Leewood Healthcare Center

a Grace HEALTHCARE Facility

Serving you from our heart

August 5, 2016

Ms. Elaine Cacciatore, LTC Supervisor

Office of Licensure and Certification

Division of Long Term Care Services

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1485

Re: Leewood Healthcare Center (Provider Number 495337)

Survey ending July 14th, 2016

Dear Ms. Cacciatore,

Enclosed for your review, please find our plan of correction for the survey ending July 14th, 2016. We submit this plan of correction as Leewood Healthcare Center's allegation of compliance. Please contact me directly if you have any questions for require additional information.

Sincerely,

Terrence Kee

Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEEWOOD HEALTHCARE CENTER	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/12/16 through 7/14/16. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 132 certified bed facility was 121 at the time of the survey. The survey sample consisted of 23 current Resident reviews (Residents #1 through #21, Resident #27 and Resident #28) and 5 closed record reviews (Residents #22 through #26).	F 000	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed for 1 resident (Resident #24) of 28 residents in the survey sample to ensure resident was free from abuse. On 4/10/16, Certified Nursing Assistant H (CNA H) was not suspended during an ongoing abuse investigation for which she and Resident #24 were involved. CNA H complained to CNA F	F 223	**F 223 Free from Abuse** Compliance Date: 8/5/16 **Immediate action taken for the resident found to have been affected include:** Resident #24 no longer resides at the facility, he was discharged on 5/3/2016. Nurse D, CNA H, CNA F are no longer employed by the facility.	8/5/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 8/5/16

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

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F 223	Continued From page 1 about the investigation. Both CNA's proceeded to intimidate and verbally threatened Resident #24. The findings included: Resident #24, a 51 year old, was admitted to the facility on 2/11/16. His diagnoses included end stage renal disease, dialysis, diabetes, hypertension, anemia, and below the knee amputation. The resident was not available for interview, as he was discharged from the facility on 5/14/16. Resident #24's most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 2/24/16. He had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He was coded to have a lower body range of motion limitation. He required extensive assistance from staff to perform his activities of daily living to include: Bed mobility= 3/2, extensive assistance with 1 person assistance Transfer= 3/3, extensive assistance with 2 person assistance Dressing= 3/2, extensive assistance with 1 person assistance Hygiene= 3/2, extensive assistance with 1 person assistance Bathing= 3/2, extensive assistance with 1 person assistance According to a Facility Reported Incident (FRI) sent from the facility to the state agency, on 4/6/16 Resident #24 notified Licensed Practical Nurse D (LPN D) that a CNA had been rough with him during a transfer and made comments about himself and his room. Through Resident #24's physical description of the CNA and time of the incident, facility staff determined the staff to be CNA H.	F 223	**Identification of other residents having the potential to be affected.** All residents have the potential to be affected Skin assessments were done on all residents on 7/13/2016 by the unit managers and licensed nurses-no bruises of unknown origin identified indicating signs of abuse. Alert residents were interviewed between 8/3/16 and 8/4/16 by the unit managers and charge nurses and there was one resident who reported an allegation of abuse concerning an employee. Employee was suspended pending outcome of investigation. Self-report process was initiated on 8/4/16. Investigation initiated.	

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F 223	Continued From page 2 The FRI documented that CNA H was on vacation during the time that the allegation was reported. CNA H returned to work on 4/10/16. Although CNA H should have been suspended during the investigation per facility policy, she was allowed to remain in the facility and work her shift. Rather than suspend CNA H during the investigation, the facility staff instructed CNA H to stay out of Resident #24's room. This was documented in the FRI as follows "On 4/10/16, (CNA H) returned to work and was taken off _____ (Resident #24 name) assignment, she was made aware of the concern by the Supervisor, _____ (Supervisor name). She was instructed not to go to _____ (Resident #24 name) room and was asked for her statement regarding her interactions with_____ (Resident #24 name). " The FRI documented that CNA H was overheard telling CNA F about the reported complaint from Resident #24. This interaction was also documented in the witness statement from LPN D. As part of the investigation, LPN D typed her own witness statement documenting the interactions that took place on 4/10/16 between CNA F, CNA H and Resident #24. LPN D's statement read as follows: "Supervisor stated to _____ (CNA H name) that she _____ (CNA H name) couldn't go in (Resident #24's room number) and proceeded to state what was said on the complaint. After the conversation ended _____ (CNA H name) walked down the hall and around the corner (while this nurse was still at nurse's station) right outside of room 132 as she came in contact with another 3-11 CNA on duty _____ (CNA F name). _____ (CNA H name) began to inform _____ (CNA F name) of what _____ (Supervisor) told her moments ago in regards to (Resident #24 ' s name and room number) reported complaint. After this being	F 223	**Actions taken/systems put into place to reduce the risk of future occurrence.** Education was done with the Administrator, Director of Nursing and the department heads by the Regional Director of Clinical Service on 7/15/2016 on abuse prevention, definition of abuse and abuse reporting to the required agencies. Education was done for all staff starting on 7/13/2016 by the Director of Nursing/Designee on Abuse Prevention Policy and Procedure, definitions of abuse and reporting abuse. Any staff member unavailable for education will receive in-services prior to their return to work.	

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F 223	Continued From page 3 witnessed, DON (Director of Nursing) was notified. DON reports to this nurse that Supervisor was informed to not allow _____ (CNA H name) to have that assignment, nor to go into that room & for this nurse to notify her immediately if there are any further issues throughout the shift. Note that _____ (CNA F name) had been assigned to that group, which includes (Resident #24 room number) for this shift." The witness statement from LPN D documented that both CNA F and CNA H entered Resident #24's room on 4/10/16. The statement read as follows: "At about 5:50 pm this nurse witnessed call light in (Resident #24's room) turn on (this nurse was at nurse's station charting at the time). CNA _____ (CNA F) walks into room slowly and stands at the foot of (Resident #24) bed, crossing her arms & begins to stare at patient. While _____ (CNA F name) proceeds to stand there, _____ (CNA H name) walks into the room behind _____ (CNA F name) & goes over to (Resident #24's room number) & cuts off call light, then goes to roommate's side of the room, picks up his tray (roommate room number) & leaves the room (not saying anything to the patient from what this nurse could hear at that point). Note that the patient had verbalized to me that he had noticed that the CNA he reported hadn't been working that assignment the past few days ((CNA H name) was out on vacation). My assumption is that _____ (CNA H name) walked into the room (after being instructed not to) basically wanting to make her presence known & that she was here tonight. After _____ (CNA H name) left the room, _____ (CNA F name) walks around to the side of (Resident #24 name) bed & begins to talk to the patient. This nurse noted her voice to get louder, in which I pulled the medication cart	F 223	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The administrator and or Director of nursing will review all allegations of abuse and injuries of unknown origin to assure the policy for employee review and discipline is followed and the incidents are reported as required for allegations of abuse or injuries of unknown origin weekly for 4 weeks then monthly for 2 months. The Administrator/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	

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F 223	Continued From page 4 directly outside of the room. This nurse overheard entire conversation _____ (CNA F name) was having with the patient. _____ (CNA F name) states 'why did you go and report _____ (CNA H name)? You should have never went and told anybody, you should had came to her first. You don't do that.' The patient states 'I never said anything about you. I told her time and time again about what she was doing and she continued to do it.' _____ (CNA F name) states ' You still shouldn't have went and said anything and made a report before you said anything to her. We all stick together, so now...' (basically insinuating that well now that you did that, you're going to get it even worse- Pt states that is what he got out of what she meant by that, in which I agree). Note the entire conversation patient is sitting on side of bed & _____ (CNA F name) is standing over him, talking down to him aggressively, almost like an interrogation. _____ (CNA F name) states "I will come to give you your tray, I will come pick up your tray, I will change your sheets, but other than that I am not doing anything else for you. Don't do anything to put my job in jeopardy because I need to provide for my family." LPN D's statement continued "Then _____ (CNA F name) walks out of patient's room. Other 3-11 nurse was in bathroom next door to (Resident #24 " s room number) (room 128) & reported to this nurse of hearing CNA (CNA F name)'going off', in which this nurse was outside of patient's room when entire conversation was heard. This nurse went into the room immediately to interview the patient. The patient was extremely hesitant of revealing further information due to retaliation of the staff members he's already getting. Pt states 'That's why I didn't want to say anything to begin with because now they're all gossiping about me	F 223		

