STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/11/17 through 4/13/17. One complaint was investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 137 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and five closed record reviews (Residents 22 through 26).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		5/19/17

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

Electronically Signed | 05/06/2017

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to notify the physician of a need to alter treatment for one of 26 residents in the survey sample, Resident #2. The facility staff failed to notify Resident #2's physician that Humulin N insulin (1) was held on multiple dates from January 2017 through April 2017. The findings include:	F 157	The Laurels of University Park wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is May 15, 2017. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of	

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F 157	Continued From page 2 Resident #2 was admitted to the facility on 10/14/16. Resident #2's diagnoses included but were not limited to: diabetes, high blood pressure and Parkinson's disease. Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/17, coded the resident as being cognitively intact. Section N documented Resident #2 was administered insulin injections seven out of the last seven days. Review of Resident #2's clinical record revealed a physician's order sheet signed by the physician on 4/7/17 that documented an order with a start date of 10/14/16 for Humulin N insulin 15 units once per day at 8:00 a.m. and an order with a start date of 10/14/16 for Humulin N 18 units once per day at 4:00 p.m. and to notify the physician for a blood sugar less than 60 or greater than 400. The orders failed to document any further parameters regarding insulin administration. Review of Resident #2's eMARs (electronic medication administration records) for January 2017 through April 2017 revealed the following regarding Humulin N insulin administration: -1/14/17 at 9:16 a.m. - "held r/t (related to) low bs (blood sugar) of 73." -1/14/17 at 8:20 p.m. - "held r/t bs 106." -1/15/17- "bs 87 held r/t low bs." -1/28/17- "bs 86 held." -1/29/17- "bs 70 held." -2/12/17- "held bs 120." -2/11/17- "held r/t low bs." The blood sugar was documented as 99. -2/25/17- "held bs 106."	F 157	deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F Tag 157: Resident #2: No negative outcome occurred as a result of this practice. Insulin orders have been reviewed with the physician Residents receiving insulin have the potential to be affected. The DON/Designee will educate licensed nursing staff on following physicians orders for insulin parameters and notifying the physician when insulin is held per orders. Nursing administration will complete an audit for the last 30 days of current insulin dependent diabetic residents. Insulin parameters will be reviewed and compared with the MAR for any insulin held and physician notification. DON will continue to monitor through review of new admissions and any new order changes to insulin for parameters and physician notification by review of the MAR . Monitoring will occur during 5x week for 4 weeks clinical meeting . Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON to the quality assurance committee.	

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F 157	Continued From page 3 -2/26/17 at 9:08 a.m. - "100 held." -2/26/17 at 9:47 p.m. - "held 122." -3/3/17- "bs 110 held." -3/11/17 at 8:15 a.m. - "held." The blood sugar was documented as 101. -3/11/17 at 9:12 p.m. - "bs 110 held." -3/25/17- "held bs 97." -3/30/17- "HELD BS 83." -4/3/17- "held bs 83." -4/8/17 at 8:50 a.m. - "HELD BS 100." -4/8/17 at 10:16 p.m. - "held bs 120." -4/9/17- "held bs 88." Resident #2's comprehensive care plan with an onset date of 1/23/17 documented, "BLOOD SU (Sugar): At risk fluctuating blood sugars r/t: IDDM (insulin dependent diabetes mellitus), receives insulin and oral hypoglycemic...Approaches/Interventions: Administer medication per orders. Observe for ineffectiveness & side effects. Report abnormal findings to physician..." Further review of Resident #2's clinical record (including eMAR notes and nurses' notes) failed to reveal Resident #2's physician was notified of the above blood sugars or that the resident's Humulin N insulin was held on the above dates. On 4/12/17 at 8:51 a.m., an interview was conducted with RN (registered nurse) #3. This surveyor read Resident #2's insulin orders to RN #3 and asked when the insulin should be held. RN #3 stated, "They don't define that in the parameters." RN #3 stated she would hold the insulin and call the physician if the resident's blood sugar was less than 60 or greater than 400. RN #3 was asked if the insulin should be held any other time. RN #3 stated, "We don't have an	F 157	Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 157	Continued From page 4	F 157		

order to do that." RN #3 was asked if nurses were supposed to have an order to hold a medication. RN #3 stated, "Not necessarily. You would have to use your judgement on that but if I held the medication I would call the doctor."

On 4/12/17 at 11:03 a.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse who held Resident #2's insulin on 4/3/17). LPN #4 stated she gives insulin per the physician's order as long as the resident's blood sugar isn't too low. When LPN #4 was asked what number was too low, she stated if a resident's blood sugar is 70ish or 80ish then the blood sugar is too low to administer insulin and she would also base her decision to hold insulin on each individualized situation. LPN #4 stated she was a new nurse so she always verifies the decision to hold insulin with another nurse. LPN #4 stated she would call the physician if she held insulin. LPN #4 was asked if she notified the physician when she held Resident #2's insulin on 4/3/17. LPN #4 stated she didn't recall.

On 4/12/17 at 10:10 a.m., this surveyor asked ASM (administrative staff member) #1 (the administrator) for a policy regarding physician notification.

On 4/12/17 at 4:50 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above findings. ASM #1 stated the facility did not have the requested policy.

No further information was provided prior to exit.

"Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many

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F 157	Continued From page 5 people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. Your numbers might be different, so check with your health care provider to find out what level is too low for you." This information was obtained from the website: https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia (1) "HUMULIN N is an intermediate-acting recombinant human insulin indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus." This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f6edd793-440b-40c2-96b5-c16133b7a921	F 157		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to	F 226		5/19/17

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F 226	Continued From page 6 the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to implement the abuse policy for screening employees prior to hire for one of five employee records reviewed, CNA (certified nursing assistant) #9. The facility staff failed to obtain reference checks prior to hire per the abuse policy, for CNA #9's employment on 3/1/17 The finding include: Review of CNA #9's employee file failed to evidence documentation of reference checks. An interview was conducted on 4/12/17 at 3:00 p.m. with OSM (other staff member) #4, the payroll processor. When asked if there were references for CNA #9, OSM #4 stated, "I don't have any" When asked the process for obtaining references, OSM #4 stated, "The department	F 226	Ftag 226 Employee # 9 is no longer employed at the facility. Current residents in the facility have the potential to be affected by this practice. NHA or designee will educate the payroll department, staffing coordinator, and department managers on obtaining 2 employee reference checks on all new hires prior to the start of employment. NHA or designee will audit that last 30 days of new hires for 2 reference checks. Additional education and/or counseling will be provided as indicated. Corrections will be made as identified. NHA will continue to monitor by reviewing new hires for 2 reference checks weekly x	

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F 226	Continued From page 7 head at the time (obtains the references)." When asked what her role was, OSM #4 stated, "My role is to try to keep things organized. Make sure they have everything completed before they start the job." When asked what she did if there was missing information, OSM #4 stated, "I let them know if we don't have the references. They sometimes get back to me." When asked why they obtained references, OSM #4 stated, "To make sure they're eligible for hire or if they have a problem with residents." An interview was conducted on 4/12/17 at 5:15 p.m. with ASM (administrative staff member) #1, the administrator. When asked who obtained references for employees, ASM #1 stated, "It depends, usually nursing, for CNAs the staffing coordinator helps with that. If it's a manager (position) I do it." ASM #1 was made aware of the findings at that time. Review of the facility's policy titled, "ABUSE, PROHIBITION, INVESTIGATION, AND REPORTING" documented, "Policy: It is the policy of this facility to prohibit mistreatment, neglect, and abuse of guests/residents and/or misappropriation of guest/resident property or resources. A. Screening: 1. The facility will screen respective employees in order to not employ individuals who have been found guilty of abusing, neglecting, mistreating, or misappropriating property/resources of residents by a court of law, or who are listed in the state Nurse Aide Registry or professional licensing agency concerning the same and in accordance with individual state law requirements. d. At least two (2) employment reference checks are to be completed on all applicants prior to employment. Negative findings regarding abuse, neglect, or	F 226	4 weeks and will report concerns to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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F 226	Continued From page 8 mistreatment eliminate the applicant from being considered for employment." No further information was provided prior to exit.	F 226		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		5/19/17

