State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0276	A. BUILDING: _____ B. WING _____	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NSG CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(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 6/20/17 through 6/22/17. Two complaints were investigated during the survey. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census is this 90 bed facilty was 81 at the time of survey. The survey sample consisted of 16 current Resident reviews (Resident #1 through #15 and #21) and 5 closed record reviews (Resident #16 through #20).	F 000	RECEIVED JUL 13 2017 VDH/OLC	
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 5-371-220. Nursing Services (A&B), Refer to F328. 12 VAC 5-371-250. Resident Assessment and Care Planning (L), Refer to F280 12 VAC-5-371-220 (A,B) Nursing Services Cross Reference F 309 and F 329 12 VAC 5-371-220 (D) Nursing Serivces. Refer to F312 12 VAC 5-371-220 (C.1) Nursing Services. Refer to F314 12 VAC 5-351-180 (C) Infection Control. Refer to 441 12 VAC 5-371-180 [C]. Please Cross-Reference to F-441	F 001	Cross reference POC for F 328 to 12 VAC 5-371-220 Cross reference POC for F280 to 12-VAC 5-371-250 Cross reference POC for F309 and F 329 to 12 VAC 5-371-220 Cross reference POC for 312 to 12 VAC 5-371-220 Cross reference POC for 314 to 12 VAC 5-371-220 Cross reference POC for 441 to 12 VAC 5-371-180 and 12 VAC 5-351-180	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jolene Whitmak — TITLE: ADMINISTRATOR — (X6) DATE: 7.12.17

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F 000	INITIAL COMMENTS An unannouced Medicare/Medicad standard survey was conducted 06/20/17 through 06/22/2017. Significant corrections are required for compliance with 42 CRF Part 483 Federal Long Term Care requiremnts. The Life Safety Code survey/report will follow. Two (2) complaints were investged during this survey. The census is this 90 bed facilty was 81 at the time of survey. The survey sample consisted of 16 current Resident reviews (Resident #1 through #15 and #21) and 5 closed record reviews (Resident #16 through #20).	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records,	F 164	1. The LPN was immediately educated on HIPPA and resident privacy. 2. All residents have the potential to be affected by this deficient practice. 3. Resident rights inservices will be conducted for all departments to include resident medically protected health information and ensuring resident privacy during nursing care. 4. DON or designee will conduct rounding and observational audits 5X per week for thirty days, then 3 X per week for sixty days. Audit results will be shared at QAPI meeting.	8/2/2017

RECEIVED
JUL 13 2017
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Juleen Whitenack	ADMINISTRATOR	7.12.17

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

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regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
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 privacy during the provision of care for 2 of 21 residents in the survey sample, Resident #8 and #2.

1. The facility staff failed to maintain resident privacy during the administration of a treatment for Resident #8.

2. The facility staff failed to provide privacy during the sacral, left hip and left buttocks wound care dressing change for Resident #2.

The findings included:

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1. Resident #8 was admitted to the facility on 6/9/17 with diagnoses to include, but not limited to vascular dementia and left lower leg wound questionable stasis ulcer (1).

The admission MDS (Minimum Data Set) with an assessment reference date of 6/18/17 was in progress and not yet completed.

The physician orders dated 6/15/17 instructed the staff to cleanse the right posterior (back) of calf with dermal wound cleanser, skin prep to peri wound (surrounding skin, apply mesalt, cover with ABD (dressing) wrap with Kerlix (gauze dressing) and secure with tape daily and as needed. The treatment was scheduled to be done on day shift as recorded on the Treatment Administration Record (TAR).

On 6/21/17 at 10:50 am, the resident was observed sitting up in the wheelchair, dressed and groomed. The dressing to the right calf was exposed and the date on the dressing was 6/19/17.

On 6/21/17 at 11:30 am, the dressing change to the right calf was conducted by Licensed Practical Nurse #3 (LPN). The resident's roommate was in bed and the privacy curtain was not drawn between the beds to provide privacy, the room door was left wide open. The resident was sitting in the wheelchair between both beds near the foot board. During the dressing change the nurse stated out loud that the wound was caused by cellulitis (2) and was looking better. This was stated loud enough for the roommate to hear as the roommate had turned the television sound off while the nurse was conducting the dressing and able to view the resident. There

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was foot traffic in the hallway and several staff were observed walking outside the door to include two different maintenance staff.

LPN #3 was interviewed later that day at 4:42 pm. The above observation was shared. The LPN's response was," I usually shut the door and pull the curtains...I got nervous".

The above findings was shared with the Administrator, the Interim Director of Nursing (DON) and a second DON from another building during the pre-exit meeting conducted on 6/22/17 at 4:00 pm.

1. Stasis ulcer- Ulcer caused by stoppage of abnormal blood flow. (Source Taber's Cyclopedic Medical Dictionary Edition 20).

2. Cellulitis-A spreading bacterial infection of the skin and subcutaneous tissues...The extremities, esp. the lower legs, are the most common sites. (Source Taber's Cyclopedic Medical Dictionary Edition 20).

2. Resident #2 was originally admitted to the facility on 08/07/15. Diagnosis for Resident #2 included but not limited to Pressure ulcer (1) sacrum region and Dementia (2).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 05/14/17 coded the resident with a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #2 requiring total dependence of two with transfers, total

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dependence of one bathing, extensive assistance of one with dressing, hygiene, bed mobility and toilet use and limited assistance of one with eating. Resident was also coded as having an indwelling Foley catheter (3) and incontinent of bowel all the time.

On 06/21/17 at approximately 11:40 a.m., Resident #2 was observed lying in bed in supine position with Foley catheter to bedside drainage on right side of bed. LPN #1 pulled the privacy curtain between Bed A and B but did not pull the privacy curtain between the door and Bed A. Prior to wound care, LPN #1 positioned resident on her right side with her left leg in a flexed positioned placed over her right leg. Resident #2's hospital gown was bundled directly under her breast exposing her entire her upper torso down to her feet. Resident #2 was not draped through the entire dressing change. At approximately 12:10 p.m., a staff member knocked on the door, open the door wide enough to observe Resident #2 receiving wound care, and then stated, I'm sorry; I'll come back later and close the door.

On 06/21/17, directly after the wound care dressing change, the surveyor asked LPN #1 should Resident #2 have been covered during her dressing change and should the curtain between A-bed and the door have been pulled for privacy during wound care, she replied "Yes, I should have pulled the curtain and Resident #2 should be covered during the dressing change."

An interview was conducted with Interim Director of Nursing (IDON) who stated, Resident #2, should have been properly covered during her dressing change".