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F 223	Continued From page 5 and all of this drama. All I do is put my headphones in and try to tune them out'." LPN D's statement concluded as follows: "After interviewing the patient, this nurse goes out to the nurse's station & witnessed _____ (CNA F name) & _____ (CNA H name) directly outside of the supply room in which confirmation was attained when conversation was again heard; _____ (CNA F name) states to _____ (CNA H name) 'I told him that he is putting my job in jeopardy because this is how I provide for my family. I told him that I will come to give his tray, I will come to pick up his tray, and I will change your sheets, but other than that I am not doing anything else for you.' CNA's then realized nurses at nurse's station and went their separate ways. Incident then was immediately reported to 3-11 Supervisor & DON. " The facility's policy "Abuse Prevention Policy & Procedure" was reviewed. Under the definition for "abuse" read the statement, "A more substantive definition of abuse is as follows: 'the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or goods and mental anguish, or deprivation by an individual including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being'." The policy definition for "mental abuse" included "humiliation, intimidation, harassment, and threats of punishment or deprivation." The definition for "verbal abuse" included "saying or doing something with intent to frighten a resident or otherwise make him/her feel unsafe or insecure." On 7/14/16 at 12:25 p.m., an interview was conducted with the Administrator and DON. At this time, they were asked why CNA H was not	F 223		

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F 223	Continued From page 6 suspended during the ongoing abuse investigation for which she was involved. The DON stated that CNA H had been on vacation and she (DON) did not know CNA H was on the schedule that day. It was reviewed with the DON and Administrator that per the facility abuse policy, CNA H should have been suspended while the investigation was ongoing. During the interview, the Administrator and DON were notified that there was concern for the way that CNA F and CNA H spoke to and threatened Resident #24. Both the Administrator and DON agreed that Resident #24 was a big guy and could take care of himself. It was reviewed with the Administrator and DON that residents, no matter physical size or cognitive ability, should not have to be in a position to defend themselves from facility staff that use verbal abuse, threats or intimidation. It was reviewed that it was the responsibility of the facility to protect residents from all forms of abuse. The DON nodded and stated that she agreed. The DON stated that both employees were sent home after the incident. The Administrator and DON stated that the facility terminated both CNA's. It was reviewed that, according to documentation in the investigation, both CNA's had resigned. Time card information was requested for both employees. No documentation was provided by facility staff showing that either CNA had been terminated. The section of the FRI titled "Facility/Employee Action initiated or taken" read " CNA F resigned from her position with the facility on 4/11/16. Based on the results of the investigation showing that she failed to follow the Supervisor's instructions not to go into (Resident #24) room CNA H will be terminated by the facility." On 4/10/16, CNA H was sent home because she	F 223		

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F 223	Continued From page 7 entered Resident #24's room despite being instructed not to go in the room. According to CNA H's time card information for 4/10/16, she clocked in for her shift at 3:23 p.m. and clocked out at 10:02 p.m. CNA H did not work another shift at the facility after 4/10/16. She resigned on 4/18/16. According to CNA F's time card for 4/10/16, she clocked in at 2:58 p.m. and clocked out at 8:45 p.m. She did not work another shift at the facility. She resigned on 4/11/16. The issue was reviewed again with the Administrator, DON and Corporate Nurse at the end of day meeting on 7/14/16. No further information was provided by the facility staff. COMPLAINT DEFICIENCY	F 223	**F 225 Investigate/Report Allegations/Individuals** Compliance Date: 8/5/16 **Immediate action taken for the resident found to have been affected include:** 1. Resident #13 was assessed by a licensed nurse on 7/13/16, head to toe assessment conducted, no skin abnormalities noted, no signs and symptoms of discomfort observed. 2. Employee #1's certification was verified with DHP on 8/5/16, by the human resource director. Employee # 3's signed sworn statement and references were obtained references on 7/12/16 No further action required. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. Skin assessments were done on all residents on 7/13/2016 by the unit managers and licensed nurses-no	8/5/16
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225		

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F 225	Continued From page 8 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation, clinical record and employee records review, the facility failed to, for one resident (Resident #13) in a survey sample of 28 residents to investigate and report a bruise of unknown origin, and verify licensure with the Department of Health Professions and failed to obtain a sworn statement prior to hire. 1. Resident #13 did not have a bruise of unknown origin reported to the OLC (office of licensure and certification). 2. For Emp. #1, the facility staff failed to verify certification with the DHP (department of health professions) prior to or at the time of hire and for Emp. #3, and failed to obtain references prior to or at the time of hire and for Emp. #3, the facility staff failed to obtain a sworn statement at the	F 225	bruises of unknown origin identified indicating signs of abuse. Alert residents were interviewed between 8/3/16 and 8/4/16 by the unit managers and charge nurses and there was one resident who reported an allegation of abuse concerning an employee. Employee was suspended pending outcome of investigation. Self-report process was initiated on 8/4/16. Investigation initiated. A 100% audit was conducted of all current C.N.A.'s, LPN's and RN license and certification to verify current status of license, by the human resource director on 7/13/16. No other employees were found to be affected by this practice.	

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F 225	Continued From page 9 time of or prior to the time of hire. The findings included: Resident #13 was initially admitted to the facility on 2/11/14 and was readmitted on 12/22/15. Her diagnoses included high blood pressure, dementia with behavior disturbance and dysphagia (difficulty swallowing). Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/17/16 was coded as a significant change in status assessment. She was coded as having a BIMS (brief interview of mental status) of "3" out of a possible 15, or severe cognitive impairment. Resident #13 was also coded as requiring extensive to total assistance of one staff to perform her activities of daily living such as bed mobility and transfer. Review of the clinical record on 7/13/16 at 10:00 AM, revealed a nurse's note dated 3/17/16, which documented a "bruise on the right inner thigh." Review of the incident report dated 3/17/16 noted, "bruise right inner thigh noted with red, slight purple in the inside, looks old. Left inner thigh has a slight discoloration." On 7/14/16 at 11:35 AM, the DON (director of nursing) was asked the process to follow with an injury of unknown origin. She stated, "Obtain statements of any preceding events, factors that may cause injury." She went on to state, "I didn't report it, yes, I should have." She went on to state that she thought the resident had caused	F 225	**Actions taken/systems put into place to reduce the risk of future occurrence.** Education was done with the Administrator, Director of Nursing and the department heads by the Regional Director of Clinical Service on 7/15/2016 on abuse prevention, definition of abuse and abuse reporting to the required agencies. Education was done for all staff starting on 7/13/2016 by the Director of Nursing/Designee on Abuse Prevention Policy and Procedure, definitions of abuse and reporting abuse. Any staff member unavailable for education will receive in-services prior to their return to work.	

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F 225	Continued From page 10 the bruises herself; there were no employee statements or further investigation. Review of the facility abuse policy revealed the following: "The facility will identify and investigate suspicion of or allegations of abuse such as suspicious bruising. They will review the occurrence and identify patterns and trends that may constitute abuse and that will be used to determine the direction of the investigation." On 7/14/16 at approximately 12:00 PM, the Administrator and DON were notified of above findings. 2. For Emp. #1, the facility staff failed to verify certification with the DHP (department of health professions) and failed to obtain references prior to or at the time of hire and for Emp. #3, the facility staff failed to obtain a sworn statement at the time of or prior to the time of hire. Emp. #1, a CNA (certified nursing assistant) was hired by the facility 6/6/16. His employee record was reviewed 7/14/16. Review of his employee record revealed no verification of his certification was obtained from DHP prior to or at the time of hire. As of review of his employee record, no verification had been obtained. Additionally, no references from previous employers had been obtained. The administrator said 7/14/16 at 1:24 p.m., he felt certain the verification had been obtained but was unable to locate it. The administrator stated he thought the references were wherever the copy of the verification was.	F 225	An in-service education program was conducted by the Administrator to the Human Resources Manager on 7/13/16 regarding completion of certificate/ license verification on all certified nurse' aides, Registered Nurses and Licensed Practical Nurses prior to hire. This education program included obtaining references for all employees and completion of sworn statement including signature, prior to hire. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Administrator and/or Director of Nursing will review all allegations of abuse and injuries of unknown origin to assure the policy for employee review and discipline is followed and the incidents are reported as required for allegations of abuse or injuries of unknown origin weekly for 4 weeks then monthly for 2 months.	

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F 225	Continued From page 11 Emp. #3, a housekeeper, was hired by the facility 6/6/16. Review of his employee record revealed a sworn statement was obtained, however there was no date entered on the sworn statement, nor other employee documents to indicate when the statement was obtained. The administrator stated 7/14/16 at 1:24 p.m., there was no documentation to indicate when the sworn statement was obtained. Review of the facility's policy entitled, "Abuse Prevention Policy & Procedure" included: "Pre-Employment Screening-When a potential new employee is considered for hire, each of the following steps should be taken to assure that the applicant is suitable for hire. 1. Complete Employment application-All candidates for employment are required to complete an Application for Employment. Material omissions or inaccuracies will exclude the candidate from further consideration. This includes a section requiring applicants to indicate whether they have been convicted of a crime and to detail the conviction. 2. Verification of License/Certificate-Verification of licensure or certification and identification of previous disciplinary actions or restrictions on licensure/certification will be obtained for all applicable positions. 3. Criminal Background check/Nurse Aid Registry check-In states where Criminal Background Checks are required; all employment candidates are required to authorize the facility to conduct a background check for conviction of	F 225	The Administrator/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. Human Resources Manager/Designee will conduct review of licenses and certification of nursing staff for verification they are current and in good standing, on all new applicants prior to hire. The Human Resources Manager will obtain references and check sworn statements for completion including signatures.	