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F 280	Continued From page 9 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 280		

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F 280	Continued From page 10 or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for four of 26 residents in the survey sample, Resident # 13, #8, #15 and #6. 1. The facility staff failed to review and revise Resident #13's comprehensive care plan on 2/18/17 when the facility staff documented a new pressure injury* on Resident #13's sacrum; on 3/11/17 when the treatment to the sacral wound was changed due to wound progression to an unstageable pressure injury*, and on 3/31/17 when the wound progressed to a Stage IV pressure injury*. 2. The facility staff failed to revise Resident # 8's comprehensive care plan following a fall on 02/01/17. 3. The facility staff failed to review and revise the comprehensive care plan when the Foley catheter was removed for Resident #15. 4. The facility staff failed to update the comprehensive care plan after a fall on 3/25/17 for Resident #6.	F 280	Ftag 280 Resident # 13: Care plan has been reviewed and updated. Resident #8: Care plan has been reviewed and updated. Resident #15: No longer resides at the facility. Resident #6: Care plan has been reviewed and updated. Current residents with wounds, PRN pain medications, Foleys, and falls have the potential to be affected. The DON or designee will educate licensed nursing staff; to include MDS staff on reviewing, revising, and including episodic documentation on the care plans. Nursing administration will audit care plans for current residents with in house acquired pressure ulcers, worsening pressure ulcers, and pressure ulcers upon admission. Nursing administration will audit the last 30 days of orders for the discontinuation of foleys and review the coinciding care plans as well as an audit	

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F 280	Continued From page 11 The findings include; 1. Resident #13 was admitted to the facility on 1/10/17 with diagnoses that included, but weren't limited to; GERD (gastroesophageal reflux disease), high blood pressure, high lipids in blood stream, and arthritis. A review of Resident #13's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/18/17, coded Resident #13 as having a score of three, out of a possible 15, on the BIMS (brief interview for mental status). Resident #13 was also coded as requiring extensive assistance of one person for activities of daily living and had a stage 2 pressure ulcer that was not present on admission. On 4/12/17 at 9:50 a.m. LPN (licensed practical nurse) #9 was observed while providing wound care to Resident #13. LPN #9 stated that she was the wound treatment nurse today and was not always the one who did treatments. When asked how she knew what the specific treatments were for each resident with a wound, LPN #9 stated it was on the MAR (medication administration record) and/or the TAR (treatment administration record). LPN #9 further stated that there was a treatment book that contained the description of the wound being treated as well as the treatment. LPN #9 stated that she could also review (the name of the wound doctor's) notes. LPN #9 had prepared her clean area with the treatments to be applied to Resident #13's wounds; LPN #9 washed her hands and placed clean gloves on, then removed the existing dressing from Resident #13's sacral area. LPN #9 washed her hands and placed clean gloves on	F 280	of care plans for residents with falls in the last 30 days. DON will continue to monitor care plans by reviews in clinical meetings of care plans for residents who are new admissions, or with new pressure ulcers, changes to Foley orders, and falls 5 times a week times 4 weeks. Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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her hands. LPN #9 was asked to measure and describe the wound. LPN #9 stated that she didn't normally measure wounds and that the unit manager usually did that with the wound doctor. LPN #9 used a cotton bud and obtained the following measurements; Depth of wound 0.7 cm, width of wound 1.9 cm, length of wound 3.0 cm. The wound was open and was observed with undermining around the circumference of the wound. When asked if there was tunneling and/or undermining in the wound, LPN #9 stated that there was none. LPN #9 completed the cleansing of the wound and applied the wound dressing as ordered.

A review of Resident #13's physician orders revealed, in part, the following telephone order;
- "2/18/17 9 pm. 1. Cleanse pink, open area to sacrum with NS (normal saline), apply calmaFX (a brand of moisture barrier cream) and dry foam drsg (dressing) every 3 (three) days."

Further review of Resident #13's clinical record revealed, in part, the physician order sheet for "ACTIVE Orders (4/1/17 - 4/30/17)" and ACTIVE Orders (3/1/17 - 3/31/17)":

- "TRTM-TRTM (treatment) Start: 02-18-17 End: 02-27-17 Initial 02-18-17 TREATMENT clean open area to sacrum with n/s apply calmaFX moisture barrier ointment and dry foam dressing q (every) 3 (three) days at day (day) telephone order from (name of medical doctor) (name of nurse) noted on 02-18-17 11:40 pm by (name of nurse)." Signed and dated by medical doctor on 3/2/17.

- "Start 03-11-17 End 03-10-18 Initial 03-11-17 09:40 (am) SANTYL OINTMENT topically daily

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(day) cleanse sacrum with ns, apply santyl cover (sic) with dry drsg qd (every day) dx (diagnosis): wound wound (sic) healing telephone order from (name of medical doctor), taken by (name of nurse) noted on 03-11-17 9:40 pm by (name of nurse)." Signed and dated by medical doctor on 3/13/17.

- "TRTM -TRTM (treatment) Start: 03-29-17 End: 03-28-18 Initial: 03-29-17 TREATMENT pack sacrum wound w/dakin soaked gauze, cover w/dry dsg. daily (day) telephone order from (name of medical doctor) taken by (name of RN [registered nurse] #1) noted on 03-29-17 12:14 pm by (name of RN #1)." Signed and dated by medical doctor on 4/7/17.

A review of Resident #13's admission care plan dated 1/10/17 revealed, in part, the following directions; "3. Pressure Sores/ Skin Care. Goal: Prevent/heal pressure sores/ skin breakdown." The following boxes were checked: "Follow facility skin care protocol. Turn every 2 (two) hours and PRN (as needed). Immediately report any redness or skin breakdown to charge nurse/physician. Lift sheet for repositioning. Braden Scale (scale used for predicting risk for pressure sores): 17"

A review of Resident #13's comprehensive care plan dated 1/16/17 revealed, in part, the following documentation; "Onset/DC (discontinued) 6/30/17. Problems / Conclusions: URINARY: Risk for complications of frequently incontinent of bladder, occasionally incontinent of bowel r/t (related to) decreased physical mobility, weakness 2nd to (secondary to) thoracic spine compression fx (fracture) s/p (status post) fall and pneumonia. Approaches/Interventions: Apply

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moisture barrier/topical treatments per policy or MD (medical doctor) order. Start 1/19/17. Evaluate skin with each episode and report any redness, skin breakdown, rash, pain, burning, odorous urine, to nurse. Start 1/19/17. Provide skin care for each episode of incontinence. Start 1/19/17. Onset / DC: 3/17/17. Problems/Conclusions: Skin04: Risk for skin impairment r/t decreased physical mobility, weakness 2nd to thoracic spine compression fx. 4/6/17 Wound tx to sacrum: apply Flagyl 500 mg (milligrams) (crushed) to wound, pack with Dakins soaked packing strip and cover with dry dsg q (every) day. Approaches/Interventions: Pressure reduction mattress on bed. Start 1/19/17. Braden Scale per protocol Start 1/19/17. Use draw sheet or pad prn (as needed) to help move up in bed. Start 1/19/17. Provide incontinent care with each episode and apply moisture barrier. Start 1/19/17. Conduct weekly head to toe skin assessments, document and report abnormal findings to physician. Start 1/19/17."