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F 164	Continued From page 5 The facility's policy: Job Aid: Dressing - Clean (Revision Date - 08/13/13). Procedure: 1) Position resident and expose area to be dressed. 2) Drape resident. 1) Pressure ulcer is localized damage to the skin and underling soft tissue usually over a body prominence or related to a medical or other device. The injury can present as an intact skin or an open ulcer and may be painful. 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) Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm). 3) Foley catheter is a tube placed in the body to drain and collect urine from the bladder (https://medlineplus.gov/druginfo/meds/a682514.html).	F 164		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10	F 280	1. A care plan meeting was scheduled for resident #13.	8/2/2017

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F 280	Continued From page 6 (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. (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	F 280	2. All residents on isolation status have the potential to be affected by this deficient practice 3. Residents on isolation status will be offered opportunity to attend care planning meeting in their rooms 4. SW or designee will audit all residents on isolation status for proof of invitation and participation in their care plan	

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F 280	Continued From page 7 (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 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 and	F 280		

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resident interviews and facility documentation review, the facility staff failed to ensure 1 out of 21 residents (Resident #13) had the opportunity to participate in his or her person-centered plan of care.

Resident #13 was not invited to the care planning, thus she was not afforded the opportunity to participate in the planning process of her care.

The findings include:

Resident #13 was admitted to the nursing facility on 3/21/17 with diagnoses that included diabetes and septicemia (foot infection).

The most recent Minimum Data Set (MDS) assessment dated 6/15/17 coded the resident with a score of 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS).

The person centered plan of care interdisciplinary review indicated the initial care conference was on 4/5/17. the review indicated a family member participated, but not the resident.

During an interview with Resident #13 on 6/22/17 at 11:30 a.m., she stated her father attended the care conference on 4/5/17 and she was very upset because she had questions about her care to include medications and future needs at discharge. She stated once the foot wound healed she would return home, but she would have loved to attend the care plan meeting because her father reported to her that he was upset about many aspects of her care. The resident was on contact isolation precautions for a right foot infection. The wound was fully contained.

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F 280	Continued From page 9 The Social Worker's resident note entry dated 4/5/17 indicated the resident's father attended the care conference and that the resident was unable to attend because she was on contact isolation. On 6/22/17 at 4:00 p.m., an interview was conducted with the Administrator, Interim Director of Nursing (IDON) and Corporate personnel. The Administrator stated the Social Worker was not available for interview and said the resident should have had been able to attend her care plan meeting regardless of her contact precautions and/or the interdisciplinary team could have come to the resident's room. The letter that addressed upcoming care conferences did not address the resident, but resident families. The Administrator stated the invitation letters should be addressed to the resident and the family and had no evidence residents were invited to their care conferences. There was no person centered plan of care policy to address resident invitation to care planning conferences.	F 280		
F 309 SS=D	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.	F 309	1. The dressing on Resident # 8 was changed prior to survey team exiting the building. 2. All residents receiving wound care have the potential to be affected by this deficient practice.	8/2/2017

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F 309	Continued From page 10 483.25 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to provide the necessary treatment and care to attain or maintain the highest practicable physical well-being according to the physicians plan of care for 1 of 21 residents in the survey sample, Resident #8. The facility staff failed to administer a treatment to Resident #8's right calf as ordered by the physician to aide in wound healing. The findings included:	F 309	3. Licensed nursing staff education on wound care healing and prevention to include dressing changes as ordered by physician and nursing follow up. 4. DON or designee will conduct weekly audits x 90 days of at least 20% of current residents with wounds to ensure treatments are completed as ordered. Results to be shared at monthly QAPI meeting	

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Resident #8 was admitted to the facility on 6/9/17 with diagnoses to include, but not limited to vascular dementia and left lower leg wound questionable stasis ulcer (1).

The admission MDS (Minimum Data Set) with an assessment reference date of 6/18/17 was in progress and not yet completed.

The physician orders dated 6/15/17 instructed the staff to cleanse the right posterior (back) of calf with dermal wound cleanser (dwc), skin prep to peri wound (surrounding skin, apply mesalt, cover with ABD (dressing) wrap with Kerlix (gauze dressing) and secure with tape daily once a day and as needed (PRN). The treatment was scheduled to be done on the day shift as recorded on the Treatment Administration Record (TAR).

On 6/15/17 the wound nurse assessed the right calf wound. The wound nurse described the wound as: "...right posterior calf - 2 areas with small islet of healed tissue in between recently hospitalized with cellulitis (2) to this extremity-irregular edges-stasis ulcer? 4 cm x 6 cm (centimeters) by {sic} unable to get depth due to slough (dead tissue) in wound bed- 95% yellow, 5% red tissue, moderate amount of serous sanguineous drainage, no odor...".

Recommendations- Cleanse right posterior calf with dwc, skin prep peri wound skin, apply mesalt, cover with ABD, wrap with kerlix, secure with tape, daily and as needed-mesalt will help debride wound while offering antimicrobial coverage and drainage control.

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On 6/21/17 at 10:50 am, the resident was observed sitting up in the wheelchair, dressed and groomed. The dressing to the right calf was exposed and the date on the dressing was 6/19/17.

On 6/21/17 at 11:30 am, the dressing change to the right calf was conducted by Licensed Practical Nurse #3 (LPN). The resident's roommate was in bed and the privacy curtain was not drawn between the beds to provide privacy, the room door was left wide open. The resident was sitting in the wheelchair between both beds near the foot board. LPN #3 (Licensed Practical Nurse) was asked what was the date on the right calf dressing and stated "6/19". She stated this was the dressing she had applied on that day (6/19). The nurse placed all supplies on a clean towel placed on the bed and opened supplies. The nurse then washed her hands and administered the treatment and dressing change as ordered.

LPN #3 was interviewed later that day at 4:42 pm. The observation that the dressing was not changed on 6/20 was shared. When asked how often is the dressing scheduled to be changed, she stated "Every day".

On 6/22/17 the nurse (LPN #2) who was assigned to the resident on 6/20/17 during the day shift was interviewed. She stated she floats between both units, and had not been assigned to care for Resident #8 prior to that day. When asked if she had changed the dressing to Resident #8's right posterior calf on 6/20/17, she stated, "No". When asked why, she stated, "I was not able to get to it...I was taken care of two other residents that I was concerned about". She

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F 309	Continued From page 13 further stated she had asked the supervisor for help and was told she would get back to her. The nurses understanding was the supervisor was doing an admission on the other unit. When asked if the supervisor got back to her, she stated, "No". When asked if there were any other dressing changes that she was not able to do that day, she stated, "I don't believe so". The nurse stated she had reported to the oncoming nurse that the dressing had not been changed. The above findings was shared with the Administrator, the Interim Director of Nursing (DON) and a second DON from another building during the pre-exit meeting conducted on 6/22/17 at 4:00 pm. 1. Stasis ulcer- Ulcer caused by stoppage of abnormal blood flow. (Source Taber's Cyclopedic Medical Dictionary Edition 20). 2. Cellulitis-A spreading bacterial infection of the skin and subcutaneous tissues...The extremities, esp. the lower legs, are the most common sites. (Source Taber's Cyclopedic Medical Dictionary Edition 20).	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure 1 resident out of 21 Residents (Resident #7) in the	F 312	1. The fingernails of Resident #7 were cut and trimmed prior to survey team leaving the building 2. All residents have the potential to be affected by this deficient practice.	8/2/2017

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F 312	Continued From page 14	F 312	3. Staff inservices will be conducted on proper resident ADL care to include nail care. 4. Clinical Manager or designee will conduct audits of resident nail care 5 X per week for ninety days. Results to be shared at monthly QAPI meeting	

survey sample who was unable to carry out activities of daily living receives the necessary services to maintain fingernail care.