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F 225	Continued From page 12 crimes. Refusal to grant authorization will eliminate the candidate from employment considerations. The facility shall take all steps necessary to assure it does not hire individuals found guilty of abusing, neglecting or mistreating residents by a court of law or those having similar findings entered into the state nurse aide registry or appropriate licensing body. If a criminal background check discloses any misrepresentations or omissions on the application or a condition unsuitable for hire, the new hire will not continue to be employed. Note: Background screens are submitted after a conditional offer is extended and must be received within the appropriate timeframe's per state requirements. 4. Prior Employment Reference (s)- Reference (s) of the candidate's prior employment must be conducted by the department director, or designee, hiring the candidate." The administrator, DON (director of nursing), and corporate consultant were informed of the failure of the staff to obtain references and verification of CNA certification for Emp. #1 or a sworn statement for Emp. #3, 7/14/16 at 1:45 p.m.	F 225	The Administrator/Designee will conduct audits of all new applicants prior to hire for certification/ license verification; references obtained and completeness of sworn statements to include signatures weekly x four (4) then, monthly for two (2) months. The Administrator/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226	**F 226 Develop/Implement Abuse/Neglect, etc. policies** Compliance Date: 8/5/2016	8/5/16

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F 226	Continued From page 13 by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for 1 resident (Resident #24) of 28 residents in the survey sample to implement the abuse prevention policy and procedure. Resident #24 reported an allegation of abuse involving Certified Nursing Assistant H (CNA H). The facility allowed CNA H to work while the investigation was ongoing. Per facility policy, CNA H should have been suspended during the investigation. On 4/10/16, Certified Nursing Assistant H (CNA H) was not suspended during an ongoing abuse investigation for which she and Resident #24 were involved. CNA H complained to CNA F about the investigation. Both CNA's proceeded to intimidate and verbally threatened Resident #24, which could have been avoided if the the facility had followed their abuse prevention policy and procedure. The findings Included: Resident #24, a 51 year old, was admitted to the facility on 2/11/16. His diagnoses included end stage renal disease, dialysis, diabetes, hypertension, anemia, and below the knee amputation. The resident was not available for interview, as he was discharged from the facility on 5/14/16. Resident #24's most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 2/24/16. He had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He was coded to have a lower body range of motion limitation. He required extensive assistance from staff to perform his activities of daily living to	F 226	**Immediate action taken for the resident found to have been affected include:** Resident #24 no longer resides at the facility, he was discharged on 5/3/2016. Nurse D, CNA H, CNA F are no longer employed by the facility. **Identification of other residents having the potential to be affected.** All residents have the potential to be affected Skin assessments were done on all residents on 7/13/2016 by the charge nurses and unit managers-no skin issues were identified indicating abuse. Alert residents were interviewed between 8/3/16 and 8/4/16 by the unit managers and charge nurses and there was one resident who reported an allegation of abuse concerning an employee. Employee was suspended pending outcome of investigation. Self-report process was initiated on 8/4/16. Investigation initiated.	

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F 226	Continued From page 14 include: Bed mobility= 3/2, extensive assistance with 1 person assistance Transfer= 3/3, extensive assistance with 2 person assistance Dressing= 3/2, extensive assistance with 1 person assistance Hygiene= 3/2, extensive assistance with 1 person assistance Bathing= 3/2, extensive assistance with 1 person assistance According to a Facility Reported Incident (FRI) sent from the facility to the state agency, on 4/6/16 Resident #24 notified Licensed Practical Nurse D (LPN D) that a CNA had been rough with him during a transfer and made comments about himself and his room. Through Resident #24's physical description of the CNA and time of the incident, facility staff determined the staff to be CNA H. The FRI documented that CNA H was on vacation during the time that the allegation was reported. CNA H returned to work on 4/10/16. Although CNA H should have been suspended during the investigation per facility policy, she was allowed to remain in the facility and work her shift. Rather than suspend CNA H during the investigation, the facility staff instructed CNA H to stay out of Resident #24's room. This was documented in the FRI as follows "On 4/10/16, _____ (CNA H name) returned to work and was taken off _____ (Resident #24 name) assignment, she was made aware of the concern by the Supervisor, _____ (Supervisor name). She was instructed not to go to _____ (Resident #24 name) room and was asked for her statement regarding her interactions with_____ (Resident #24 name). " The FRI documented that CNA H was overheard	F 226	**Actions taken/systems put into place to reduce the risk of future occurrence.** Education was done with the Administrator, Director of Nursing and the department heads by the Regional Director of Clinical Service on 7/15/2016 on abuse prevention, definition of abuse and abuse reporting to the required agencies. Education was done for all staff starting on 7/13/2016 by the Director of Nursing/Designee on Abuse Prevention Policy and Procedure, definitions of abuse and reporting abuse. Any staff member unavailable during the education period will receive in-services prior to their return to work.	

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F 226	Continued From page 15 telling CNA F about the reported complaint from Resident #24. This interaction was also documented in the witness statement from LPN D. As part of the investigation, LPN D typed her own witness statement documenting the interactions that took place on 4/10/16 between CNA F, CNA H and Resident #24. LPN D's statement read as follows "Supervisor stated to _____ (CNA H name) that she _____ (CNA H name) couldn't go in (resident #24's room number) and proceeded to state what was said on the complaint. After the conversation ended _____ (CNA H name) walked down the hall and around the corner (while this nurse was still at nurse's station) right outside of room 132 as she came in contact with another 3-11 CNA on duty _____ (CNA F name). _____ (CNA H name) began to inform _____ (CNA F name) of what _____ (Supervisor) told her moments ago in regards to (Resident #24 ' s name and room number) reported complaint. After this being witnessed, DON (Director of Nursing) was notified. DON reports to this nurse that Supervisor was informed to not allow _____ (CNA H name) to have that assignment, nor to go into that room & for this nurse to notify her immediately if there are any further issues throughout the shift. Note that _____ (CNA F name) had been assigned to that group, which includes (Resident #24 room number) for this shift." The witness statement from LPN D documented that both CNA F and CNA H entered Resident #24's room on 4/10/16. The statement read as follows "At about 5:50 pm this nurse witnessed call light in (Resident #24's room) turn on (this nurse was at nurse's station charting at the time). CNA _____ (CNA F) walks into room slowly and stands at the foot of (Resident #24) bed, crossing	F 226	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The administrator and or Director of nursing will review all allegations of abuse and injuries of unknown origin to assure the policy for employee review and discipline is followed and the incidents are reported as required for allegations of abuse or injuries of unknown origin weekly for 4 weeks then monthly for 2 months. The Administrator/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	

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F 226	Continued From page 16	F 226		

her arms & begins to stare at patient. While _____ (CNA F name) proceeds to stand there, _____ (CNA H name) walks into the room behind _____ (CNA F name) & goes over to (Resident #24's room number) & cuts off call light, then goes to roommate's side of the room, picks up his tray (roommate room number) & leaves the room (not saying anything to the patient from what this nurse could hear at that point). Note that the patient had verbalized to me that he had noticed that the CNA he reported hadn't been working that assignment the past few days ((CNA H name) was out on vacation). My assumption is that _____ (CNA H name) walked into the room (after being instructed not to) basically wanting to make her presence known & that she was here tonight. After _____ (CNA H name) left the room, _____ (CNA F name) walks around to the side of (Resident #24 name) bed & begins to talk to the patient. This nurse noted her voice to get louder, in which I pulled the medication cart directly outside of the room. This nurse overheard entire conversation _____ (CNA F name) was having with the patient. _____ (CNA F name) states 'why did you go and report _____ (CNA H name)? You should have never went and told anybody, you should had came to her first. You don't do that.' The patient states 'I never said anything about you. I told her time and time again about what she was doing and she continued to do it.' _____ (CNA F name) states ' You still shouldn't have went and said anything and made a report before you said anything to her. We all stick together, so now...' (basically insinuating that well now that you did that, you're going to get it even worse- Pt states that is what he got out of what she meant by that, in which I agree). Note the entire conversation patient is sitting on side of bed & _____ (CNA F name) is