On 4/12/17 at 3:38 p.m. an interview was conducted with LPN (licensed practical nurse) #4, a floor nurse. LPN #4 was asked when a care plan should be updated. LPN #4 stated that anytime there was a change the care plan was updated. LPN #4 was asked to review Resident #13's care plan and was asked if the care plan was reviewed and updated on 2/18/17 when a "pink, open area" was documented on a physician's telephone order, and on 3/11/17 when Resident #13's wound changed from a "pink, open area" to an unstageable wound and then on 3/31/17 when the wound care doctor documented that Resident #13's wound was now a Stage IV (four). LPN #4 reviewed the notes and the care

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plan and stated, "The care plan should have been updated with each of those changes, most definitely." LPN #4 was asked if the care plan was or was not reviewed and revised for the described changes in skin condition. LPN #4 stated it was not. LPN #4 was asked who was responsible for updating the care plan when there were changes in the condition of the skin. LPN #4 stated, "The unit managers take care of it."

On 4/13/17 at 8:15 a.m. an interview was conducted with RN (registered nurse) #3, the unit manager. RN #3 was asked who was responsible for reviewing and revising the comprehensive care plan. RN #3 stated, "Everyone is responsible." RN #3 was asked who was responsible for ensuring that the comprehensive care plan was reviewed and revised when there was a change in a resident's condition or treatments. RN #3 stated, "The team and the unit manager. I am the first level of review." RN #3 was asked how often she reviewed the comprehensive care plan. RN #3 stated, "Quarterly or if something comes up, for example the resident is put on an antibiotic, has a new device or develops a pressure ulcer." RN #3 was asked to review Resident #13's care plan and to evidence where her care plan was reviewed and revised following the development of a wound on 2/18/17, worsening of the wound along with a change of treatment on 3/11/17 and the decline of the wound into a stage 4 on 3/31/17. RN #3 stated, "When I saw an order for an open area, my process would be to look at the area and if (the area) open then I would have added (the open area) to the care plan." RN #3 was asked should the care plan have been reviewed and revised. RN #3 stated, "Yes." RN #3 was asked to describe the purpose of a

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comprehensive care plan. RN #3 stated, "To notify staff of the plan of care. Staff should be looking at the care plan after reviewing the 24 hour report and notice changes. The care plan also lets the physicians and MDS coordinators know what is in place. This process was not followed for (name of Resident #13's) care plan."

On 4/13/17 at 11:20 a.m. a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. The administrative staff were made aware of the above findings. A policy regarding the completion of care plans was requested at this time.

A review of the facility policy titled "Interdisciplinary Care Plan" revealed, in part, the following documentation; "Policy: It is the policy of this facility to develop an interdisciplinary care plan for each guest that includes measurable goals and time frames directed toward achieving and maintaining each guest's optimal medical, physical, mental and psychosocial needs. Procedure: 4. Care Plans are revised as dictated by change(s) in the guest's condition. Reviews are done at least quarterly."

No further information was provided prior to the end of the survey process.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates

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nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

* Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 1 Pressure Injury: Non-blancheable erythema of intact skin
Intact skin with a localized area of non-blancheable erythema, which may appear differently in darkly pigmented skin. Presence of blancheable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red,

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moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured

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full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. This information was obtained from the website: http://www.npuap.org/
2. The facility staff failed to revise Resident # 8's comprehensive care plan following a fall on 02/01/17.

Resident # 8 was admitted to the facility on 08/05/16 with diagnoses that included but were not limited to: hypertension (1), arthritis, dementia (2), Parkinson's disease (3), chronic kidney disease (4), anemia (5) and cataracts (6).

Resident # 8's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/20/17, coded Resident # 8 as scoring an eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight being moderately impaired of cognition for making daily decisions. Resident # 8 was coded as requiring extensive assistance of one staff member for activities of daily living.

The facility's "Incident Report" for Resident # 8 dated 02/01/17 revealed resident # 8 was found sitting on the floor between her wheelchair and bed and no injury. The incident report further documented, "Immediate Interventions: Remind pt (patient) to use call bell."

The care plan for Resident # 8 with a review date

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of 03/19/17 was reviewed. The care plan failed to evidence documentation of a revision or review following Resident # 8's fall of 02/01/17.

On 4/13/17 at 9:10 a.m. an interview was conducted with ASM # 2, the director of nursing regarding Resident # 8's care plan and fall on 02/01/17. When asked about the purpose of the care plan, ASM # 2 stated, "It tells the staff how to take care of the resident." When asked to describe the procedure that is followed after a resident's fall, ASM # 2 stated, "We complete an investigation, put interventions in place or continue the current interventions, put the new interventions on the care plan and the resident's care card. If the interventions continue the care plan is documented that it was reviewed." When asked who was responsible for updating the care plan, ASM # 2 stated, "It could be anyone on the ID (interdisciplinary) team, nurse manager, nurse, DON (director of nursing), ADON (assistant director of nursing), Rehabilitation director, social worker, administrator or the MDS (minimum data set) nurse." When asked when a resident's care plan is updated, ASM # 2 stated, "If any of the interventions in place are not working, when there are new orders or a change in the resident's status." After reviewing Resident # 8's care plan with a review date of 03/19/17 ASM # 2 was asked if the care plan was reviewed or revised following Resident # 8's fall on 02/01/17, ASM # 2 stated, "No."

On 04/12/17 at 4:40 p.m. an interview was conducted with LPN (licensed practical nurse) # 10. When asked if he completed the incident report for Resident # 8's fall on 02/01/17, LPN # 10 stated, "Yes." When asked to describe the purpose of the care plan, LPN # 10 stated, "It's to

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communicate with the ID Team what the resident needs, their requirements, condition and how to take care of the resident." When asked who was responsible for updating the care plan, LPN # 10 stated, "Nursing staff, the RN (registered nurse), LPN or unit manager." When asked to describe the procedure that is followed after a resident's fall, LPN #10 stated, "I would complete the incident report, do neuro (neurological) checks and vital signs on the resident, review or revise the care plan in case we put in a new intervention or to determine if the current interventions are still effective." After reviewing Resident # 8's care plan with a review date of 03/19/17 LPN# 10 was asked if the care plan was reviewed or revised following Resident # 8's fall on 02/01/17. LPN # 10 stated, "No. I should have documented that the resident needed reminders to use the call bell."

The facility's policy "Interdisciplinary Care Plan" documented, "Care plans are revised as dictated by change(s) in the guest's condition. Reviews are done at least quarterly."

On 4/13/17 at 9:120 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

1. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

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2. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

3. A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

4. Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/chronickidneydisease.html.

5. Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

6. A cataract is a clouding of the lens of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001001.htm.

7. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https:

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https://medlineplus.gov/druginfo/meds/a681004.html.

8. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.
3. The facility staff failed to review and revise the comprehensive care plan when the Foley catheter was removed for Resident #15.