The findings included:

Resident #7 was admitted to the facility on 12/18/15. Diagnosis included but not limited to: Cerebrovascular accident (CVA)(1) with hemiplegia (2) to the left side.

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 03/30/17 coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #7 requiring extensive assistance of one two with transfers, dressing, hygiene, bed mobility, toilet use and bowel and bladder, extensive assistance of one with bathing.

Resident #7's comprehensive care plan indicated a problem with self-care deficit- assistance required with bathing, hygiene, dressing, and grooming related to (R/T) left hemiparesis status post (S/P) CVA. The goals the facility staff set for the resident was to be odor free, dressed and out of bed daily. Some of the interventions included but not limited to: clean and manicure fingernails as needed.

An interview was conducted with Resident #7 on 06/21/17 at approximately 1:45 p.m., who stated she had asked the nursing staff to cut and trim her nails and was told they don't cut nails; someone comes in on Monday so you can have your nails done then. Resident #7's fingernails were long and thick with a black substance noted

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F 312	Continued From page 15 under all of her nails. Resident #7 stated, "My fingernails are really dirty". On 06/22/17 at approximately 9:10 a.m., the Interim Director of Nursing, clinical manager and surveyor went to inspect the fingernails of Resident #7. After the Interim Director of Nursing (IDON) inspected her fingernails she replied, "They need to be soaked, cut and trimmed; we will take of this right away". The IDON was asked, "Who cuts and trims the resident fingernails, she replied, "The nursing staff should be providing routine fingernail care; that could be the Certified Nursing Assistance (CNA) or the nurse." The IDON stated a volunteer comes to the facility but only to do manicures and polishes their nails; she does not cut the residents fingernails. The surveyor requested the facility's policy on ADL care to include fingernail care on 06/22/17 at 5:15 p.m., from the Administrator but did not receive. 1) 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). 2) Hemiplegia is the loss of muscle function on one side of the body (https://medlineplus.gov/druginfo/meds/a682514.html).	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314	1. No corrective action was possible for Resident #17 as resident had already discharged from the facility	8/2/2017

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F 314	Continued From page 16	F 314	2. All residents who are a high risk for pressure ulcers have the potential to be affected by this deficient practice. 3. Inservices will be conducted for nursing staff on preventative measures for pressure ulcers to include: assessing risk, interventions to prevent pressure ulcers, wound care, skin care and assessment and review of stop and watch. 4. Weekly EMR Audits of 20% of scheduled skin assessments to ensure assessments are being completed X 90 days. 100% audit of all new admissions to ensure proper identification of risk and accurate care plans. Results will be shared at monthly QAPI meeting.	

(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 and facility document review the facility staff failed to ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers (1) and does not develop pressures wounds for 1 out of 21 residents (Resident #17) in the survey sample resulting in harm.

Resident #17 was discharged from another facility, to the hospital and entered the facility on 02/08/17 without any pressure ulcers. On 02/13/17, Resident #17 was first identified with a total of nine (9) pressure ulcers to the following areas: left heel, right posterior heel, right heel, right mid heel, right inner ankle, left and right buttocks, left great toe and 2nd toe on right foot.

The findings included:

Resident #17 was admitted to the facility on

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02/08/17 and discharged home on 02/17/17. Diagnoses for Resident #17 included but not limited to: Dementia disease (2), Major Depressive Disorder (3) and muscle weakness (4).

Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date of 02/15/17 coded Resident # 17's Brief Interview for Mental Status (BIMS) score of 09 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #17 total dependence of two with bed mobility, transfers and toilet use, total dependence of one with dressing, eating and bathing and requiring extensive assistance of two with personal hygiene for Activities of Daily Living care.

A Braden Risk Assessment Report was completed on 02/08/17; Resident #17 scored an 11 indicating high risk for the development of pressure ulcers. Mobility (ability to change and control body position) coded very limited - does not make even slight changes in body or extremity position without assistance, sensory perception (ability to respond meaningfully to pressure-related discomfort) coded very limited - unresponsive to painful stimuli due to diminished level or consciousness or sedation or limited ability to feel pain over most of body surfaces.

Review of Resident #17's Nursing Admission Assessment Comprehensive dated 02/08/17 indicated the following: skin turgor (good), skin color (normal for ethnicity), skin type (diaphoretic), pressure ulcers (no), pressure ulcers on prior assessment (no). In addition, the 02/08/17 Nursing Admission Assessment

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Comprehensive indicated always incontinent of bowel and bladder.

The weekly skin condition progress report documentation revealed Resident #17 was first identified with the following pressure ulcers on 02/13/17: Left heel - Deep Tissue Pressure Injury (DTI) measuring 5.5 cm (centimeter) x 4.5 cm x 1, right posterior heel (DTI) measuring 2 cm x 3 cm x 0.1, right heel [stage 1 (5)] measuring 7 cm x 10.5 cm x 0.1 cm area that wraps around the heel with a (stage II) ruptured blister inside the noted area which measured 5.5 cm x 6.2 cm, right inner ankle as [stage II (6)] measuring 5.5 cm x 3.2 cm x 0.1 cm, right mid heel as [DTI (7)] measuring 1 cm x 4 cm x 0.1 cm, left buttocks as (stage II - intact blister) measuring 1 cm x 1.5 cm x 0.1 cm, right buttocks as (stage II - intact blister) measuring 1 cm x 1.2 cm x 0.1 cm, left great toe as (DTI) measuring 0.2 cm x 0.2 cm x 0.1 cm and right toe 2nd digit (DTI) measuring 0.2 cm x .2 cm x 0.1 cm.

The MDS with an ARD of 2/15/17 under section "M" under skin condition (M0100) was coded: Resident has a stage 1 or greater (M0150) at risk for developing pressure ulcers was coded yes, (M00210) was coded yes for unhealed pressure ulcers, (M0300) was coded for having 1 (stage 1), coded for having 3 (stage 2) and coded for having 5 (DTIs).

The MDS with an ARD of 2/15/17 under section "M" (Skin and Ulcer Treatments) also revealed the resident was not coded for pressure reducing device for chair, turning/repositioning program, applications of ointments/medications other than feet. The resident was coded always incontinent

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for bowel and bladder under section H (Bladder and Bowel). Under section E (Behaviors) was coded 0 for behavioral symptoms - presence and frequency, rejection of care to include ADL assistance.