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F 226	Continued From page 17 standing over him, talking down to him aggressively, almost like an interrogation. _____ (CNA F name) states "I will come to give you your tray, I will come pick up your tray, I will change your sheets, but other than that I am not doing anything else for you. Don't do anything to put my job in jeopardy because I need to provide for my family." LPN D's statement continued "Then _____ (CNA F name) walks out of patient's room. Other 3-11 nurse was in bathroom next door to (Resident #24 " s room number) (room 128) & reported to this nurse of hearing CNA (CNA F name)'going off', in which this nurse was outside of patient's room when entire conversation was heard. This nurse went into the room immediately to interview the patient. The patient was extremely hesitant of revealing further information due to retaliation of the staff members he's already getting. Pt states 'That's why I didn't want to say anything to begin with because now they're all gossiping about me and all of this drama. All I do is put my headphones in and try to tune them out'." LPN D's statement concluded as follows "After interviewing the patient, this nurse goes out to the nurse's station & witnessed _____ (CNA F name) & _____ (CNA H name) directly outside of the supply room in which confirmation was attained when conversation was again heard; _____ (CNA F name) states to _____ (CNA H name) 'I told him that he is putting my job in jeopardy because this is how I provide for my family. I told him that I will come to give his tray, I will come to pick up his tray, and I will change your sheets, but other than that I am not doing anything else for you.' CNA's then realized nurses at nurse's station and went their separate ways. Incident then was immediately reported to 3-11 Supervisor & DON. "	F 226		

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F 226	Continued From page 18 The facility's policy "Abuse Prevention Policy & Procedure" was reviewed. The section titled "Reviewing and Disciplining" read "This facility will conduct a comprehensive review of any employee suspected of abuse, neglect, or mistreatment of residents and will implement disciplinary action according to company policy. Any employee, who is accused of resident abuse, whether physical, verbal or sexual, will be suspended pending further investigation." The facility's policy "Abuse Prevention Policy & Procedure" was reviewed. Under the definition for "abuse" read the statement "A more substantive definition of abuse is as follows: 'the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or goods and mental anguish, or deprivation by an individual including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being'." The policy definition for "mental abuse" included "humiliation, intimidation, harassment, and threats of punishment or deprivation." The definition for "verbal abuse" included "saying or doing something with intent to frighten a resident or otherwise make him/her feel unsafe or insecure." On 7/14/16 at 12:25 p.m., an interview was conducted with the Administrator and DON. At this time, they were asked why CNA H was not suspended during the ongoing abuse investigation for which she was involved. The DON stated that CNA H had been on vacation and she (DON) did not know CNA H was on the schedule that day. It was reviewed with the DON and Administrator that per the facility abuse policy, CNA H should have been suspended while the investigation was ongoing.	F 226		

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F 226	Continued From page 19 During the interview, the Administrator and DON were notified that there was concern for the way that CNA F and CNA H spoke to and threatened Resident #24. Both the Administrator and DON agreed that Resident #24 was a big guy and could take care of himself. It was reviewed with the Administrator and DON that residents, no matter physical size or cognitive ability, should not have to be in a position to defend themselves from facility staff that use verbal abuse, threats or intimidation. It was reviewed that it was the responsibility of the facility to protect residents from all forms of abuse. The DON nodded and stated that she agreed. The DON stated that both employees were sent home after the incident. The Administrator and DON stated that the facility terminated both CNA's. It was reviewed that, according to documentation in the investigation, both CNA's had resigned. Time card information was requested for both employees. No documentation was provided by facility staff showing that either CNA had been terminated. The section of the FRI titled "Facility/Employee Action initiated or taken" read "CNA F resigned from her position with the facility on 4/11/16. Based on the results of the investigation showing that she failed to follow the Supervisor's instructions not to go into (Resident #24) room CNA H will be terminated by the facility." On 4/10/16, CNA H was sent home because she entered Resident #24's room despite being instructed not to go in the room. According to CNA H's time card information for 4/10/16, she clocked in for her shift at 3:23 p.m. and clocked out at 10:02 p.m. CNA H did not work another shift at the facility after 4/10/16. She resigned on 4/18/16. According to CNA F's time card for 4/10/16, she	F 226		

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F 226	Continued From page 20 clocked in at 2:58 p.m. and clocked out at 8:45 p.m. She did not work another shift at the facility. She resigned on 4/11/16. The issue was reviewed again with the Administrator, DON and Corporate Nurse at the end of day meeting on 7/14/16. No further information was provided by the facility staff.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, observation, and clinical record review, the facility staff failed to develop a comprehensive plan of care for one Resident (Resident #14) in a survey sample of 28	F 279	**F 279 Develop Comprehensive Care Plans** Compliance Date: 8/5/2016 **Immediate action taken for the resident found to have been affected include:** Resident #14 had a wash cloth applied to the right hand by certified nursing assistant on 7/14/2016. The intervention for the wash cloth was added to the care plan for contracture management on 7/14/2016 by the Director of Nursing.	8/5/16

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F 279	Continued From page 21 Residents. For Resident #14, the facility staff failed to develop a care plan to include the use of a rolled wash cloth in his hand to prevent further decline in range of motion. Resident #14, a male, was admitted to the facility 10/12/15 and readmitted after a hospitalization 10/28/15. His diagnoses included muscle weakness, hyperlipidemia, cerebrovascular accident, dysphagia, aphasia, adult failure to thrive, urinary retention, nontraumatic subdural hemorrhage, hypertension, and atrial fibrillation. Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/20/16 was coded as a quarterly assessment. Resident #14 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #14 was also coded as needing extensive to total assistance of one to two staff members to perform his activities of daily living. He was coded as having decline in range of motion of one upper and lower extremity. Of note, his MDS with an ARD of 10/19/15 was coded as an admission assessment. He was coded as having no range of motion deficits. Resident #14 was observed on initial tour of the facility 7/12/16, 7/12/16 at 4:10 p.m., 7/13/16 at 2:45 p.m., and 7/14/16 at 8:34 a.m. At all observations, he was lying on his back or receiving personal care. Nothing was observed in Resident #14's hands. Review of Resident #14's clinical record revealed a signed physician's order that included "1/11/16	F 279	**Identification of other residents having the potential to be affected.** The facility has determined that residents with physician orders for contracture management have the potential to be affected. All residents with contracture management interventions were reviewed by the restorative nurse and the care plans were updated to include the physician orders starting on 7/14/2016. **Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee to the licensed nurses on the use of devices for contracture management on 7/15/16.	

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F 279	Continued From page 22 PLACE ROLLED WASHCLOTH IN (R) HAND/PALM TO PREVENT CONTRACTURES AT ALL TIMES." The order was on the most recently signed "Physicians Order Sheet Plan of Care" signed by the physician 5/20/16. Review of Resident #14's care plan revealed no care plan had ever been developed to address Resident #14's decline in range of motion. Documentation revealed the comprehensive care plan had been reviewed 10/28/15, 11/4/15, 11/11/15, 3/2/16, and 4/25/16. When interviewed 7/14/16 at 8:34 a.m., both CNA (certified nursing assistant) D and E stated they were unaware that Resident #14 was to have anything in his right hand. CNA D stated she knew how to take care of Resident #14 by what the nurse told her or what was in the computer under the ADL (activities of daily living) program. The DON was interviewed 7/13/16 at 11:28 A.M. in the conference room. She stated that the care plans are updated quarterly, and as needed. She also said that the nursing staff are responsible for updating any nursing related issues on the care plan. The administrator, DON, and corporate consultant were informed of the failure of the staff to develop a comprehensive care plan to reflect strategies to prevent a decline in range of motion (rolled wash cloth in right hand), 7/14/16 at 1:15 p.m.	F 279	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or unit managers will review nurse's notes and physician's orders daily during the morning clinical meeting to identify new treatment orders including rehabilitation, restorative and contracture management orders, to determine if care plans are updated and interventions are in place and orders are carried out. The Director of Nursing/Designee will review printed treatment and restorative orders from the pharmacy monthly to ensure all contracture management orders are identified, care plans are updated, interventions are in place and are carried out. The Assistant Director of Nursing or designee will audit the residents with orders for contracture management, daily for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks to assure interventions for contracture management is in place and care planned.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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F 280	Continued From page 23 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed for 1 resident (Resident #10) of the survey sample of 28 residents, to revise the plan of care in a timely manner to prevent a re-current stage 2 pressure ulcer. For Resident #10, the facility staff failed to revise the care plan to identify a previous Stage 2 pressure wound and implement preventative measures to prevent it from re-opening. The NPUAP (National Pressure Advisory Panel) definitions of a Stage II pressure ulcer: "Stage II: Partial-thickness loss of dermis presenting as a	F 280	The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. **F 280 Right to Participate Planning Care-Revise CP** Compliance Date: 8/5/2016 **Immediate action taken for the resident found to have been affected include:** Resident #10 Interventions were updated on the resident's care plan by the MDS nurse on 7/13/2016 addressing the care and treatment of the wounds.	8/5/16

