nursing, Corporate Administrator and the Regional Nurse Consultant. No additional information was provided. The hydrocollator was first introduced in 1947 by the Chattanooga Pharmaceutical Company. The device consists of a thermostatically controlled water bath for placing bentonite-filled cloth heating pads. When the pads are removed from the bath, they are placed in covers and placed on the patient. The device is primarily used by athletic trainers and physical therapists. (The above definition was derived from 2000 Chattanooga Group, Inc. at www.chattgroup.com).	F 323		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility failed to ensure its medication error rate was not above 5% or greater. Thirty opportunities were observed with two medication errors, resulting in a medication error rate of 6.66 %. The medication errors involved one resident, Resident #11.	F 332	F332 1. Resident #11 medication was obtained from pharmacy and inhaler administered appropriately. 2. Residents who have physician order for inhaler and medication have the potential to be affected. 3. Facility licensed nurses will be in-serviced on medication administration including inhalers. 4. DON/designee will conduct medication administration observation 3xs a week for 30days, then 2xs a week for 30days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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The Licensed Practical Nurse (LPN #1) failed to administer an inhaler per the manufacturer's recommendations and failed to administer a 30 mg (milligram) tablet of mirtazapine (an antidepressant) during the medication pass observation for Resident #11.

The findings included:

Resident #11 was admitted to the facility on 7/22/16 with diagnosis to include chronic obstructive airway.

The current MDS (Minimum Data Set) an Annual with an assessment reference date of 5/29/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status.

A medication pass and pour observation was conducted with LPN #1 on 7/25/17 at 5:16 p.m., for Resident #11. The nurse prepared three medications to include Sertraline 100 mg (an anti-depressant), Risperdone 100 mg (an anti-psychotic) and Metformin 500 mg (an anti-diabetic medication), and a Ventolin Hfa Inhaler. The nurse administered the three pills and then shook the Ventolin hand held inhaler and gave it to the resident. The resident placed the mouthpiece into her mouth, the nurse then pressed down on the inhaler once to release the medication, the resident inhaled and then exhaled; within two seconds the nurse then pressed down on the inhaler one more time to release a second dose. The nurse did not reshake the inhaler or wait at least 1-2 minutes between inhaler doses.

After the medication pass to Resident #11 the

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LPN was interviewed. The observation of not allowing at least 1-2 minutes between doses as indicated on the inhaler box was reviewed and shared. The nurses response was, "I didn't know".

A reconciliation of the administered medications and the physician orders was conducted on 7/26/17. The physician orders indicated the resident should have been administered one 30 mg dose of mirtazapine during the medication pass observation conducted on 7/25/17. The order dated 5/20/17 read to administer mirtazapine tab 30 mg one tablet by mouth daily at 5 pm for depression.

The Medication Administration Records (MAR) were then reviewed. The entry for the daily dose of mirtazapine 30 mg scheduled at 5:00 pm for 7/25/17 was circled with LPN #1's initials. On the back of the MAR LPN#1 wrote, "7-25-17 5 p Mirtazapine 30 mg awaiting from pharm (pharmacy) did not give" and initialed the entry.

The above medication observation pass was shared with the Administrator, the Corporate Administrator, the Director of Nursing and the Regional Director of Clinical Services during a pre-exit meeting conducted on 7/27/17 at 5:15 pm.

The facility's Policy and Procedure titled "Oral Inhalation Administration" effective date June 2016 read, in part: "Purpose-To allow for safe, accurate, and effective administration of medication using an oral inhaler (with or without a spacer/chamber) or nebulizer.
Metered Dose and Dry-Powdered Inhalers:
M. Press down on inhaler once to release