Resident #15 was admitted to the facility on 11/14/16 with a recent readmission on 2/20/17 with diagnoses that included but were not limited to: intestinal obstruction, urinary tract infection, chronic obstructive pulmonary disease, sleep apnea, diabetes, and fracture of lower leg.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/18/17, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one staff member for moving in the bed, moving on the unit, dressing, toileting, personal hygiene and bathing. Resident #15 was coded as being dependent upon the staff for transfers between surfaces.

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The nurse's note dated, 3/30/17 at 2:03 a.m. documented, "F/C (Foley catheter) discontinued at 11 PM per guest request, 900 ML (milliliters) in bag, MD (medical doctor) and PR (responsible party) aware, well tolerated will cont (continue) to monitor output."

The physician order dated, 3/30/17 at 12:06 a.m. documented, "Discontinue Catheter."

The comprehensive care plan dated, 1/23/17 documented in part, "Problems: Risk for complications R/T (related to) indwelling catheter 2o (secondary to) NWB (non-weight bearing) (a w with a line over it indicating 'with') R (right) ankle Hx (history) Fx (fracture)/ ORIF (open reduction internal fixation) (repair surgically of the fracture)." The "Approaches/Interventions" documented in part, "Provide cath (catheter) care per protocol. Change catheter per physician orders. Change catheter bag per protocol. Keep catheter tubing free of kinks. Keep drainage bag below level of bladder. Prevent tension on urinary meatus from catheter."

An interview was conducted with RN (registered nurse) #1, on 4/12/17 at 1:53 p.m. When asked who updates the care plans, RN #1 stated, "Anyone."

An interview was conducted with RN #2, the MDS coordinator, on 4/12/17 at 2:47 p.m. When asked who is responsible for updating the care plans, RN #2 stated, "MDS, activities, nursing and social work."

An interview was conducted with RN #3, the unit manager, on 4/12/17 at 4:40 p.m. When asked who updates the care plans, RN #3 stated, "If it's

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emergent, the nurses on the unit can do so. MDS comes behind us and updates the majority of the care plan." Resident #15's care plan regarding the indwelling catheter was reviewed with RN #3. When asked if the foley catheter should have been discontinued off of the care plan, RN #3 stated, "All nurses should update the care plan as things come up." When asked if the nurse who took the order to discontinue the indwelling catheter and discontinued the catheter, should have updated the care plan to remove the concerns for the indwelling catheter, RN #3 stated, "Yes."

The administrator, administrative staff member - ASM #1 and ASM #3, the regional quality assurance manager were made aware of the above findings on 4/12/17 at 5:17 p.m. A policy on reviewing and revising the care plan was requested and p provided.

No further information was provided prior to exit.

4. The facility staff failed to update the comprehensive care plan after Resident #6 had a fall on 3/25/17.

Resident #6 was admitted to the facility on 5/7/11 with diagnoses including, but not limited to: Bipolar disorder (1), seizure disorder, low thyroid function, arthritis, dementia and depression. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 1/2/17, Resident #6 was coded as being moderately cognitively impaired for making daily decisions. She was coded as not having had a fall during the look back period.

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A review of Resident #6's clinical record revealed the following nurse's note dated 3/25/17 at 1:20 p.m.: "Writer was called to the dining room at approximately 11:45 a.m. and noted guest laying (sic) down on the floor, with her head resting on a cushion. Per witnesses's (sic), guest was trying to adjust herself in her chair and accidentally slipped out; wheelchair rolling away from her. Guest denied having any pain, being abused or mistreated. No visible injuries noted. Guest was readjusted in her wheelchair and was set up for lunch per guest request. Immediate intervention: contact PT to re-evaluate proper seating device."

A review of Resident #6's comprehensive care plan dated 1/11/17 with a revised date of 4/11/17 failed to reveal evidence of any review or revisions following Resident #6's fall on 3/25/17.

On 4/12/17 at 5:45 p.m., ASM (administrative staff member) #1, the administrator, was informed of this concern.

On 4/13/17 at 8:50 a.m., LPN (licensed practical nurse) #1, the unit manager, was interviewed. She stated: "The care plan was not updated after that fall [on 3/25/17]. I can't tell you exactly why not. We typically update the care plan in the morning meeting. I don't think her chart was available on this day." When asked why the resident's chart would not have been available to the staff for the morning meeting, LPN #1 stated: "I really don't remember." She added: "It certainly should have been updated after the fall."

No further information was provided prior to exit.

(1) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that

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F 280	Continued From page 27 causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure services were provided by qualified personnel for one of 26 residents in the survey sample, Resident #3; and failed to follow the written plan of care for two of 26 residents in the survey sample, Resident #12 and Resident #8. 1. The facility staff failed to ensure that a nurse turned on Resident #3's oxygen. 2. The facility staff failed to follow Resident #12's comprehensive care plan by not floating his heels while the resident was in bed. 3a. The facility staff failed to follow the comprehensive care plan for the implementation of non-pharmacological interventions prior to the administration pf PRN (as needed) pain	F 282	Ftag 282 Resident #3: Oxygen is in place and on the correct settings ordered by the physician. No negative outcomes occurred. Resident #12: No longer resides at the facility. Resident #8: Pain assessment has been updated and care plan has been reviewed and revised. No negative outcome occurred. All residents with orders for oxygen, heels floated, or PRN pain medication have the potential to be affected. The DON or designee will educate	5/19/17

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F 282	Continued From page 28 medication for Resident # 8. b. The facility staff failed to follow the comprehensive care plan for Resident # 8's assessment of pain. The findings include: 1. Resident #3 was admitted to the facility on 5/11/15 and readmitted on 3/7/16 with diagnoses that included but were not limited to: high blood pressure, stroke, dementia and headaches. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/10/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as receiving oxygen. An observation was made on 4/11/17 at 4:50 p.m. of Resident #3. The resident was sitting up in a wheelchair in her room. Her oxygen was connected to a portable tank secured to the back of the wheelchair. The gauge on the oxygen was in the red range indicating the tank was almost empty. An interview was conducted on 4/11/17 at 4:50 p.m. with CNA #6, the resident's aide. When asked who checked the oxygen tanks to see how much oxygen was left in them, CNA #6 stated. "The nurse or me and the restorative (aide), comes and switches the tanks out." When asked if she had checked Resident #3's oxygen tank, CNA #6 stated, "I haven't checked the tank so	F 282	licensed nursing staff and certified nursing assistances on the license requirements for administering oxygen, floating heels and following the plan of care, and non pharmalogical approaches and following the care plan for residents receiving PRN pain medication as directed by care plan. Nursing administration will conduct an audit orders and settings for current guests receiving oxygen. Any corrections needed will be corrected by a licensed nurse. An audit of all residents with orders for heels floated with observation of the practice in place will be conducted. An audit of residents who have triggered for pain on the MDS in the last 90 days, their orders, their care plans, and MAR□s for documentation of non pharmalogical approaches will be reviewed. Additional education and/or counseling will be provided as indicated. Corrections will be made as appropriate and will be reported to the DON. Nursing administration will continue to monitor new orders and new admissions with orders for oxygen and will observe the appropriate settings, new orders and new admissions for heels floated with observation of this practice being in place weekly X 4 weeks. The unit managers will also review MAR□s weekly x 4 weeks in clinical meeting for residents who trigger for pain on the MDS orders for non pharmalogical approaches as per the care plan. Any additional education and/or counseling will be provided as indicated	