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F 280	Continued From page 24 shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. *Bruising indicates suspected deep tissue injury". The Findings included: Resident #10 was a 103 year old who was admitted to the facility on 9/10/09. Resident #10's diagnoses included Osteoarthritis, Heart Disease, Dementia without Behavioral Disturbance, and Contracture of Right Hand. The Minimum Data Set, which was a Quarterly Assessment, with an Assessment Reference Date of 6/22/16 coded Resident #10 as having a Brief Interview of Mental Status Score of 3, indicating severely impaired cognition. In addition, she was coded as having range of motion limits in both her upper and lower extremities. She was coded as requiring the extensive assistance of 2 people for transfers. On 7/13/16, at 9:00 A.M. a review was conducted of Resident #10's clinical record, revealing Physician orders. Resident #10's Physician Orders read, "7/2/16. Apply Zinc Oxide to sacrum (buttocks) three times daily and as needed for moisture reduction." According to National Institutes of Health.com," Zinc Oxide is used to protect skin from being irritated and wet."	F 280	Education was done by the Director of Nursing/Designee to the licensed nursing staff, initiated on 7/12/16 regarding documentation of skin issues including, descriptions, measurements, new treatment orders, care plan updates, preventative measures, revision of turning schedule, physician and family notifications. Education was done by the Director of Nursing/Designee to the licensed nursing staff and nurses aides, initiated on 8/4/16, regarding revision of the turning schedules. Identified residents had their care plans reviewed and updated accordingly on 8/4/16. Residents with skin conditions, care plans were reviewed by the unit managers and MDS nurse on 7/13/2016. Care plans were updated with interventions for preventions and treatment of pressure areas by the MDS nurse starting on 7/13/2016.	

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F 280	Continued From page 25 On 7/13/16 at 2:30 P.M. an interview was conducted with LPN A. He stated that the wound on the sacrum was an old wound that had re-opened. He was unable to state any interventions that had been put in place to prevent the wound from re-opening. He stated that it had been several months since the previous wound had resolved. He was unable to provide any supporting documentation of the previous wound. According to a Wound Assessment Report dated 7/6/16, the sacrum wound was a reopened wound that was found at stage 2. A Nurse's note dated 6/30/16 read, "Resident was noted with old scar reopen to right buttocks, barrier cream apply to site. Call place to RP (Responsible Party) for update message." The clinical record also contained a Braden Risk Assessment Report dated 5/21/15, and 6/24/16. Both reports identified Resident #10 as having a High Risk Level for the development of pressure ulcers. Although Resident #10 had been previously identified as being at high risk for pressure wound development, her care plan did not address her history of pressure wounds, to prevent re-opening. In addition, the facility staff were unable to locate documentation of when the previous Stage 2 ulcer had been identified, or resolved. Three observations were made of Resident #10 during the survey. She was always lying in the same position, which was on her back. According to her Resident Turning Schedule, on 7/12/16 at 4:00 P.M. she was on her back, when she should have been turned toward the window. On 7/12/13	F 280	**Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. Skin assessments were done on all residents on 7/13/2016 by the charge nurses and unit mangers with one resident identified with a new area. The area was measured, documented and treatment initiated for the resident identified on 7/13/2016 by the unit manager. **Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee on documentation of skin issues including, descriptions, measurements, new treatment orders, care plan updates, revision of turning schedule for residents and physician and family notifications, to the licensed nursing staff starting on 7/12/16.	

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F 280	Continued From page 26 at 4:45 P.M., she was still lying on her back when the surveyor conducted an observation of her wound. On 7/13/16 at 10:00 A.M. she was lying on her back, instead of facing the window. The surveyor observed a Stage 3 wound on Resident #10's heel with 30% maceration, slough and minimal drainage. Definitions of pressure ulcers provided by NPUAP (National Pressure Ulcer Advisory Panel): "Stage III: Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a Stage III pressure ulcer varies by anatomic location. The bridge of the nose, ear, occiput (back of head), and malleolus (ankle bone) do not have subcutaneous tissue, and Stage III ulcers can be shallow. In contrast, areas of significant adiposity (fatty tissue) can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable. The surveyor observed a Stage 2 pressure wound on Resident #10's sacrum, with 20% granulation and slough. (According to Authors Potter and Perry, "Fundamentals of Nursing 7th ed. page 1282, granulation tissue is "red moist tissue composed of new blood vessels, the presence of which indicated progression towards healing. Soft yellow of white tissue is characteristic of slough - stringy substance attached to wound bed.) Resident #10's Bath Roster was reviewed. Baths were given on 6/29/16, 7/2/16, and 7/6/16. There was no documentation that any skin	F 280	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or unit managers will review nurse's notes during the morning clinical meeting to identify new skin issues, to determine if care plans are updated with interventions, and physicians are notified for orders five times per week for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks. The Director of Nursing/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	

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F 280	Continued From page 27 abnormalities were reported. On 7/13/16 at 11:00 A.M. a review of facility documentation was conducted, revealing a Wound Care Management Policy revised on 3/13/15. It read, "Each resident receives the care and services necessary to retain or regain optimal skin integrity to the extent possible. Each resident is evaluated by the interdisciplinary team to determine his or her risk for skin compromise or the presence of wounds and/or pressure ulcers. A plan of care is developed and implemented based on this evaluation with ongoing review. If skin compromise occurs, evaluation is conducted by the interdisciplinary team to ensure appropriate measures are in place to minimize further compromise and aid in healing to the extent possible." On 7/13/16 at 11:28 A.M. an interview was conducted with the DON in the conference room. She stated that the care plans are updated quarterly, and as needed. She also said that the nursing staff are responsible for updating any nursing related issues on the care plan. When asked if it was appropriate to wait a week or more before updating a care plan, she stated, "No". The DON was unable to state why the care plan had not been updated, or what preventive measures had been implemented to prevent the previous pressure wound from re-opening. On 7/13/16 at 4:30 P.M. the facility Administrator (Administration A) was informed of the findings. No further information was received.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	**F 281 Professional Services Provided Meet Professional Standards** Compliance Date: 8/5/2016	8/5/16

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F 281	Continued From page 28 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow the professional standards of nursing for documentation of a physician order for one Resident (Resident #1) of 28 Residents in the survey sample. Resident #1's physician order did not specify the medication that was to be administered. The findings included: Resident #1, an 80 year old female, was admitted to the facility on 11/12/13 and readmitted after hospitalization on 3/17/14. Her diagnoses included hypertension, dysphasia, dementia, anemia, heart disease, anxiety, diabetes and pressure ulcer. Resident #1's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/1/16 was coded as a quarterly assessment. Resident #1 was coded for short and long term memory problems. Resident #1 was also coded dependent on one to two staff members for assistance with her activities of daily living and was coded as always incontinent of bowel and as having a urinary catheter in place. On 7/13/16 at 8:05 a.m. an observation of Resident #1's sacral pressure ulcer was conducted with the assistance of the unit manager, RN (registered nurse) A. Resident #1's sacral wound had a small opening in the center and moistened skin surrounding the opening. RN A said Resident #1 was admitted with the wound, that it was now considered a healing stage IV and she was being treated for excoriation. Resident	F 281	**Immediate action taken for the resident found to have been affected include:** Resident #1 physician was notified on 7/13/2016 and a clarification order was received for pain medication prior to treatment by the Unit Manager RN A. Resident with pain medications ordered for prior to treatment administration were reviewed 7/13/2016 by the unit managers for the specific medication to be received. No other residents were identified as needing clarification. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. The residents with orders to be medicated prior to treatments were reviewed on 7/13/2016 by the unit managers and charge nurses and no other residents were identified as needing clarification of orders for specific pain medications.	

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F 281	Continued From page 29 #1 tolerated the observation of her wound without any signs of pain or discomfort. The NPUAP (National Pressure Ulcer Advisory Panel) defines a stage IV pressure ulcer as: "Category/Stage IV: Full thickness tissue loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling." On 7/13/2016 at 8:45 a.m. a review of the clinical record was conducted and revealed a care plan dated 1/2/16 for excoriation of the sacrum and approaches to provide treatment as ordered. A physician's progress note dated 5/18/16 stated, Resident #1's sacral wound had improved but was still open. A review of the current physician order's sheet signed 5/18/16 had wound care orders that read, "3/23/16, Cleanse sacrum with wound cleanser, apply Silvasorb and Bactroban to wound base, loosely pack with Xeroform, cover with foam dressing daily." A telephone order dated 4/5/16, "Medicate resident 1/2/hr hour prior to wound care daily." The physician's order did not specify the medication that was to be administered. A review of the Medication Administration Record (MAR) for April, May, June and July revealed a corresponding entry for the order that read, "Medicate resident 1/2 hr prior to wound care daily." The MAR entry of the physician order did not include the medication that was to be administered. Further review of Resident #1's physician orders and MARs revealed the following two pain	F 281	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee to all licensed nurses on obtaining specific medication orders for residents prior to treatments starting on 7/14/2016. The Director of Nursing and/or unit managers will review physician orders during the morning clinical meeting to assure medication orders for pain prior to treatments are specific to the medication to be administered-five times per week for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks.	