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F 332	Continued From page 100 medication as resident starts to breathe in slowly through the mouth over 3 to 5 seconds. N. Hold breath for 10 seconds or as long as possible to allow medication to reach deeply into lungs. O. Slowly exhale through nose. P. If another puff of the same or different medication is required, wait at least 1-2 minutes between, then repeat procedures above." The manufacturer's package insert for Ventolin Hfa read, in part as follows: "Step 2. Hold the inhaler with the mouthpiece down. Step 3. Breath out through you mouth and push as much air from your lungs as you can. Put the mouthpiece in your mouth and close you lips around it. Step 4. Push the top of the canister all the way down while you breath in deeply and slowly through your mouth. Step 5. After the spray comes out, take your finger off the canister. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth. Step 6. Hold your breath for about 10 seconds, or for as long as is comfortable. Breath out slowly as long as you can. If your healthcare provider has told you to use more sprays, wait 1 minute and shake the inhaler again. Repeat Steps 2 through Step 6." www.gsksource.com/pharm/content/dam/GlaxoSmithKline/US/en/prescribinginformation/ventolinHfa/pdf	F 332		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 101 (a) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility failed to provide pharmacy services to meet the needs of 1 resident (Resident #11) in the survey sample of 35. Resident #11's mirtazapine 30 mg (an antidepressant) was not available for administration on 7/25/17. The findings included: Resident #11 was admitted to the facility on 7/22/16 with diagnosis to include chronic obstructive airway. The current MDS (Minimum Data Set) an Annual with an assessment reference date of 5/29/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status indicating no cognitive impairment. A medication pass and pour observation was conducted with LPN #1 on 7/25/17 at 5:16 p.m., for Resident #11. The nurse prepared three	F 425	F425 1. Resident #11 medication was obtained from the pharmacy. 2. Residents that have physician orders for medication administration have the potential to be affected. 3. Facility licensed nurses in-serviced on medication administration policy and re-ordering mediation in a timely manner and utilizing the Cubex in facility. 4. DON/designee will audit MAR/TAR 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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medications to include Sertraline 100 mg (an anti-depressant), Risperdone 100 mg (an anti-psychotic) and Metformin 500 mg (an anti-diabetic medication), and a Ventolin Hfa Inhaler. The nurse administered the three pills and then shook the Ventolin hand held inhaler and administered it to the resident.

A reconciliation of the administered medications and the physician orders was conducted on 7/26/17. The physician orders indicated the resident should have also been administered one 30 mg dose of mirtazapine during the medication pass observation conducted on 7/25/17. The order dated 5/20/17 read to administer mirtazapine tab 30 mg (milligram) one tablet by mouth daily at 5 pm for depression.

The Medication Administration Records (MAR) were then reviewed. The entry for the daily dose of mirtazapine 30 mg scheduled at 5:00 pm for 7/25/17 was circled with LPN #1's initials. On the back of the MAR LPN #1 wrote, "7-25-17 5 p Mirtazapine 30 mg awaiting from pharm (pharmacy) did not give" and initialed the entry.

The above medication observation pass was shared with the Administrator, the Corporate Administrator, the Director of Nursing and the Regional Director of Clinical Services during a pre-exit meeting conducted on 7/27/17 at 5:15 pm.

The pharmacy policy titled "Medication Ordering and Receiving From Pharmacy" effective date June 2016 read, in part:
Policy: Medications and related products are received from the dispensing pharmacy on a timely basis...

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F 425	Continued From page 103 2. If not automatically refilled by the pharmacy, repeat medications (refills) are ordered by peeling the top label from the physician order sheet and placing it in the appropriate area on the order form provided by the pharmacy for that purpose or ordered electronically ordered as follows* c. The refill order is called in, faxed, sent electronically or otherwise transmitted to the pharmacy. When available and legible, the pharmacy label (including bar-code, if used is pulled and transmitted to the pharmacy. Pharmacy Process Training: 2. Pharmacy Fax Cutoff Times and Delivery Schedule (fax line #). ***Please allow 48-72 hours for refills to be delivered***	F 425		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		

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F 431	Continued From page 104 (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 general observations of the nursing facility, the facility failed to ensure medications were dated in accordance with currently accepted professional principles in 1 out of 2 facility medication refrigerators.	F 431	F431 1. The vial of PPD Aplisol solution was discarded appropriately. 2. Residents who have physician order for medication/PPD requiring refrigeration and dating upon opening have the potential to be affected. 3. Facility licensed nurses in-serviced on medication storage and dating upon opening. 4. DON/designee will audit med room refrigerator medication storage 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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The North West Unit medication refrigerator possessed 1 undated vial of (Purified Protein Derivative) PPD-Aplisol.

The findings include:

On 7/26/17 at 1:30 p.m., during inspection of the medication rooms, on the North West Unit, 1 undated vial of multidose (Purified Protein Derivative) PPD-Aplisol (for tuberculosis testing) was identified in the medication refrigerator. The vial was one in use and half full. The Licensed Practical Nurse (LPN) #15 stated the vial should have been dated once it was opened. She stated the medication would have been good for 28-30 days. She proceeded to put the PPD vial back into the medication refrigerator.

On 7/26/17 at approximately 1:45 p.m., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were asked what should be done with a multi-dose vial if it was undated in the medication refrigerator. They responded that the vial needed to be disposed of in the sharps container because there was no way to determine when it was opened. They retrieved the undated PPD vial and disposed of it.

The facility's policy and procedure titled "Administering Medications" dated 12/2012 indicated, "The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.