On 06/22/17 at 12:00 p.m., surveyor requested behavior monitoring sheet from Director of Nursing (DON) who replied she reviewed Residents #17's medical record and was unable to locate any behavioral monitoring sheet for her.

Clinical record review did not indicate any type of behaviors from 02/08/17 through resident's discharge to home on 02/17/17.

An interview was conducted with LPN #1 who stated, "Resident #17 never exhibited any behaviors to include refusal of care in ADL's or positioning with bed mobility."

Resident #17's Interim care plan documented resident with actual problem with skin integrity related to immobility, incontinence and on 2/13/17 multiple DTIs and blisters. The goal: "absence of skin breakdown as evidenced by redness/swelling; skin intact breakdown with evidence of healing & no infection." Some of the intervention/approaches to manage goal included: "position every 2 hours & prn (as needed), assess skin every week and as needed, implement pressure reducing devices as needed, maintain nutritional and mobility status, main hygiene routine skin care and treatment as ordered."

According to the Treatment Administration Record (TAR) for February 2017, a new order was written for Prevalon boots (8) continuous

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except during physical therapy (PT) and low air loss mattress (9) to protect skin starting on 02/13/17.

The current treatment as of 02/13/17 is to clean blister to right heel with DWC (wound cleanser), skin prep (10) around blister, apply Xeroform (yellow gauze bandage) and apply abdominal pad and Opsite (11) every other day.

The current treatment to left heel as of 02/13/17 is to apply skin prep and apply Allevyn (12) every other day.

The current treatment as of 02/13/17 is to skin prep sacrum and intact blister and apply sacrum Allevyn every other day.

During medical record review, Resident #17 was assessed by PACE (Programs of All-Inclusive Care for the Elderly) physician on 02/16/17 and documented: "Prevalon boots not on but did address a dressing was intact to the right medial malleolus (right ankle)." The resident's Treatment Administration Record (TAR) for February 2017, revealed there was no active order for the right inner ankle wound.

During the review of the medical record and TAR for February 2017 revealed there was no treatments for the following pressure ulcers: right inner ankle as (stage II) measuring 5.5 cm x 3.2 cm x 0.1 cm, right posterior heel (DTI) measuring 2 cm x 3 cm x 0.1, right mid heel as (DTI) measuring 1 cm x 4 cm x 0.1 cm, left great toe as (DTI) measuring 0.2 cm x 0.2 cm x 0.1 cm and right toe 2nd digit (DTI) measuring 0.2 cm x .2 cm x 0.1 cm.

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An interview was conducted on 06/21/17 at approximately 9:50 a.m. with Occupational Therapy who stated Resident #17 was totally dependent with bed mobility and showed difficulty following commands. The surveyor asked if resident had a specialty cushion in her wheel chair or recliner when out of bed. The occupation therapy (OT) stated after reviewing OT notes, "I didn't see where it was documented; that something that is mentioned in our notes if a resident was sitting on a specialty cushion." The OT also stated the resident's chart was reviewed for skin issues but did not see where she had skin problems so we wouldn't have given her a specialty cushion.

An interview was conducted with physical therapy (PT) on 06/21/17 at approximately 10:20 a.m., who stated if there was a specialty cushion in Resident #17's wheel chair, we would have documented in our notes if resident was on a specialty cushion. PT also stated, "We read all admission paperwork and will address needs as indicated. There was nothing in the hospital discharge notes about resident having any wounds or skin issues; we also review the discharge summary to include active orders, skin assessment and treatments."

An interview was conducted with LPN #1 on 06/21/17 at approximately 2:30 p.m., who stated, "The PACE nurse was here to see someone else but decided to do a skin assessment on Resident #17 and needed another nurse to assist with the assessment. I was Resident #17's nurse so I assisted with the skin assessment." LPN #1 stated, "A CNA reported to me earlier, before my assessment with the PACE nurse that Resident had a pressure ulcer to her right heel and I

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reported it to the unit manager (RN #1) but didn't do an assessment at that time." LPN #1 also stated, "The PACE nurse is the one that completed the skin assessment and found all the pressure ulcers on Resident #17 except for the right heel, I wrote all the measurements down as she called them out to me." The unit manager (RN #1) informed the RR (Resident Representative) of all pressure ulcers.

During the interview with LPN #1 on 06/21/17 at approximately 2:30 p.m., the surveyor asked if a Resident receives weekly skin assessment and prn (as needed), when is the prn assessment completed and by whom, the LPN replied, "Mainly by the CNA but anyone really, if they see any areas they will notify the nurse." The surveyor then asked, "The prn is only after an area is found, the LPN replied, "Pretty much, but the CNAs should be looking at the residents skin daily."

On 06/21/17 at approximately 3:50 p.m., an interview was conducted with RN #1 who stated, "I wasn't in the room during the skin assessment on Resident #2 but I did inform the responsible party (RP) of all the wounds found on 06/13/17. The surveyor asked if resident's have daily skin assessments done, RN #1 stated, "Yes, the CNAs should be doing skin assessments daily and to inform nurses of skin changes."

The resident's nutritional assessment was completed by the registered dietitian (RD) on 02/09/17. The assessment indicated Resident #17's oral intake was Good/fair with a current weight of 179 lbs. (overweight related to excessive caloric intake as evidenced by BMI = 27.5 -29.9). The nutritional supplements included

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ensure Enlive three times daily and Prostat twice daily. Resident's current diet was puree with thin liquids. On 02/16/17 Ensure was increased to four times daily.

The RD note dated 02/16/17 reads as follows: "(Resident #17) was noted a 28-lbs weight loss over 5 months (13.5%); verified a 39-lb loss in past 7 months (17.9% significant). Pureed diet with thin liquids. Appetite poor (<20%) (Fed by staff/family). Receives Ensure and Prostat 30 ml twice daily. Plan: Goals to included but not limited to: 1) Stabilize weight (<or=a 2 lb weight change/month); comfort-focused care, 2) Honor food preferences/intolerance and RD will update regularly, 3) Suggest 3 cans daily if poor appetite, 2 cans if fair, 1 can if good appetite in the home, 4) Daughter and grandson at the conference today; planned discharge home on 02/17/17."

Labs results for 02/17 revealed an albumin level of 4.5; the normal albumin range (3.4 to 5.4 g/dL.) a low albumin level is indicative of prolonged protein depravation / malnutrition. Low albumin levels are indicative that the body has begun to breakdown muscle to compensate for an inadequate intake of protein. In individuals with bed sores, protein is essential to help the body heal the wounds.
https://www.bedsorefaq.com/what-does-a-patients-albumin-level-have-to-do-with-bed-sores/

An interview was conducted with the Medical Director (MD -who is a wound care specialist) and RN #3 on 06/22/17 at approximately 3:05 p.m. with four other surveyors. The surveyor informed the MD and RN #3, Resident #17 was first identified on 02/13/17 with 9 pressure ulcers to her lower extremities including both heels (DTIs).