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F 281	Continued From page 30 medication orders: a. "Tylenol .3 ml (milliliters) via gast-tube every 6 hours as needed for pain. b. Ultram 50 mg(milligram) tablet via gast - tube every 6 hours as needed for pain." The MARs did not reveal nurses' initials on the entries for these medications. On 7/13/16 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) C regarding the administration and documentation of Resident #1's pain medication. After reviewing the MAR, LPN C stated, "We just know to give her the Tylenol." On 7/13/16 at 10:30 a.m., an interview was conducted with RN A, the unit manager. RN A was asked about the order that did not specify a medication and the documentation (by way of initialing the MAR) of the administration of an unspecified medication by the nursing staff. After reviewing Resident #1's clinical record, RN A said she had written the order after a care plan meeting to ensure Resident #1 received pain medication before her dressing changes. RN A stated, "I'll call the doctor to get clarification on which pain medication to administer." Lippincott was cited as the facility's professional nursing standard reference. Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, Ambler, PA, page 181 reads "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation ... "	F 281	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	

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F 281	Continued From page 31 On 7/14/16 at 2:30 p.m., the administration was informed of the findings.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed for 1 resident (Resident #10) of the survey sample of 28 residents, to identify a pressure ulcer on the left heel prior to it developing to Stage 3, resulting in harm. For Resident #10, the facility staff failed to identify a pressure ulcer prior to it developing to Stage 3. Definitions of pressure ulcers provided by NPUAP (National Pressure Ulcer Advisory Panel): "Stage III: Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a	F 314	**F 314 Treatment/Services to Prevent/Heal Pressure Sores** Compliance Date: 8/5/2016 **Immediate action taken for the resident found to have been affected include:** Resident #10 was assessed by the Wound Care Physician (other A) on 7/13/2016 and documented the stage, depth, length, width and the description of the wound bed on the sacrum and left heel. Resident #10 pressure sore assessment and pressure prevention checklist was completed on 7/13/2016 by the charge nurse. Interventions were updated on the resident's care plan by the MDS nurse on 7/13/2016 addressing the care and treatment of the wounds.	8/5/16

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(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 314	Continued From page 32 Stage III pressure ulcer varies by anatomic location. The bridge of the nose, ear, occiput (back of head), and malleolus (ankle bone) do not have subcutaneous tissue, and Stage III ulcers can be shallow. In contrast, areas of significant adiposity (fatty tissue) can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." The Findings included: Resident #10 was a 103 year old who was admitted to the facility on 9/10/09. Resident #10's diagnoses included Osteoarthritis, Heart Disease, Dementia without Behavioral Disturbance, and Contracture of Right Hand. The Minimum Data Set, which was a Quarterly Assessment, had an Assessment Reference Date of 6/22/16. Resident #10 was coded as having a Brief Interview of Mental Status Score of 3, indicating severely impaired cognition. In addition, she was coded as having range of motion limits in both her upper and lower extremities. She was coded as requiring the extensive assistance of 2 people for transfers. On 7/13/16, at 9:00 A.M. a review was conducted of Resident #10's clinical record, revealing a Wound Assessment Report. It read, "Date wound identified - 7/6/16, Location: Left Heel, Assessment Occasion: New Wound, Stage 3, Drainage: Serous/Small, Measurements: Length - 0.90 cm (centimeters), Width: 1.2 cm, Depth: 13.00 cm. Surrounding skin: Macerated. The wound bed was not described." The wound edges were not described. The Director of Nursing was interviewed on	F 314	Education was done by the Director of Nursing and the Administrator on documentation of skin issues and completion of wound assessment with the date identified, description and measurements on 7/12 and 7/13/2016 for the wound care nurse. Skin reviews and Pressure sore risk assessments were completed on all residents 7/13/2016 by the charge nurses and unit managers. Based on the risk assessment score a pressure ulcer prevention checklist was completed for all residents on 7/13/2016 by the charge nurses and unit managers. Care plans were updated with interventions for preventions and treatment of pressure areas by the MDS nurse starting on 7/13/2016.	

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F 314	Continued From page 33 7/13/16 at 10:00 A.M. She stated that there was a typo on the report, and that the correct Depth was "3.00 cm.", not "13 cm.". She also stated that the wound report was dated incorrectly. The wound was first identified on 6/30/16, not 7/6/16, which was verified by the wound nurse (Licensed Practical Nurse A, who wrote the report). Resident #10's Physician Orders read, 1) "7/1/16. Clean left heel with wound cleanser pat dry apply Silversorb gel (SilverSorb is manufactured by Medline. According to www.medline.com <http://www.medline.com>, indication for use was as follows: " For lightly draining wounds in need of antimicrobial barrier. Helps manage bacterial burden. Indications: Pressure Injuries. " 2) "7/2/16. Apply Zinc Oxide to sacrum (buttocks) three times daily and as needed for moisture reduction." The National Institutes of Health ' s U.S. Library of Medicine describes zinc oxide as follows: "Zinc Oxide is a mild astringent and topical protectant with some antiseptic action. " Their website is: <https://pubchem.ncbi.nlm.nih.gov/compound/14806> On 7/13/16 at 2:30 P.M. an interview was conducted with Licensed Practical Nurse (LPN) A. He stated that he identified the pressure ulcer on Resident #10's left heel, but didn't describe the wound bed because he didn't want to describe it, in case his description would be different from the wound care physician's description. He also stated that the wound on the sacrum was an old wound that had re-opened. He was unable to state any interventions that had been put in place to prevent the wound from re-opening.	F 314	**Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. Skin reviews and Pressure sore risk assessments were completed on all residents 7/13/2016 by the charge nurses and unit managers. Based on the risk assessment score a pressure ulcer prevention checklist was completed for all residents on 7/13/2016 by the charge nurses and unit managers. Care plans were updated with interventions for preventions and treatment of pressure areas by the MDS nurse starting on 7/13/2016.	

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F 314	Continued From page 34 The clinical record also contained 2 Wound Care Specialist Evaluations. 1) "7/6/16. Stage 3 pressure would of the left heel greater than 1 days duration. Wound size L x W x D: 0.9 x 1.2 x 0.3 cm. 100% Granulation tissue. (According to Authors Potter and Perry, "Fundamentals of Nursing 7th ed. page 1282", granulation tissue is "red moist tissue composed of new blood vessels, the presence of which indicated progression towards healing. Soft yellow of white tissue is characteristic of slough - stringy substance attached to wound bed".) Dressing: Silver Hydrogel every 3 days, Foam every 3 days." 2) "7/13/16. "Stage 3 pressure ulcer Left Heel. Wound size: Lx W x D = 0.5 x 0.9 x 0.3 cm. 100% granulation tissue. (Duration greater than 7 days. Dressing: Silver Hydrogel every 3 days, Foam every 3 days. Recommendation: Off -Load wound, Reposition per facility protocol." This report also stated that Resident #10 had a Stage 2 pressure wound on her sacrum of greater that 1 days duration. This sacral wound had 100% granulation tissue." According to a Wound Assessment Report dated 7/6/16, the sacrum wound was a reopened wound that was found at stage 2. A Nurse's note dated 6/30/16 read, "Resident was noted with old scar reopen to right buttocks, barrier cream apply to site. Call place to RP (Responsible Party) for update message." The NPUAP (National Pressure Advisory Panel) definitions of a Stage II pressure ulcer: "Stage II:	F 314	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee on documentation of skin issues including, descriptions, measurements, new treatment orders, care plan updates, revision of turning schedule, and physician and family notifications, to the licensed nursing staff starting on 7/12/16. Residents will have pressure sore risk assessments and pressure ulcer prevention checklist completed on admission, quarterly and with changes in skin conditions by the unit managers or charge nurses. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or unit managers will review nurse's notes during the morning clinical meeting to identify new skin issues, assure documentation is complete, care plans are updated with interventions, and the physicians are notified for orders five times per week for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks.	