The professional standard from Drug Inserts.com

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F 431	Continued From page 106 indicated Aplisol vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.	F 431		
F 469 SS=E	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility staff failed to maintain an effective pest control program on two of two living units and the dining room. The findings included: During the initial facility tour and general observations of the facility from 7/25/17 through 7/27/17, flies were observed as listed: On 7/25/17 at approximately 11:30 a.m., on the 300 hall flies were observed in the corridor, in room 401, sitting on a urinal in room 405 B and flying about room 309 A. Also on 7/25/17 at approximately 1:20 p.m., flies were observed flying about in the 100 hall corridor and in room 102 A sitting on the over the bed table. At approximately 4:30 p.m., flies were observed sitting on the medication cart and swarming around the nurse's station. On 7/26/17 at approximately 5:20 p.m., flies were observed in the dining room flying about. As the outside door to the smoking area opened for	F 469	F469 1. The facility Maintenance Director contacted Ecolab for pest control services regarding flies and Ecolab serviced facility on 7/28/17. 2. Residents that reside in the facility have the potential to be affected. 3. The facility Director of Maintenance in-serviced on maintaining pest control schedule and as needed service call protocol. 4. Maintenance Director/designee will monitor pest control 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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F 469	Continued From page 107 residents to enter 3 flies were observed coming into the dining area. Residents were observed waving their hands to keep the flies away from their food. On 7/27/17, at approximately 11:00 a.m., a facility wide observation of the building was conducted with the Director of Maintenance. The Director of Maintenance stated the facility had the Ecolab ultraviolet lights (an insect trap that uses powerful ultraviolet rays to attract flies and other flying insect pests without the use of chemicals harmful, toxic chemicals.) to aide with fly control but often the lights are found unplugged. The Director of Maintenance also stated there were only three exit doors with fly curtains (a unit which circulates air across a doorway to reduce penetration of insects) but the facility would be obtaining quotes to have the air curtain installed at the front entrance door and the dining room exit door to reduce the fly population. An invoice was provided which revealed the pest control company had identified large flies in the facility on 7/25/17 and performed interior spot treatment. Also on 7/27/17 during the lunch meal at approximately 11:55 a.m., a female resident was observed with a fly swatter in the dining room swatting flies. The resident stated the flies were coming in as the residents who smoke go in and out of the door because the door closes so slowly. The resident was observed returning to her seat and placing the swatter in a bag on the walker. Periodically she would swat at a fly near her table and get up and chase flies around the dining room.	F 469		

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F 469	Continued From page 108 On 7/27/17 at approximately 6:15 p.m., the above findings were shared during the pre-exit debriefing with the Administrator, Director of Nursing, Corporate Administrator and the Regional Nurse Consultant. The Administrator stated they were addressing the fly control problem and would be looking at other options to reduce flies in the facility.	F 469		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 514		

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F 514	Continued From page 109 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review the facility staff failed to transcribe a physician order to include Dakins (1) solution on the Treatment Administration Record (TAR) for October 2016 for 1 of 35 Residents (Resident #25) in the survey. The facility staff failed to transcribe an order written on 10/13/16 to include Dakins solution on the October 2016 Treatment Administration Record. The findings included: Resident #25 was originally admitted to the facility on 11/04/03, discharged to local hospital on 05/23/16 through 05/27/16 after a fall resulting in right femur fracture; return to the facility on 05/27/16 then discharged to a local hospital on 10/24/16, Resident #25 did not return to the nursing facility. Diagnosis for Resident #25 included but not limited to: Sacral Pressure Ulcer (2). Resident #25's Quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 08/31/17 was coded 00 out of a possible 15 indicating severe cognitive impairment. In addition to the MDS coded Resident #25 requiring total dependence of one with personal hygiene	F 514	F514 1. Resident #25 has been discharged from facility. 2. Residents that have physician order for treatment administration to pressure injury has the potential to be affected. 3. Wound Physician in-serviced on writing own physician order. Facility licensed nurses in-serviced on physician order transcription. 4. DON/designee will conduct audit of new physician orders transcription to MAR/TAR 3xs a week for 30 days, then 2xs a week for 30 days. 5. Results of audits will be reported to QAPI committee for recommendations. A.O.C. 9/06/17.	