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The MD stated, "I reviewed Resident #17's medical record and was under the impression that all of her wounds had resolved." The surveyor informed the MD and RN #3 that the surveyor had spoken with the resident's responsible party (RP) the morning of 06/21/17 and she stated, "My mom came home from Windermere with pressure ulcer to her heels, toes and buttocks." The MD then stated, "I didn't realize that, I thought they all had been resolved, that changes things." The MD also stated her records indicated she had pedal pulses; if you can palpate a pulse is reasonable to say she had blood flow to her lower extremities.

The MD proceeded to say, "We must do everything we can to prevent skin breakdown starting with good care; I'm transparent, we have to take ownership of this one and do better, you as surveyors are here to educate us so we can do a better job."

On 06/22/17 at 3:20 p.m., an interview was conducted with unit manager (RN#1); the surveyor asked, "An order was written on 02/13/17 for Prevalon boots to be worn continuous, can you tell me when they were applied and if she wore them continuous as ordered?" On the same day at 3:40 p.m., after RN #1 reviewed Resident's #17's nurses notes and TAR, she replied, "I don't know when they were applied or if she wore them at all, she then proceed to say, "The way the order was written, it did not generate over to the TAR to be signed off with initials as applied and nothing was documented in the nurses notes that she ever wore them." The surveyor informed unit manager (RN #1) on 02/16/17 the resident was seen by the PACE physician and document, "Prevalon boots

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not on" indicating resident was not wearing her Prevalon boots during the time of her assessment, she replied, "I didn't know that".

During the pre-exit meeting on 06/22/17 at approximately 4:10 p.m. with four other surveyors and the facility's administration, the surveyor stated, "Resident #17 was first identified on 02/13/17 with nine (9) pressure ulcer, "What should or could have been done to prevent Resident #17's pressure ulcers from developing" The Administrator stated, "We could have done a better with prevention; we recognized there was a problems with skin issues; we did a huge training on identifying skin issues sooner" and the Interim Director of Nursing stated, "We should have evaluated her as a whole, looked more closely at the diagnosis, reviewed hospital record before coming to the facility and the type of mattress that's needed."

The facility's policy: "Life Care- Pressure Ulcer Prevention:" (Revised 06/23/16).
Policy Statement: To prevent development of pressure ulcers.
Performed by: SLC Nursing Staff
1.) All residents are assessed for pressure ulcer on admission, every week x 4 weeks after admission, quarterly, with significant change and annually using the Braden Scale.
Braden Score Risk:
High Risk = Score of 12 or less
Moderate Risk= Score of 13 or 14
Low Risk = Score of 15 to 18
2) Turning and repositioning frequency is dependent on resident assessment and chart on TAR.
3) Pressure ulcer prevention order set is implemented based on need.

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Exceptions: None
Monitoring: Outcomes Monitoring
Document Management

(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) Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions (https://medlineplus.gov/ency/article/007365.htm).

(3) Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time (https://medlineplus.gov/ency/article/007365.htm).

(4) Muscles weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm).

(5) Stage 1 Pressure Injury: Non-blanchable erythema of intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation,

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temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

(6) Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis; Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

(7) Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may

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resolve without tissue loss (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/).

(8) Prevalon 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).

(9) Low air loss mattress is used for pressure prevention and treatment of pressure ulcers.

(10) 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/).

(11) Opsite is a transparent, adhesive film. The film is moisture vapor permeable, conformable and extensible. It is widely used to provide a moist wound environment for superficial wounds (http://www.smith-nephew.com/professional/products/advanced-wound-management/opsite/).

(12) Allevyn Adhesive Hydroceullar Foam Dressing allows for the formation and maintenance of a moist wound healing environment, preventing eschar formation and promoting rapid, trouble-free healing (http://www.hightidehealth.com/allevyn-adhesive-foam-dressing-home.html).

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	COMPLAINT DEFICIENCY			
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS	F 328	1. The nurse was educated on the proper procedure for the administration of IV antibiotics. Labs were drawn on Resident #14 to ensure no harm had been caused as the result of the improper administration of medication. 2. All residents receiving IV medication have the potential to be affected by this deficient practice. 3. Inservices will be conducted for licensed nursing staff on the proper administration of IV medication. 4. Observational audit of 100% of nursing staff during administration of IV medication to ensure proper technique is being used. Results to be shared at monthly QAPI meeting	8/2/2017

(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's

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goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review and staff interviews, the facility staff failed to ensure specialty care and procedures were followed in accordance to physician's orders and professional standards of practice for 1 of 21 residents (Resident #14) in the survey sample.

The facility staff failed to follow physician's orders for the heparin flush, as well as failed to provide PICC line (1) protocol before and after Intravenous (IV) antibiotic therapy for Resident #14.

The findings include:

Resident #14 was admitted to the nursing facility on 6/23/16 with diagnoses that included but not limited to Urinary Tract Infection (UTI) with ESBL

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(2).

The most recent Minimum Data Set (MDS) assessment dated 5/15/17 coded Resident #14 with a score of 1 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the skills for daily decision making.

The resident's person centered care plan dated 6/14/17 identified the resident had a UTI with ESBL and a PICC line for Intravenous Antibiotic therapy. The goal set by the staff for the resident was that the nursing staff would maintain a properly functioning PICC line. One of the approaches the staff would implement to accomplish this goal included using the SASH method (3) to flush the PICC line.

The resident had physician's orders dated 6/12/17 for Meropenem (antibiotic) 1 gram IV every eight hours for ten days. Heparin, porcine (PF) 100 units/ml IV 3 milliliters (ml) every eight hours. Note: Flush each PICC lumen with 10 ml of normal saline, then flush lumen with 3 ml of 100 unit/ml heparin every 8 hours.

The following observation was made during the administration of IV antibiotic therapy:

On 6/21/17 at 1:30 p.m., Licensed Practical Nurse (LPN) #1 connected the IV tubing and hung a 100 ml bag of Meropenem 1 gram IV. Upon completion of the antibiotic infusion, the LPN flushed the PICC line with 5 ml of heparin, porcine (PF) followed by 10 ml of normal saline.

On 6/21/17 at approximately 3:00 p.m., an

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interview was conducted with LPN #1. Three additional surveyors were present during this interview. The LPN stated she was trained by the nursing facility to flush all PICC lines in the manner she did during the aforementioned antibiotic infusion.