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F 282	Continued From page 29 far." CNA #6 then went into Resident #3's room and checked the oxygen tank and stated, "It's almost empty." An interview was conducted on 4/11/17 at 5:00 p.m. with LPN (licensed practical nurse) #3. When asked about the process staff follows for checking resident's oxygen, LPN #3 stated, "We check when we make rounds. We check that it's on the right setting." LPN #3 and this surveyor went into Resident #3's room. The resident's oxygen was now connected to the concentrator and set at three liters/minute. When asked who had turned on and connected the oxygen, LPN #3 stated it was CNA #6. When asked where CNA #6 was, LPN #3 stated, "She must be taking a break." An interview was conducted on 4/12/17 at 8:25 a.m. with CNA #7, Resident #3's aide. When asked who could turn on an oxygen concentrator for the residents, CNA #7 stated, "I do." When asked how she knew what rate to set the oxygen on, CNA #7 stated, "I ask the nurse." When asked if she knew oxygen was a medication, CNA #7 stated, "No." When asked if she was allowed to give medications, CNA #7 stated, "No." An interview was conducted on 4/12/17 at 8:40 a.m. with LPN #1, the unit manager. When asked who was allowed to administer oxygen to a resident, LPN #1 stated, "It should be a nurse." When asked if oxygen was considered a medication, LPN #1 stated it was. When asked if there was any time a CNA was allowed to turn on or adjust a resident's oxygen, LPN #1 stated there was not. An attempt was made to contact CNA #6, the	F 282	and will be reported by the DON to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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aide who turned on the resident's oxygen; on 4/13/17 at 9:30 a.m. CNA #6 could not be contacted.

An interview was conducted on 4/13/17 at 11:15 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked who was allowed to turn a residents oxygen on, ASM #2 stated, "The nurse." When asked if a CNA could turn on or adjust a resident's oxygen rate, ASM #2 stated, "No." When asked why, ASM #2 stated, "Because oxygen is considered a medication."

Review of the facility's policy titled, "Service Delivery" documented, "Policy: The respiratory therapist/nurse shall follow the procedure outlined below after providing ANY care, treatment or service."

No further information was provided prior to exit.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

2. The facility staff failed to follow Resident #12's comprehensive care plan by not floating his heels while the resident was in bed.

Resident #12 was admitted to the facility on 8/1/16 with diagnoses that included but were not

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limited to Alzheimer's Disease, Dementia, COPD (Chronic obstructive pulmonary disease), and high blood pressure. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/18/17. Resident #12 was coded as being severely impaired of cognition scoring 02 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring extensive assistance with one staff member for bed mobility and extensive assistance with two or more staff for transfers. Section M "Skin Conditions" of the 01/08/17 MDS documented Resident #12 as being a high risk for developing pressure ulcers. Resident #12 was coded in Section O "Special Treatments, Procedures, and Programs," as receiving hospice services.

Review of Resident #12's wound documentation revealed that Resident #12 was admitted on 8/1/16 with a stage two pressure ulcer [1] to his left inner buttock, a left heel intact blister, and a right heel DTI (deep tissue injury [2]). All areas were documented as resolved on 9/23/16 on the Weekly Skin Assessment Sheets.

Review Resident #12's most recent Braden Score for Predicting Pressure Sore Risk [3] dated 1/18/17, documented Resident #12 as being as being at high risk for developing pressure sores scoring a "17." The following was documented, "Total Score: Total score of 17 or less indicates that the individual is AT RISK."

Review of Resident #12's care plan dated 8/18/16 and updated 1/23/17 documented the following under the area of Skin: "Potential for impaired skin integrity related to mobility, cognitive

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impairments, and incontinence (r/t (related to) advanced stages of Alzheimer's Dementia. Measurable Goals: Skin will remain intact with no further signs of breakdown through next review. Approaches...Float heels while in bed."

On 4/11/17 at 2:26 p.m., an observation was made of Resident #12. He was sleeping in bed. His lower extremities and heels were flat on the bed.

On 4/11/17 at 3:30 p.m., an observation was made of Resident #12. He was sleeping in bed. His lower extremities and heels were flat on the bed.

On 4/11/17 at 4:30 p.m., an observation was made of Resident #12. He was sleeping in bed. His lower extremities and heels were flat on the bed.

On 4/11/17 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #3, the nurse assigned to Resident #12 that shift. When asked how often nurses round on their residents, LPN #3 stated that nurses including CNAs (Certified nursing assistants), should be rounding on residents every two hours. When asked how nursing staff know resident needs as far as skin preventive measures, LPN #3 stated that she would look at the treatment orders for each resident or look at the care plan. When asked if CNA's had access to the care plan, LPN #3 stated that CNAs had access to the care plan and also used a Care Card that is created from the care plan for each resident. When asked what Resident #12 needed to protect his skin, LPN #3 stated that he received skin protectant to his sacrum, skin prep to heels, and his heels

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needed to be floated while in bed. When asked what heels floated meant, LPN #3 stated, "Heels should not be touching the surface of the bed, the heels need to be alleviated from pressure." When asked how the heels are floated, LPN #3 stated, "With pillows or boots." When asked if Resident #12's heels were floated, LPN # 3 stated that she was not sure. This writer followed LPN #3 to Resident #12's room. LPN #3 stated, "No they are not floated." When asked if his heels should be floated, LPN #3 stated, "Yea. He's in bed." LPN #3 walked out of Resident #12's room. Resident #12's heels were still not floated at that time. LPN #3 was asked if nursing was following the care plan to "float heels" for Resident #12. LPN #3 stated that the care plan was not being followed.

On 4/11/17 at 4:50 p.m., an interview was conducted with CNA (certified nursing assistant) #1, the CNA assigned to Resident #12. When asked how CNAs determine residents' needs in regards to skin preventive measures, CNA #1 stated that she would look at the care plan. When asked how often she rounded on her residents, CNA #1 stated that she rounded constantly. CNA #1 stated, "I can't say I'll be there every one to two hours, sometimes it's longer than that." When asked what it meant to float heels, CNA #1 stated, "Something is placed under the heels to prevent the heels from rubbing." When asked when she had rounded on Resident #12 last, CNA #1 stated that she had rounded on Resident #12 when she first arrived to the facility. When asked if his heels were floated, CNA #1 stated, "I can look." This writer followed CNA #1 to Resident #12's room. CNA #1 lifted up the blankets and stated, "Don't look floated." When asked if his heels should be

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floated, CNA #1 stated that she was not sure. Resident #12's heels were observed flat directly on the surface of the mattress. There were no pillows under the Resident's legs. CNA #1 put the blankets back in place and left the room stating that she would get to him next.

On 4/12/17 at 7:37 a.m. (the following morning), an observation was made of Resident #12. He was sleeping in bed and his heels did not appear to be floated. His knees and feet were flat on the mattress surface.

On 4/12/17 at 7:38 a.m., an interview was conducted with CNA #2, a CNA who was assigned to Resident #12. When asked how CNAs determined residents' needs for skin preventive measures, CNA #2 stated that she received a little paper documenting the Resident's needs or she used the care card. When asked if Resident #12's heels should be floated, CNA #2 stated, "Not that I know of." When asked to see the paper or care card, CNA #2 pulled out a list of residents with their needs documented. CNA #2 stated, "I am missing the sheet with his name. I can try to go find it."