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F 314	Continued From page 35 Partial-thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. *Bruising indicates suspected deep tissue injury." The clinical record also contained a Braden Risk Assessment Report dated 5/21/15, and 6/24/16. Both reports identified Resident #10 as having a High Risk Level for the development of pressure ulcers. Although Resident #10 had been previously identified as being at high risk for pressure wound development, her care plan did not address her history of pressure wounds, to prevent re-opening. Three observations were made of Resident #10 during the survey. She was always lying in the same position, which was on her back. According to her Resident Turning Schedule, on 7/12/16 at 4:00 P.M. she was on her back, when she should have been turned toward the window. On 7/12/13 at 4:45 P.M., she was still lying on her back when the surveyor conducted an observation of her wound. On 7/13/16 at 10:00 A.M. she was lying on her back, instead of facing the window. The surveyor observed a Stage 3 wound on Resident #10's heel with 30% maceration, slough and minimal drainage. Another surveyor observed a Stage 2 pressure wound on Resident #10's sacrum, with 20% granulation and slough.	F 314	The Director of Nursing/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	

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F 314	Continued From page 36 Resident #10's Bath Roster was reviewed. Bed baths were given on 6/29/16, 7/2/16, and 7/6/16. There was no documentation that any skin abnormalities were reported. On 7/13/16 at 11:00 A.M. a review of facility documentation was conducted, revealing a Wound Care Management Policy revised on 3/13/15. It read, "Each resident receives the care and services necessary to retain or regain optimal skin integrity to the extent possible. Each resident is evaluated by the interdisciplinary team to determine his or her risk for skin compromise or the presence of wounds and/or pressure ulcers. A plan of care is developed and implemented based on this evaluation with ongoing review. If skin compromise occurs, evaluation is conducted by the interdisciplinary team to ensure appropriate measures are in place to minimize further compromise and aid in healing to the extent possible." On 7/13/16 at 11:28 A.M. an interview was conducted with the DON (Director of Nursing) in the conference room. She stated that the care plans are updated quarterly, and as needed. She also said that the nursing staff are responsible for updating any nursing related issues on the care plan. When asked of it was appropriate to wait a week or more before updating a care plan, she stated, "No". When asked about how bed baths are given by Certified Nursing Assistants, the DON stated, " They clean from head to toe. They use several washcloths. They clean the feet. They call the nurse if there are any skin abnormalities." The DON was also asked about the importance of describing the wound bed during an initial assessment of a pressure wound.	F 314		

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F 314	Continued From page 37 She stated, "It is important to describe the wound bed in order to know what stage it is and what treatment should be done." On 7/13/16 at 8:30 A.M. an interview was conducted with the Wound Care Physician, (Other A). When asked about the importance of identifying a pressure wound prior to it becoming Stage 3, he stated, "You know the answer. You'd like to catch it in as early a stage as possible." On 7/13/16 at 4:30 P.M. the facility Administrator (Administration A) was informed of the findings. No further information was received. This is a harm level deficiency.	F 314	**F 318 Increase/Prevent Decrease in Range of Motion** Compliance Date: 8/5/2016 **Immediate action taken for the resident found to have been affected include:** Resident #14 had a wash cloth applied to the right by certified nursing assistant on 7/14/2016. The intervention for the wash cloth was added to the care plan for contracture management on 7/14/2016 by the Director of Nursing.	8/5/16
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to implement a physician ordered assistive device to prevent further decline in range of motion for one Resident (Resident #14) in a survey sample of 28 Residents. For Resident #14, the facility staff failed to ensure a rolled washcloth was placed in Resident #14's	F 318	**Identification of other residents having the potential to be affected.** The facility has determined that residents with physician orders for contracture management have the potential to be affected. All residents with contracture management interventions were reviewed by the restorative nurse and the care plans were updated to include the physician orders starting on 7/14/2016.	

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F 318	Continued From page 38 right hand per physician's orders on initial tour of the facility 7/12/16, on 7/12/16 at 4:10 p.m., 7/13/16 at 2:45 p.m., and 7/14/16 at 8:34 a.m. The findings included: Resident #14, a male, was admitted to the facility 10/12/15 and readmitted after a hospitalization 10/28/15. His diagnoses included muscle weakness, hyperlipidemia, cerebrovascular accident, dysphagia, aphasia, adult failure to thrive, urinary retention, nontraumatic subdural hemorrhage, hypertension, and atrial fibrillation. Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/20/16 was coded as a quarterly assessment. Resident #14 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #14 was also coded as needing extensive to total assistance of one to two staff members to perform his activities of daily living. He was coded as having decline in range of motion of one upper and lower extremity. Of note, his MDS with an ARD of 10/19/15 was coded as an admission assessment. He was coded as having no range of motion deficits. Resident #14 was observed on initial tour of the facility 7/12/16, on 7/12/16 at 4:10 p.m., 7/13/16 at 2:45 p.m., and 7/14/16 at 8:34 a.m. At all observations, he was lying on his back or receiving personal care. Nothing was observed in Resident #14's hands. Review of Resident #14's clinical record revealed a signed physician's order that included "1/11/16 PLACE ROLLED WASHCLOTH IN (R)	F 318	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee on the use of devices for contracture management on 7/15/16. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Assistant Director of Nursing or designee will audit the resident's physician orders daily for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks to assure interventions for contracture management is in place and care plans are updated with the intervention.	

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F 318	Continued From page 39 HAND/PALM TO PREVENT CONTRACTURES AT ALL TIMES." The order was on the most recently signed "Physicians Order Sheet Plan of Care" signed by the physician 5/20/16. Review of Resident #14's care plan revealed no care plan had ever been developed to address Resident #14's decline in range of motion. Documentation revealed the comprehensive care plan had been reviewed 10/28/15, 11/4/15, 11/11/15, 3/2/16, and 4/25/16. When interviewed 7/14/16 at 8:34 a.m., both CNA (certified nursing assistant) D and E stated they were unaware that Resident #14 was to have anything in his right hand. CNA D stated she knew how to take care of Resident #14 by what the nurse told her or what was in the computer under the ADL (activities of daily living) program. CNA A stated she was a hospice CNA and cared for Resident #14 several days a week. CNA D stated she had cared for Resident #14 for several weeks. RN (registered nurse) A, the unit manager, stated 7/14/16 at 8:42 a.m., she would inform the staff that Resident #14 was to have a rolled wash cloth in his right hands. RN A was unaware that the physician ordered rolled wash cloth was to be in his hand to prevent further decline in range of motion. RN A stated CNAs were informed of Resident needs by the nurses or the ADL care was entered into the computer. The administrator, DON, and corporate consultant were informed of the failure of the staff to ensure a physician ordered rolled wash cloth was in Resident #14's right hand/palm to prevent a decline in range of motion, 7/14/16 at 1:15 p.m.	F 318	The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	

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F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a safe environment on 1 of 4 units. The supply closet on Cardinal Unit was unlocked. The closet contained approximately 400 lancets and 130 syringes. (2) 200 count boxes of lancets. The syringes were individually wrapped. They were in baskets on the shelf. The findings included: On 7/13/16 at 2:10 p.m., the supply closet on the Cardinal Unit was observed to be unlocked. The closet contained approximately 400 lancets and 130 syringes. During the observation, two nurses were at the nursing station across from the closet door. Three residents sitting in wheel chairs were seated in the hallway near the closet door. These residents appeared to have cognitive impairments. These residents did not appear to have the ability to self propel.	F 323	**F 323 Free of Accident Hazards/Supervision/Devices** Compliance Date: 8/5/2016 **Immediate action taken for the resident found to have been affected include:** The supply closet of Cardinal Unit was locked on 7/13/2016 by the charge nurse. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. **Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee to all nursing personnel on securing supply closets to prevent unauthorized entry by residents starting on 7/14/2016.	8/5/16

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F 323	Continued From page 41 On 7/13/16 at 2:21 p.m., the door remained unlocked. Two staff were at the nursing station. On 7/13/16 at 3:45 p.m., the door remained unlocked. Four staff were at the nursing station. On 7/13/16 at 4:50 p.m., the Director of Nursing (DON) and Administrator were notified that the Cardinal Unit supply closet containing syringes and lancets was unlocked. The DON stated that she expected that the door be locked.	F 323	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The Assistant Director of Nursing or designee will audit the resident care areas to assure supply closets are locked daily for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks. The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to ensure that hair restraints were worn and that food was stored in a sanitary manner. Facility staff failed to wear hair restraints while storing clean plates after washing them, and while storing a delivery of milk in the walk-in refrigerator.	F 371		