On 6/21/17 at approximately 4:00 p.m., the Interim Director of Nursing (IDON) and Staff Development Coordinator (SDC) stated she trained the licensed nursing to use the SASH method to flush central lines. When reviewed the observation of LPN #1's administration of an IV antibiotic via PICC line, the IDON stated she did not follow the standard by not flushing prior to the IV antibiotic infusion with normal saline, again after the antibiotic infusion and last the 3 ml of heparin. The LPN failed to follow the physician's order for only 3 ml of heparin; instead LPN #1 infused 5 ml of heparin. She also failed to follow the standard of practice with the SASH method by not flushing with normal saline prior and after the infusion, but flushed away the heparin by using the normal saline as the last step leaving the PICC line at risk for clotting off.

On 6/21/17 at 5:40 p.m. the Administrator and Corporate personnel presented the company's IV Pump Skill Station Education and stated they collaborated with the hospital to make the process uniform and that heparin would be used with PICC lines upon physician orders. LPN #1 had completed the Skill Station Education 9/15/16. The Administrator also stated the nurses had access to Nursing Practice and Skill information in order to gain specific nursing standards.

The facility's policy and procedure titled "Central

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Lines-Medication Administration" dated 6/1/17 indicated administration of medications via central lines is performed in accordance with physician's orders while maintaining patency of the central line. The policy clearly indicated normal saline was used before and after IV administration and the job aid indicated heparin 3 ml used as the last step with the SASH method.

(1) A PICC line is a catheter inserted into a peripheral vein and guided to a central vein is called a peripherally inserted central catheter. It's also called a PICC line. PICC line placement involves inserting a PICC line into a large blood vessel that leads to your heart (http://www.mayoclinic.org/diseases-conditions/cancer/multimedia/picc-line-placement/vid-20084657).

(2) ESBL (Extended Spectrum Beta-Lactamase) are Gram-negative bacteria that produce an enzyme; beta-lactamase that has the ability to break down commonly used antibiotics, such as penicillins and cephalosporins and render them ineffective for treatment (www.health.gov.nl.ca/health/publichealth/cdc/.../extended_spectrum_hcp.pdf).

Extended-spectrum beta-lactamase-producing bacteria require contact isolation practices necessary within a health care facility to prevent the spread of these bacteria, which can potentially cause life-threatening infections. Recommendations from the Centers for Disease Control and Prevention are discussed, including isolation practices utilized at a multi-hospital health care system (https://www.ncbi.nlm.nih.gov/pubmed/21160300).

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F 328	Continued From page 34 (3) Central Venous Catheter (single, double, triple lumen Hickman, Broviac, PICC lines, Midline Catheter, Midclavicular Catheter) - SASH protocol is to flush with 2-5 ml Normal Saline (0.9%) before and after each medication. The catheter is then flushed with 3 ml Heparin (100 units/ml) as a final flush (http://www.mayo.edu).	F 328		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329	1. Resident #9 was assessed for any signs/symptoms of negative effects of medication 2. All residents receiving antipsychotic medication have the potential to be affected by this deficient practice. 3. Licensed staff will be educated on diagnosis requirements for the use of antipsychotics. Residents with new behaviors will be reviewed by IDT to determine source of resident behavior and potential for non-pharmacological interventions.	8/2/2017

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F 329	Continued From page 35	F 329	4. Clinical manager or designee will audit any new orders for antipsychotic medication to ensure appropriate use of behavioral tracking sheets are implemented. Clinical manager or designee will conduct a weekly audit on 10% of resident's behavioral monitoring sheets to ensure non pharmacological interventions are attempted and documented. Results will be shared at monthly QAPI meeting.	

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

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility document review the facility staff failed to ensure 1 of 21 residents was free from unnecessary drugs, Resident #9.

Resident #9 was administered the psychoactive drug Ativan (an anti-anxiety agent) as needed (PRN) on multiple occurrences without identification of targeted behaviors, monitoring of side effects, and implementation of non-pharmacological behavioral interventions prior to administration.

The findings included:

Resident #9 was admitted to the facility on 11/25/16 with diagnosis to include, but not limited to Non-Alzheimer's dementia.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 5/9/17 coded the resident as scoring a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. Under Section E. Behavior the resident was coded as exhibiting wandering behaviors. No other behaviors were

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identified that impacted the resident or others. Under Section N. Medications the resident was coded as having received an antipsychotic medication seven (7) of the last seven days, and an anti-anxiety medication one (1) time in the last seven days.

The physician order sheet for June 2017 included the following:
1. Ativan 0.5 mg tablet (0.5 tab) for anxiety as needed every six hours.
2. Quetiapine (Seroquel an antipsychotic drug) 25 mg tablet two times a day.

The Resident Centered Plan of Care with effective date of 5/17/17-present identified the resident is receiving anti-anxiety drugs on PRN (as needed) basis. The goal was that symptoms will be controlled with minimal side effects over the next 90 days. Several interventions to obtain the goals included: Monitor for side effects of medication (drowsiness, loss of coordination, fatigue, mental slowness, confusion, constipation), notify physician if side effects noted, engage resident in group/individual activities that reduce periods of anxiety, re-direct resident by providing reading material, and set TV on sports station.

The clinical records evidenced that on 3/23/17 at 6:31 pm, the nurse documented that the resident was noted to be anxious and wandering throughout the facility. The nurse notified the Physician Assistant (PA) and obtained orders for a Stat CBC (complete blood count) and BMP (basic metabolic panel) and a urine culture and sensitivity.

On 3/25/17 at 7:58 pm, a nurse documented the

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following: "...PA made aware of resident's continued wandering/pacing behaviors. Noted with all stuff packed concerned of living arrangements since roommate's admission. Facials expressions display worry/confusion. New order for Ativan 0.5 mg-0.5 tab PO (by mouth) Q (every) 6 hours PRN for anxiety. Will continue to monitor."

The March 2017 Medication Administration Records (MARs) evidenced documentation that the resident was administered the PRN Ativan one time on 3/28/17, and it was not effective. There was no documentation found of non-pharmacological behavioral interventions being implemented prior to or in addition to the Ativan.

Further review of the April, May and June 2017 MARs evidenced the resident was administered Ativan PRN on the following dates without identification of targeted behaviors, monitoring for side effects and implementation of non-pharmacological behavioral interventions prior to or in addition to the Ativan as follows:
1. April 2017-Twelve (12) total doses given on 4/2, 4/3, 4/5, 4/6, twice on 4/14, 4/20, 4/21, 4/23, 4/24, 4/26 and 4/27/17.
2. May 2017-Ten (10) total doses given on 5/6, 5/10, 5/11, 5/12, 5/13, twice on 5/14, 5/22, 5/25 and 5/26/17.
3. June 2017-Three (3) total doses given on 6/8, 6/11 and 6/15/17.

On 6/21/17 at 10:45 am, the resident was observed asleep in the bed. Groomed, with glasses on. At 1:55 pm, the resident was in bed, awakened easily, affect was pleasant and cooperative.