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F 514	Continued From page 110 and bathing, extensive assistance of two with bed mobility, transfer and dressing, extensive assistance of one with eating and toilet use for Activities of Daily Living care. Resident #25's comprehensive care plan documented resident with potential for further skin breakdown due to (d/t) decreased mobility, incontinent of bowel elimination and cognitive deficits. Resident has use of splints and pressure reductions devices; history of healed pressure ulcers with an unstageable (3) to sacrum and right heel with ongoing treatments to sacrum and heel. The goal: to have no increase in size of pressure ulcer or signs or symptoms (s/s) infection by next review. Some of the intervention/approaches to manage goal included: wound nurse and Wound Physician as needed and treatment as ordered. On 10/13/16 the wound care specialist documented the sacral wound pressure ulcer as stage 3 (4). The wound had deteriorated due to infection. The wound measured 4 cm x 5 cm x 0.1 cm with a surface area of 20.00 cm2, light purulent exudate with 100% yellow necrotic with red periwound radius. The sacral wound was surgically debrided removing necrotic tissue and establish the margins of the viable tissue. The treatment to sacral wound was changed to the following: skin prep (5) to peri-wound, apply Santyl (6), apply Dakins moistened gauze and cover with dry protective dressing. According to the October 2016 Treatment Administration Record (TAR), the last sacral wound order was written on 09/29/16 as follows: skin prep to periwound, apply Santyl and cover with dry protective dressing daily.	F 514		

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F 514	Continued From page 111 An interview was conducted with the wound care specialist on 07/27/17 at approximately 11:25 a.m., who stated Resident #25's sacral wound was an unstageable and not a stage 3 on 10/13/16. The clinical record review, October 2016 Treatment Administration Record (TAR) did not indicate the physician order was transcribed for the following order written on 10/13/16: Skin prep to periwound, apply Santyl, cover with Dakins moistened gauze and covered with protective dressing daily. During an interview with wound care specialist on 07/27/17 at 11:25 a.m., the surveyor informed the wound care specialist that after reviewing Resident #25's TAR for October 2016, the order written on 10/13/16 to apply skin prep to peri-wound, apply Santyl then apply Dakins moistened and cover with dry protective dressing daily was never transcribed indicating the treatment to add Dakins solution was never started to the sacral wound. The surveyor asked the wound care specialist, "How important was the Dakins solution to sacral wound treatment" she replied "Dakins never added, that's an issue unfortunately, Dakins was a significant form of treatment in managing the sacral wound for infection." The surveyor asked, "What is your expectations when you write wound care orders," the wound specialist stated, "I expect for the orders to be transcribed as ordered," the surveyor asked if she was informed that the order she had written on 10/13/16 to add Dakins was never transcribed to the October 2016 TAR, she replied, "No, I had no idea that Resident #25 wasn't receiving the Dakins to her sacral wound."	F 514		

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The wound care specialist proceeded to say that the nurse making wound rounds is always communicated verbally of all new orders that's going to be written that day, and a copy of the wound progress report that includes all new orders is also emailed to the Director of Nursing (DON) and the wound nurse. The surveyor asked, "When is the wound progress report available for review", she replied, "The same day, everything is completed the same day before I leave the facility."

The facility administration was informed of the finding during a briefing on 07/27/17 at approximately 5:15 p.m., the DON was asked what is the facility process and procedure for following up on orders written by the wound specialist, the DON replied, "The wound specialist will send out and email to me and the wound care nurse and also gives a verbal order to the nurse making rounds with the wound specialist. The night shift will review all new orders written for that day to make sure they have been transcribed and put on the Medication Administration Record (MAR) or TAR. The surveyor asked if the night shift reviews the progress report written by the wound care specialist for new orders, she replied, "No". The DON proceeded to say that moving forward the wound specialist will be writing all new orders and then give them orders the nurse to transcribe to the MAR or TAR.

The facility's policy: "Medication and Treatment Orders" (Revised April 2014).

"Policy Statement: Orders for medications and treatments will be consistent with principles of

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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
	495330	A. BUILDING _____ B. WING _____	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE OF CHESAPEAKE	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

(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 514	Continued From page 113 safe and effective order writing. Policy Interpretation and Implementation and included but not limited to: #7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the order and must include prescriber's last name, credentials, he date and time of the order. #8. Verbal orders must be signed by the prescriber at his or her next visit." Definitions: 1. Dakins solution is used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. It is also used before and after surgery to prevent surgical wound infections. Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation (healthcentral.com/skin-care/medications/dakin-misc-62261/uses). 2. Pressure Ulcer is localized damage to the skin and 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 (http://www.npuap.org/resources/educational-and	F 514		

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F 514	Continued From page 114 -clinical-resources/npuap-pressure-injury-stages). 3. 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 the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) 4. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages). 4. Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/).	F 514		

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F 514	Continued From page 115 5. Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts).	F 514		