On 4/12/17 at 8:04 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse assigned to Resident #12 that shift. When asked how she would determine residents' needs in regards to skin preventive measures, LPN #4 stated that she would look at the TAR (treatment administration record) for treatment orders, and look in the ADL records. LPN #4 stated that she would also verify with the unit manager and care plan. LPN #4 stated that she was a new nurse to the facility and didn't know many residents. When asked if Resident #12

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needed his heels floated while in bed, LPN #4 stated that she would check the TAR. The TAR did not address the need for Resident #12's heels to be floated. When asked if Resident #12's heels were currently floated, LPN #4 stated that she could check. This writer followed LPN #4 to Resident #12's room. LPN #4 lifted up Resident #12's blanket and stated "They are not floated." Resident #12's heels were flat on the mattress with no pillow in place. This writer requested to see Resident #12's heels. Resident #12's heels were observed with no skin issues. Resident #12's heels were intact and his skin was blanachable. LPN #4 stated, "I'll float his heels before I leave." LPN #4 was then observed floating Resident #12's heels.

On 4/12/17 at approximately 9:00 a.m., the care card was presented. Review of Resident #12's most current "Nursing Care Card" documented the following: "...Float heels."

On 4/13/17 at 7:36 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated that all nursing staff had access to the care plan and that CNAs could use the care card to determine residents' needs. ASM #2 stated that she prefers residents to have orders or interventions on the care plan that states "float heels as tolerated" because so many residents do not keep their heels floated on the pillow. When ASM #2 was informed that Resident #12 did not have a pillow underneath his legs or around his legs to evidence staff were attempting to float his heels, ASM #2 stated that nursing should have been floating his heels. When asked if facility staff were following Resident #12's care plan, ASM #2 stated that nursing staff were not

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following the care plan.

On 4/13/17 at 7:36 a.m., ASM #2, the DON was made aware of the above concerns.

The facility policy titled, "Interdisciplinary Care Plan," documented the following: It is the policy of this facility to develop an interdisciplinary care plan for each guest that includes measurable goals and time frames directed towards achieving and maintaining each guest's optimal medical, physical, mental and psychosocial needs." This policy did not address following the care plan.

No further information was presented prior to exit.

References:

[1] Stage II: 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. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

[2] Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation

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revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

[3] The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. A lower Braden Scale

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Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development. This information is taken from the website https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN/

3a. The facility staff failed to follow the comprehensive care plan for the implementation of non-pharmacological interventions prior to the administration pf PRN (as needed) pain medication for Resident # 8.

Resident # 8 was admitted to the facility on 08/05/16 with diagnoses that included but were not limited to: hypertension (1), arthritis, dementia (2), Parkinson's disease (3), chronic kidney disease (4), anemia (5) and cataracts (6).

Resident # 8's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/20/17, coded Resident # 8 as scoring an eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight being moderately impaired of cognition for making daily decisions. Resident # 8 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) For Resident # 8 dated 04/01/17 - 04/30/17, signed by the physician on 04/05/17 documented the following:
- "Acetaminophen (7) 500 MG (milligram). One TAB (tablet) oral every 6 hrs (hours) prn (as needed) nte (not to exceed) 3g/24 (three grams per 24 hours) pain. Start: 08/05/16."

- "NORCO (8) 5-325 (mg) Tablet. ONE-HALF TAB oral every 4 hours prn, give ½ tab po (by

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mouth) q4h (every four hours) nte 3gm/24h pain. Start 02-15-17."

The care plan for Resident # 8 with a review date of 06/18/17 documented, "Problem / Conclusions: Pain: Potential for pain related to debility, hx (history) of Arthritis and Guest complains of pain in her hand occasionally." Under "Approaches / Interventions" it documented, "Assist to position for comfort with physical support as necessary."

The eMAR (electronic medication administration record) for Resident # 8 dated "February 2017 documented,
"Acetaminophen 500 MG TABLET. One tab every 6 (six) hour prn; oral for pain. Start: 08/05/16."
The MAR dated February 2017 revealed acetaminophen 500 MG was administered on 02/14/17 at 4:16 p.m., 02/18/17 at 11:27 p.m. and on 02/26/17 at 8:04 p.m.

The eMAR for Resident # 8 dated "March 2017 documented, "Acetaminophen 500 MG TABLET. One tab every 6 (six) hour prn; oral for pain. Start: 08/05/16." "NORCO 5-325 MG TABLET one-half tab every 4 hours prn; oral for pain. Start: 02-15-17." The MAR dated March 2017 revealed Acetaminophen 500 MG administered on 03/11/17 at 8:50 p.m., 03/17/17 at 5:49 p.m., and on 03/20/17 at 9:29 p.m. and NORCO 5-325 MG on 03/06/17 at 2:59 a.m., 03/13/17 at 10:16 p.m. and on 0319/17 at 12:34 a.m.

The "Progress Notes" for Resident # 8 dated 02/01/2017 through 03/31/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of acetaminophen and NORCO.

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On 4/13/17 at 9:10 a.m. an interview was conducted with ASM # 2, the director of nursing regarding Resident # 8's care plan. When asked the purpose of the care plan, ASM # 2 stated, "It tells the staff how to take care of the resident." When asked about the interventions on a care plan, ASM # 2 stated, "If it's on the care plan it should be followed. ASM # 2 was asked to review the eMARS dated February and March 2017, the nurse's notes dated 02/01/17 through 03/31/17 and the care plan for Resident # 8's pain management. When asked about the "Approaches/Interventions" on the care plan that documented, "Assist to position for comfort with physical support as necessary" ASM # 2 stated that it referred to using non-pharmacological interventions. When asked if non-pharmacological interventions were attempted prior to the administration of prn pain medications on the dates and times documented above, ASM # 2 stated, "No." When asked if the care plan was followed for Resident # 8's pain management, ASM # 2 stated, "No."

On 4/13/17 at 9:120 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

1. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

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2. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

3. A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

4. Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/chronickidneydisease.html.

5. Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

6. A cataract is a clouding of the lens of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001001.htm.

7. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https:

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https://medlineplus.gov/druginfo/meds/a681004.html.

8. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.

b. The facility staff failed to follow the comprehensive care plan for assessment of Resident # 8's pain.

The care plan for Resident # 8 with a review date of 06/18/17 documented, "Problem/Conclusions: Pain: Potential for pain related to debility, hx (history) of Arthritis and Guest complains of pain in her hand occasionally." Under "Approaches/Interventions" it documented, "Assist to position for comfort with physical support as necessary., Administer medications for pain and observe for effectiveness/side effects and report effectiveness to physician., and Assess characteristics of pain: on scale of 0-10 (zero to ten)."

The eMAR for Resident # 8 dated "March 2017 documented, "Acetaminophen 500 MG TABLET. One tab every 6 (six) hour prn; oral for pain. Start: 08/05/16." The MAR dated March 2017

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revealed Acetaminophen 500 MG administered on 03/21/17 at 5:17 p.m. Further review of the eMAR failed to evidence documentation of the non-pharmacological interventions, effectiveness of the pain medication, or the location, type, severity of Resident # 8's pain.

The "Progress Notes" for Resident # 8 dated 03/21/2017 were reviewed and failed to evidence documentation of the non-pharmacological interventions effectiveness of the pain medication, or the location, type, severity of Resident # 8's pain.