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On 6/22/17 at 10:00 am, the resident was standing by the sink, the Certified Nurse Aide (CNA #1) was shaving the resident's face. The resident's affect was calm, pleasant and cooperative.

CNA #1 was interviewed later that day at 1:31 pm. She was asked about the resident's behavior, such as exhibiting anxiety. She stated, "I've never seen that happen...no behaviors...he's real mellow in the day, not sure about night time... When asked if she was aware of the resident's care plan addressing anxiety behaviors she stated, "No". When asked about the wandering behavior she stated, "He walks near the side exit door on the unit and the alarms sounds off because of the wander guard he has on, when he hears the alarm he turns around and goes the other direction". The CNA stated the resident is "calm and mellow".

On 6/22/17 at 11:57 am, the RN unit manager was interviewed. A request was made to review the Psychoactive Medication Monthly Flow Record(s) for April, May and June 2017 specific to the the anti-anxiety agent Ativan. The RN unit manager stated there were none for the Ativan. She produced May and June's for the monitoring of the antipsychotic Seroquel for the resident. She stated the Psychoactive Medication Monthly Flow Record(s) are only used for antipsychotic medications. When asked how are the staff monitoring the use of the Ativan she stated, identification of targeted behaviors, monitoring every shift and daily if behaviors are exhibited and document non-pharmacological interventions in the nurses notes or MARs. After reviewing the nurses notes and the MARs for April, May and

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June 2017 together with the unit manager there was only one time that the staff implemented non-pharmacological interventions as noted on 6/4/17. Identified targeted behaviors and evidence of monitoring for side effects were also not found in the clinical record, to include nurses notes or MARs.

After reviewing the facility's policy titled "Life Care-Psychoactive Medications" revision date 1/17/17, the RN unit manager was asked if the facility was following the policy, she stated, "According to the policy we have not".

The facility's policy titled "Life Care-Psychoactive Medications" revision date 1/17/17, read, in part:
Policy Statement-The facility will develop and maintain a system for assuring the proper use and monitoring of psychoactive agents.
Psychoactive agents can only be used on receipt of a physician's order to eliminate of reduce identified behavioral symptoms or to treat a specific diagnosis.
Present psychoactive agents include the following classes:
Anxiolytics (anti-anxiety)
Initiation Of Psychoactive Drug Therapy:
Non-Drug interventions have been attempted and documented as effective.
Anxiolytic Medications:
Define and document specific behavioral problems within the nurses notes.
Set reasonable and measurable objectives and reflect these in the resident's care plan.
Occurrences of specific behaviors and incidences of adverse side effects will be monitored daily and totaled monthly on the Psychoactive Drug Monitoring Form.
Charting of occurrences will be reflected as

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F 329	Continued From page 40 follows: Each occurrence or lack of occurrence will be noted for each day and shift. The above findings was shared with the Administrator, the Interim Director of Nursing (DON) and a second DON from another building during the pre-exit meeting conducted on 6/22/17 at 4:00 pm. The Administrator's response was, "We need to change the policy or follow it."	F 329		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441	1. Residents #6, #2, and #21 were monitored for signs/symptoms of infection 2. All residents have the potential to be affected by this deficient practice. 3. Inservices will be conducted for all departments on infection control practices to include proper handwashing technique and transport of food. 4. Clinical manager or designee will conduct observational handwashing audits weekly x thirty days. Weekly observational audits will be conducted by clinical mangers or designee on proper food transport X 30 days. Results of audits will be shared at monthly QAPI meeting.	8/2/2017

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communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical

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record review and facility document review, the facility staff failed to maintain good infection prevention and control practices to prevent infection for 3 of 21 residents in the survey sample, Resident #6, Resident #2 and Resident #21.

1. The facility staff failed to wash hands after removal of gloves x4 and failed to disinfect the overbed used for wound care procedure for Resident #6.

2. The facility staff failed to wash her hands according to standards of practice during wound care for Resident #2.

3. The facility staff failed to cover Resident #21's dinner tray when transporting from main dining room to room #36.

The findings included:

1. Resident #6 was admitted to the facility on 6/7/17. Diagnoses for Resident #6 included, but not limited to, high blood pressure.

The most recent Minimum Data Set (MDS) with an assessment reference date of 6/7/17, coded Resident #6 as having short-term and long-term memory impairment with moderately impaired abilities for daily decision making. A Brief Interview for Mental Status (BIMS) was not conducted.

On 6/21/17 at 1:00 pm, an observation of a wound dressing change on Resident #6 was conducted. LPN (Licensed Practical Nurse) #4 performed the procedure. The treatment order on the Physician Order Sheet stated, "Cleanse

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sacrum with DWC (brand name - wound cleanser), (brand name - ointment) to intact periwound skin, (brand name - wound dressing) to wound bed, cover with ABD (an absorbent dressing), secure with (brand name - wound dressing) daily and as needed."

LPN #4 proceeded with the dressing change for the first wound and the following was observed:
LPN #4 washed her hands with soap and water;
Put on 2 pairs of gloves;
Removed the soiled wound dressing with gloves on;
Did not change gloves; using the same gloves to remove the soiled dressing, proceeded to use gloved finger to apply the ointment on the skin around the wound.
Removed gloves, did not wash hands;
Put on another 2 pairs of gloves;
Applied the clean wound dressing;
Removed gloves, did not wash hands.

LPN #4 proceeded to clean and dress the second wound. There was no dressing observed on the wound.
LPN #4 put on 2 pairs of gloves;
Cleaned the wound;
Removed gloves, did not wash hands.
Put on 2 pairs of gloves.
Applied the ointment on the wound with gloved finger.
Removed gloves, did not wash hands.

After changing the wound dressings, LPN #4 cleared the overbed table used for wound dressing supplies and washed her hands with soap and water. LPN #4 failed to disinfect the overbed table after use. The overbed table was used as the dining table by the resident in bed.

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On 6/21/17 at 1:45 pm, an interview was conducted with LPN #4 and she stated, "Always wash hands after removing gloves."

On 6/21/17 at 4:45 pm, RN (Registered Nurse) #2, Supervisor was interviewed and was asked regarding the facility procedure for wound dressing change and she stated, "After removing gloves, wash hands. It should be done twice. When removing the dressing, must have gloves on, remove gloves and wash hands. Put on a new pair of gloves to put the dressing on, remove gloves and wash hands." She also stated that when using the overbed table for treatment procedure, to clean and disinfect prior to draping and after the procedure.

On 6/22/17 at 10:00 am, the interim Director of Nursing (DON) was interviewed and she stated that staff were expected to wash their hands after removing gloves.

On 6/22/17 at 1:40 pm, the Corporate Nurse stated that the overbed table used during treatment must be wiped with disinfectant, barrier placed, and disinfected after use.