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F 371	Continued From page 42 The Findings included: On 7/12/16 at 2:17 P.M. an observation was conducted of the kitchen. The Dietary Aide (Other E) was not wearing an effective hair restraint. He wore a baseball cap which only covered the top of his head, above the top of his ears. His hair on the sides and in the back were approximately between 1 - 1 1/2 inches long. He was washing dishes and then storing them. In addition, a delivery man (Other C) from the milk company was observed walking back and forth into the walk-in refrigerator storing milk. He was not wearing a hair restraint. The Dietary Supervisor (Other B) accompanied the surveyor on the tour. The Dietary Supervisor directed Other E to put on a hairnet. When the Dietary Supervisor was asked about the importance of effectively wearing hair restraints he stated, "There could be contamination. A resident can choke on an inch of hair depending on their situation." On 7/13/16 at 11:56 A.M. in the hallway, an interview was conducted with the Dietary Services Manager (Other F). When asked about the importance of delivery personnel wearing hair restraints in the kitchen she stated, "The milk delivery man should have been stopped at the door." On 7/13/16 at 1:00 P.M. a review was conducted of facility documentation. The Personal Hygiene Policy (Revised 4/20/16) read, "Wear a clean hat or other hair restraint. Hair must be appropriately restrained or completely covered."	F 371	**F 371 Food Procure, Store/Prepare/Serve/Sanitary** Compliance date: 8/5/2016 **Immediate actions taken for the residents found to have been affected:** The Dietary Aide (other E) removed his baseball cap and replaced it with a hairnet while in the dietary department on 7/12/2016 while the surveyor was observing. The milk delivery person was educated by the food service director on 7/15/16. **Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be affected. **Action taken/systems put into place to reduce the risk of future occurrence include:**	8/5/16

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F 371	Continued From page 43 On 7/13/16 at 4:30 P.M. the facility Administrator (Administration A) was informed of the findings. No further information was received.	F 371	The food service director started education on the use of hair restraints on 7/12/2016 to the dietary staff. The food service director has educated the milk delivery person on 7/15/16 regarding using hair restraints when in the dietary department. A sign was posted outside the dietary department to remind vendors to apply hair restraints prior to entering the department.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**How the corrective action will be monitored to ensure the practice will not recur:** The food service director or designee will monitor the dietary staff and delivery persons daily for two weeks then three times a week for two weeks then weekly for four weeks for the application of proper hair restraints.	

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	495337	A. BUILDING _____ B. WING _____	C 07/14/2016

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F 441	Continued From page 44 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure the infection control program was effective. 1. For Resident #5, CNA (certified nursing assistant) C threw dirty linen and clothing on the floor of Resident #5's bedroom while performing morning care; and 2. A licensed nursing staff member was observed with long artificial fingernails. The findings included: 1. For Resident #5, CNA (certified nursing assistant) C threw dirty linen and clothing on the floor of Resident #5's bedroom while performing morning care. Resident #5, a female, was admitted to the facility 3/7/16. Her diagnoses included fall with subarachnoid hemorrhage, hemothorax, fractured seven ribs, hypertension, acute encephalopathy, right distal clavicular fracture, acute pulmonary insufficiency, atrial fibrillation, and congestive heart failure. Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of	F 441	The food service director/designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. **F 441 Infection Control, Prevent Spread, Linens** Compliance Date: 8/5/2016 **Immediate action taken for the resident found to have been affected include:** Resident #5 medical record was reviewed on 7/15/2016 and no infections were identified. The certified nursing assistant C received counseling on handling soiled linen on 7/19/2016 by the Director of Nursing.	8/5/16

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F 441	Continued From page 45 3/14/16 was coded as an admission five day assessment. She was coded as having short and long term memory deficits and required moderate assistance with making daily life decisions. Resident #5 was coded as needing extensive to total assistance of one to two staff members to perform her activities of daily living. Resident #5 was observed 7/13/16 at 8:58 a.m. Resident #5 was lying on her bed, dressed. CNA C was performing morning care. Upon entering the bedroom, Resident #5's hospital gown was on the floor near the end of her bed. CNA C removed the pillow case and threw the dirty one on the floor by the gown. CNA C then threw the used towel on the floor. With a gloved hand, CNA C picked up all the dirty linen and gown and put them in a plastic bag in the trash can. He then removed the bag and left the room. CNA A was not working at the facility during the rest of the survey, therefore he was unable to be interviewed. The DON (director of nursing) stated 7/14/16 at 11:15 a.m., CNA C should not have thrown the dirty linen nor gown on the floor. "The dirty linen should be bagged and taken to the soiled utility room." The infection control nurse, RN (registered nurse) C, stated 9/14/16 at 11:40 a.m., "dirty linen should go in the hamper or a bag, not on the floor." www.infectioncontroltoday.com provides guidance for handling soiled or dirty laundry, "Infectious disease experts agree that soiled linen should be handled as little as possible and with a minimum of agitation to prevent gross microbial	F 441	Registered Nurse B was educated on the dress code policy addressing finger nails on 7/14/2016 by the Director of Nursing. Registered Nurse B's nails were trimmed on 7/16/2016 and polish replaced with light color polish. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. A review of nursing staff's nails was done by the assistant director of nursing on 8/3/2016 and the nursing staff identified as having nails long, or acrylic or bright polish was instructed to trim, remove and replace to polish with light colored polish.	

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F 441	Continued From page 46 contamination of the air and hospital personnel handling the linen. All soiled linen should be bagged at the location where it was used, and the collection bag must be of sufficient quality to contain the wet/soiled linens and prevent leakage during handling and transportation. OSHA (Occupational Safety and Health Administration) mandates that linens must be placed and transported in labeled or color-coded bags or containers. Double-bagging has been shown to be unnecessary unless the HCW (Health Care Worker) believes the body fluid-soaked linens cannot be hygienically contained in the primary bag. Studies have demonstrated that the exteriors of single bags do not harbor significant levels of bacteria.7 Standard Precautions requires that personnel who handle soiled linens utilize PPE (Personal Protective Equipment), particularly gloves." The administrator, DON, and corporate consultant were informed of the failure of CNA C to care for used linen and gown in a manner to prevent the spread of infection, 7/14/16 at 1:15 p.m. 2. A licensed nursing staff member was observed with long artificial fingernails. During the survey period of 7/13 - 7/14/16, RN (registered nurse) B, the unit manager of the Azalea unit) was observed to have long artificial nails. RN B's fingernails were approximately 3/4 inches in length and painted a neon yellow color. On 7/14/16 at 11:55 A.M., an interview was conducted with the infection control nurse, RN C. When asked about the expectation of the unit	F 441	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program was conducted by the Director of Nursing/Designee on the handling of soiled linen and the Dress Code policy addressing finger nails length, no acrylic and light colored polish to the nursing staff starting on 7/14/16. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Assistant Director of Nursing or designee will audit the resident care area to assure the soiled linen is being handled correctly by the nursing staff, and the dress code addressing finger nails is being followed, daily for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks.	

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F 441	Continued From page 47 managers' fingernails, RN C stated, "Well I haven't been very hard on them about that." RN C said the unit managers were considered administrative and direct care staff. On 7/14/16 at 12:00 p.m., RN B was observed exiting a resident's room and walking to the sink to wash her hands. Her fingernails were long and painted a bright yellow color. RN A was interviewed and asked about the facility's Dress Code policy as it pertained to fingernails. RN A was shown a copy of the Dress Code she had signed on hire. After reviewing the Dress Code policy, RN B said, "That policy applies to direct care staff." RN B said she had never had to perform direct care to the residents, but in the event of an emergency she would perform direct resident care. When asked the type of fingernails she was wearing, RN B said she had gel nails. Regarding fingernails, the facility's DRESS CODE Policy read: "3. Fingernails (applies to dietary and nursing employees) Fingernails will be kept short (1/4" or less) and filed smooth. No acrylic or gel nails. Clear or light color nail polish is acceptable. No glitter, nail ornaments or studs." Regarding RN B's work responsibilities, a review of the Unit Manager's job description under General Purpose read, "Assess resident needs, develop care plans, administer nursing care, evaluate nursing care, and supervise CNAs (certified nursing assistants) and other personnel in the delivery of nursing care." Guidance regarding fingernails as they relate to	F 441	The Director of Nursing/Designee will present the results of audits to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	

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F 441	Continued From page 48 infection was provided at www.cdc.gov, "Although the relationship between fingernail length and wound infection is unknown, keeping nails short is considered key because the majority of flora on the hands are found under and around the fingernails (156). Fingernails should be short enough to allow DHCP (Direct Health Care Personnel) to thoroughly clean underneath them and prevent glove tears (122). Sharp nail edges or broken nails are also likely to increase glove failure. Long artificial or natural nails can make donning gloves more difficult and can cause gloves to tear more readily. Hand carriage of gram-negative organisms has been determined to be greater among wearers of artificial nails than among nonwearers, both before and after handwashing (157--160). In addition, artificial fingernails or extenders have been epidemiologically implicated in multiple outbreaks involving fungal and bacterial infections in hospital intensive-care units and operating rooms (161--164). Freshly applied nail polish on natural nails does not increase the microbial load from periungual skin if fingernails are short; however, chipped nail polish can harbor added bacteria (165,166)." On 7/14/16 at 2:30 p.m., the administration was informed of the findings.	F 441		