On 6/20/17 at 5:55 pm, received a copy of the facility Job Aid titled, "Dressing - Clean", with a revision date of 8/13/13. The Job Aid stated, "...Clean surface on which dressing will be placed: ...Put on gloves; Remove soiled dressing; Wash hands."

The Administrator, interim DON and Corporate Nurse were made aware of these findings on 6/22/17 at approximately 4:10 pm. No further information was provided.

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2. Resident #2 was originally admitted to the facility on 08/07/15. Diagnoses for Resident #2 included but not limited to Pressure ulcer (1) sacrum region and Dementia (2).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 05/14/17 coded the resident with a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #2 requiring total dependence of two with transfers, total dependence of one bathing, extensive assistance of one with dressing, hygiene, bed mobility and toilet use and limited assistance of one with eating of Activities of Daily Living care. Resident #2 was coded always incontinent of bowel, has indwelling Foley (3) catheter to prevent urine from contaminating the sacral wound.

On 06/21/17 at approximately 11:15 a.m., Resident #2 was observed lying in bed on a Plexus P/2500 mattress in supine position with Foley catheter to bedside drainage to right side of bed. LPN #1 positioned resident on her right side with her left leg in a flexed positioned placed over her right leg.

Resident #2's revised Comprehensive care plan documented Resident #2 with actual skin breakdown to sacrum, left hip and left buttocks. The goal: size of ulcer will decrease with evidence of healing over the next 90 days. Some of the intervention/approaches to manage goal included the use pressure-reducing mattress and pads when sitting, use pillows, pads, to reduce pressure on heels and pressure points, turn and

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reposition, assess and document location and size weekly and treatment per MD orders.

On 06/21/17 at approximately 11:15 a.m., Resident #2 was observed lying in bed in supine position with Foley catheter to bedside drainage on right side of bed. Prior to wound care, LPN #1 positioned resident on her right side with her left leg in a flexed positioned placed over her right leg. LPN #1 performed wound care without staff assistance. Prior to starting wound care LPN #1 washed her hands for 16 seconds; applied gloves, removed dressing and packings from left hip, left buttocks and sacral wound (sacral wound being treated with a wound vac (4)) then washed hands for 16 seconds. LPN #1 proceeded to do wound care to left buttock wound: gloves applied, cleansed with Dakins (5) solution x 2, gloves removed, hands washed for 17 seconds, gloves applied, skin prep (6) applied around wound; 4 X 4 gauze were cut into strips, soaked in normal saline, excess liquid squeezed out then applied Santyl (7) to strips, packed into wound, covered with abdominal pad and secured with opsite (8) , gloves removed, hands washed for 9 seconds.

LPN #1 then proceeded to do wound care to left hip wound: gloves applied, cleansed with normal saline (NS) x 2, gloves removed, hands washed for 10 seconds, gloves applied, skin prep applied around wound, solosite (9) applied to gauze and packed into wound, covered with abdominal pad and secured with opsite, gloves removed, hands washed for 13 seconds.

LPN #1 then applied gloves, cleansed sacral wound with NS then Dakins solution x 3 in circular motion, gloves removed, hands washed for 10 seconds, Wound Vac applied, hands

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washed for 10 seconds. The LPN placed all dressing into trash bag and put in solid utility room.

An interview was conducted with LPN #2 on 06/22/17 at approximately 2:35 p.m. LPN #2 stated, "Okay, I thought I washed my hands longer than 9-13 seconds each time but maybe I didn't".

The facility's policy: "Life Care - Standard Precautions - Hand Hygiene"... (Revision Date: 09/08/15).

Purpose: To provide guidelines to employees for proper and appropriate hand washing that will aid in the prevention of transmission of nosocomial infections.
Required Action Steps:
1) Vigorously lather hands with soap and rub them together using friction to all surfaces for 20 seconds under a moderate stream of running water at a comfortable temperature.

1). Pressure ulcer is localized damage to the skin and underling soft tissue usually over a body prominence or related to a medical or other device. The injury can present as an intact skin or an open ulcer and may be painful. 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). Dementia is a progressive organic mental disorder characterized by chronic personality

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disintegration, confusion, disorientation and impairment of control of memory, judgment, and impulses.

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

4). Wound vac (also referred to negative pressure wound therapy) is a machine used to treat advanced bed sores. A wound vac uses a pump to suction fluids from bed sores or other wounds that are difficult to heal on their own

5). Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kill most forms of bacteria and viruses (http://www.webmd.com/drugs/2/drug-62261/Dakins'-misc/details).

6). 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/).

7). 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.

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8). Opsite is a transparent, adhesive film. The film is moisture vapor permeable, conformable and extensible. It is widely used to provide a moist wound environment for superficial wounds (http://www.smith-nephew.com/professional/products/advanced-wound-management/opsite/).

9). Solosite is a hydrogel wound dressing with preservatives. It can donate moisture to rehydrate non-viable tissue. It absorbs exudate while retaining its structure in the wound (http://www.smith-nephew.com/professional/products/advanced-wound-management/other-wound-care-products/solosite-gel/).

3. Resident #21 was admitted to the facility on 12/10/12. Diagnosis for Resident #21 included but not limited to Dementia without behavioral disturbance (1) and Gastro-Esophageal Reflux Disease (GERD) (2).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 03/28/17 coded the resident with a 12 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #21 requiring total dependence of two with bathing, total dependence of one with dressing, extensive assistance of one two with bed mobility and transfers, extensive assistance of one with toilet use and personal hygiene and limited assistance of one with eating.

On 06/21/17 at approximately 5:10 p.m., CNA #2 was observed leaving the main dining room caring an uncovered dinner tray down the hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. BUILDING _____ B. WING _____	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NSG CENTER-WINDERMERE	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(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
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This surveyor followed the CNA into room 36 A. Resident #21 was lying in bed in supine position, the CNA repositioned the resident, place the tray on the bedside table, put the head of her bed in high fowlers position then gave her the tray of food that was transported down the hall uncovered. The surveyor asked, "Should Resident #21 tray have been covered with transporting from the dining area to her room, he replied, "Resident #21 was eating in the dining room but wanted to go to bed so we put her in the bed then took her dinner tray to her. I guess I should have covered her food but there were no covers in the dining room to cover the trays".

An interview was conducted with the Administrator on 06/21/17 at approximately 6:05 p.m., who stated, "The meal tray should have been covered; even if they had to use a napkin, the tray should have been covered when transporting from dining room to the resident's room to prevent the potential spread of infection".

The facility's policy: Resident Tray and Dining Room Meal Services (Revision 09/30/16).

Room Tray Service and Assisting Residents
1) Meal delivery is preferred in an enclosed care. When enclosed cart is not available, all food and beverages must be covered to prevent potential sanitation issues.

1) Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become

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F 441	Continued From page 51 agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm). 2) GERD is a backflow of contents of the stomach into the esophagus (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th edition).	F 441		