On 4/13/17 at 9:10 a.m. an interview was conducted with ASM # 2, the director of nursing regarding Resident # 8's care plan. When asked the purpose of the care plan, ASM # 2 stated, "It tells the staff how to take care of the resident." When asked about the interventions on a care plan, ASM # 2 stated, "If it's on the care plan it should be followed. ASM # 2 was asked to review the eMAR dated 03/21/2017, the nurse's notes dated 03/21/17 and the care plan for Resident # 8's pain management. When asked if the approaches and interventions documented on Resident # 8's care plan to "Assist to position for comfort with physical support as necessary., Administer medications for pain and observe for effectiveness/side effects and report effectiveness to physician., and Assess characteristics of pain: on scale of 0-10 (zero to ten)" were followed, ASM # 2 stated, "No." When asked if the care plan was followed for Resident # 8's pain management, ASM # 2 stated, "No."

On 4/13/17 at 9:120 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the

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F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		5/19/17

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F 309	Continued From page 45 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services to maintain the highest level of well-being for two of 26 residents in the survey sample, Residents #2 and #8. 1.a. The facility staff failed to administer insulin to Resident #2 as ordered by the physician. The facility staff held Resident #2's insulin on multiple occasions without consulting the physician. b. The facility staff failed to obtain Resident #2's orthostatic blood pressures per physician's order on 12/31/16 and 1/1/17. 2. The facility staff failed to implement non-pharmacological interventions prior to the administration pf PRN (as needed) pain medication for Resident # 8. The findings include: 1.a. The facility staff failed to administer insulin to Resident #2 as ordered by the physician. The facility staff held Resident #2's insulin on multiple occasions without consulting the physician. Resident #2 was admitted to the facility on 10/14/16. Resident #2's diagnoses included but were not limited to: diabetes, high blood pressure and Parkinson's disease. Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/17, coded the resident as being	F 309	Ftag 309 Resident #2: Insulin orders and blood pressure medication orders have been reviewed with the physician for appropriate parameters. Resident does not currently have orders for orthostatic blood pressures. No negative outcome occurred as a result of this practice. Resident #8: No negative outcome occurred as a result of this practice. Pain medication was reviewed for continued appropriate intervention for pain management. DON or designee will educate licensed nursing staff on insulin orders, BP medication orders their parameters and following physician□s orders and appropriately entering prompts in the electronic health record for these parameters. Education will also be provided on non pharmalogical approaches to pain prior to administering PRN medication. Nursing administration will complete an audit for the last 30 days of current insulin dependent diabetic residents. Insulin parameters will be reviewed and compared with the MAR for any insulin held and physician notification. Nursing administration will conduct an audit of	

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F 309	Continued From page 46 cognitively intact. Section N documented Resident #2 was administered insulin injections seven out of the last seven days. Review of Resident #2's clinical record revealed a physician's order sheet signed by the physician on 4/7/17 that documented an order with a start date of 10/14/16 for Humulin N insulin 15 units once per day at 8:00 a.m. and an order with a start date of 10/14/16 for Humulin N 18 units once per day at 4:00 p.m. and to notify the physician for a blood sugar less than 60 or greater than 400. The orders failed to document any further parameters regarding insulin administration. Review of Resident #2's eMARs (electronic medication administration records) for January 2017 through April 2017 revealed the following regarding Humulin N administration: -1/14/17 at 9:16 a.m. - "held r/t (related to) low bs (blood sugar) of 73." -1/14/17 at 8:20 p.m. - "held r/t bs 106." -1/15/17- "bs 87 held r/t low bs." -1/28/17- "bs 86 held." -1/29/17- "bs 70 held." -2/12/17- "held bs 120." -2/11/17- "held r/t low bs." The blood sugar was documented as 99. -2/25/17- "held bs 106." -2/26/17 at 9:08 a.m. - "100 held." -2/26/17 at 9:47 p.m. - "held 122." -3/3/17- "bs 110 held." -3/11/17 at 8:15 a.m. - "held." The blood sugar was documented as 101. -3/11/17 at 9:12 p.m. - "bs 110 held." -3/25/17- "held bs 97." -3/30/17- "HELD BS 83."	F 309	orders and settings for current guests receiving oxygen. Any corrections needed will be corrected by a licensed nurse. An audit residents triggering for pain over the last 90 days on the MDS, their care plans, and MAR□s for documentation of non pharma logical approaches will be reviewed. Corrections will be made as appropriate and will be reported to the DON. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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-4/3/17- "held bs 83."
-4/8/17 at 8:50 a.m. - "HELD BS 100."
-4/8/17 at 10:16 p.m. - "held bs 120."
-4/9/17- "held bs 88."

Resident #2's comprehensive care plan with an onset date of 1/23/17 documented, "BLOOD SU (Sugar): At risk fluctuating blood sugars r/t: IDDM (insulin dependent diabetes mellitus), receives insulin and oral hypoglycemic...Approaches/Interventions: Administer medication per orders. Observe for ineffectiveness & side effects. Report abnormal findings to physician..."

Further review of Resident #2's clinical record (including eMAR notes and nurses' notes) failed to reveal Resident #2's physician was notified of the above blood sugars or that the resident's Humulin N insulin was held on the above dates.

On 4/12/17 at 8:51 a.m., an interview was conducted with RN (registered nurse) #3. This surveyor read Resident #2's insulin orders to RN #3 and asked when the insulin should be held. RN #3 stated, "They don't define that in the parameters." RN #3 stated she would hold the insulin and call the physician if the resident's blood sugar was less than 60 or greater than 400. RN #3 was asked if the insulin should be held any other time. RN #3 stated, "We don't have an order to do that." When RN #3 was asked if nurses were supposed to have an order to hold a medication, she stated, "Not necessarily. You would have to use your judgement on that but if I held the medication I would call the doctor."

On 4/12/17 at 11:03 a.m., an interview was conducted with LPN (licensed practical nurse) #4

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(the nurse who held Resident #2's insulin on 4/3/17). LPN #4 stated she gives insulin per the physician's order as long as the resident's blood sugar isn't too low. LPN #4 was asked what number was too low. LPN #4 stated if a resident's blood sugar is 70ish or 80ish then the blood sugar is too low to administer insulin and she would also base her decision to hold insulin on each individualized situation. LPN #4 stated she was a new nurse so she always verifies the decision to hold insulin with another nurse. LPN #4 stated she would call the physician if she held insulin. LPN #4 was asked if she notified the physician when she held Resident #2's insulin on 4/3/17. LPN #4 stated she didn't recall.

On 4/12/17 at 10:10 a.m., this surveyor asked ASM (administrative staff member) #1 (the administrator) for a policy regarding holding medication.

On 4/12/17 at 4:50 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above findings. ASM #1 stated the facility did not have the requested policy.

No further information was provided prior to exit.

"Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less. Your numbers might be different, so check with your health care provider to find out what level is too low for you." This information was obtained from the website: https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glu

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F 309	Continued From page 49 cose-hypoglycemia (1) "HUMULIN N is an intermediate-acting recombinant human insulin indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus." This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f6edd793-440b-40c2-96b5-c16133b7a921 b. The facility staff failed to obtain Resident #2's orthostatic blood pressures per physician's order on 12/31/16 and 1/1/17. Review of Resident #2's clinical record revealed a physician's order dated 12/29/17 that documented, "Orthostatics Q (every) AM X (times) 3 days. BP (blood pressure) & HR (heart rate) lying & sitting & record." Further review of Resident #2's clinical record (including the electronic medication administration record and nurses' notes) revealed only one blood pressure was documented on 12/31/16 and no blood pressure was documented on 1/1/17. Resident #2's comprehensive care plan revised on 1/23/17 documented, "Orthostatic hypotension (low blood pressure) with med (medication) changes. ER (Emergency room) visit < (less than) 30 last month for c/o (complaint of) chest pains...Obtain vital signs as ordered..." On 4/12/17 at 8:51 a.m., an interview was conducted with RN (registered nurse) #3. RN #3 was asked to explain the above order. RN #3 stated Resident #2's blood pressure while lying,	F 309		

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blood pressure while sitting and heart rate were supposed to be obtained each day for three days. RN #3 was asked where the blood pressures and heart rate should be recorded. RN #3 stated they should be recorded in the nurses' notes or the medication administration record. RN #3 was asked to review Resident #2's clinical record and show this surveyor where the blood pressures were recorded on all three days. RN #3 confirmed she could not find both blood pressures recorded on 12/31/16 or 1/1/17.

On 4/12/17 at 10:10 a.m., this surveyor asked ASM (administrative staff member) #1 (the administrator) for a policy regarding following physician's orders.

On 4/12/17 at 4:50 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above findings. ASM #1 stated the facility did not have the requested policy.

No further information was provided prior to exit.

2. The facility staff failed to implement non-pharmacological interventions prior to the administration pf PRN (as needed) pain medication for Resident # 8.

Resident # 8 was admitted to the facility on 08/05/16 with diagnoses that included but were not limited to: hypertension (1), arthritis, dementia (2), Parkinson's disease (3), chronic kidney disease (4), anemia (5) and cataracts (6).

Resident # 8's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/20/17,

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coded Resident # 8 as scoring an eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight being moderately impaired of cognition for making daily decisions. Resident # 8 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) For Resident # 8 dated 04/01/17 - 04/30/17and signed by the physician on 04/05/17 documented:
- "Acetaminophen (7) 500 MG (milligram). One TAB (tablet) oral every 6 hrs (hours) prn (as needed) nte (not to exceed) 3g/24 (three grams per 24 hours) pain. Start: 08/05/16."

- "NORCO (8) 5-325 (mg) Tablet. ONE-HALF TAB oral every 4 hours prn, give ½ tab p0 (by mouth) q4h (every four hours) nte 3gm/24h pain. Start 02-15-17."

The care plan for Resident # 8 with a review date of 06/18/17 documented, "Problem / Conclusions: Pain: Potential for pain related to debility, hx (history) of Arthritis and Guest complains of pain in her hand occasionally." Under "Approaches/Interventions" it documented, "Assist to position for comfort with physical support as necessary."

The eMAR (electronic medication administration record) for Resident # 8 dated "February 2017 documented,
"Acetaminophen 500 MG TABLET. One tab every 6 (six) hour prn; oral for pain. Start: 08/05/16."
The MAR dated February 2017 revealed acetaminophen 500 MG was administered on 02/14/17 at 4:16 p.m., 02/18/17 at 11:27 p.m. and on 02/26/17 at 8:04 p.m.

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The eMAR for Resident # 8 dated "March 2017 documented, "Acetaminophen 500 MG TABLET. One tab every 6 (six) hour prn; oral for pain. Start: 08/05/16." "NORCO 5-325 MG TABLET one-half tab every 4 hours prn; oral for pain. Start: 02-15-17." The MAR dated March 2017 revealed Acetaminophen 500 MG administered on 03/11/17 at 8:50 p.m., 03/17/17 at 5:49 p.m., and on 03/20/17 at 9:29 p.m. and NORCO 5-325 MG on 03/06/17 at 2:59 a.m., 03/13/17 at 10:16 p.m., 0319/17 at 12:34 a.m. and on 03/21/17 at 5:17 p.m.

The "Progress Notes" for Resident # 8 dated 02/01/2017 through 03/31/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of acetaminophen and NORCO.

On 4/11/17 at 4:10 p.m. an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe the procedure for administering PRN (as needed) pain medication, LPN # 3 stated, "I would ask where the pain is, what type of pain, determine the level of pain on a scale one to ten. Try non-medical interventions like repositioning or elevating. Take vital signs. If the interventions don't work I would check the MAR (medication administration record) to see what was ordered. Give the medication and check the resident's pain level at 30 minutes." When asked where it would be documented that non-pharmacological interventions were attempted, LPN # 3 stated, "On the MAR."

On 4/11/17 at 4:50 p.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing regarding

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the documentation of non-pharmacological interventions prior to the administration of PRN pain medication. ASM # 2 stated, "Staff documents the pain levels and interventions on the back of the eMAR."

On 4/13/17 at 9:10 a.m. an interview was conducted with ASM # 2, the director of nursing regarding the procedure of administering PRN (as needed) pain medication. ASM # 2 stated, "Assess the resident's pain, the location, type and rate it on a scale of one to ten, with ten being the most severe, medicate using what is prescribed and reassess after 45 minutes to an hour." When asked if non-pharmacological interventions should be attempted prior to administering PRN pain medication, ASM # 2 stated, "They [nurses] should attempt non-pharmacological interventions every time." After reviewing the eMARS dated February and March 2017 and the nurse's notes dated 02/01/17 through 03/31/17 for Resident # 8. When asked if non-pharmacological interventions were attempted prior to the administration of prn pain medications on the dates and times documented above, ASM # 2 stated, "No. It should have been attempted."

On 4/13/17 at 9:120 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

1. High blood pressure. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

2. A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

3. A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

4. Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/chronickidneydisease.html.

5. Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

6. A cataract is a clouding of the lens of the eye. This information was obtained from the website: https://medlineplus.gov/ency/article/001001.htm.

7. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing

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F 309	Continued From page 55 the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. 8. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.	F 309		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 314		5/19/17

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F 314	Continued From page 56 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services to prevent the development, promote healing, and prevent infection of a pressure ulcer for two of 26 residents in the survey sample, Resident #s 13 and 12. 1. On 2/18/17 the facility staff obtained physician orders for a newly developed pink, open area on Resident #13's sacrum. There was no documentation that provided the stage, size or description of the wound. A treatment was put in place on 2/18/17, and the facility staff administered the treatment as ordered but failed to document any ongoing monitoring of the wound including measurements, to determine whether or not the wound was improving or declining with the ordered treatment. On 3/11/17 the wound declined and was assessed and documented as an unstageable wound*. A new treatment was initiated on 3/11/17 and the facility staff documented that the treatment was administered as ordered. There was no documentation provided to evidence ongoing monitoring of the wound to determine the effectiveness of the treatment between 3/11/17 and 3/23/17 (approximately12 days), at which time the wound was documented as having no change. No further assessment was documented between 3/23/17 and 3/31/17. On 3/31/17 the wound doctor assessed the wound as containing 85% necrotic tissue (dead tissue [1]) and staged the wound as a Stage 4* pressure injury, resulting	F 314	Ftag 314 Resident # 12: No longer resides at the facility. Resident #13: Skin assessment has been updated with current measurements, and treatments are in place. DON or designee will educate all licensed nursing staff on accurate staging and assessment and the tracking and treatment of pressure ulcers, and the facility wound care program. In addition, licensed nursing staff will be educated on the responsibility of the facility for resident care even with hospice services in place. DON will also provide education to licensed nursing staff and certified nursing assistants on the process of floating heels and following physician□s orders. Nursing administration will conduct an audit of current residents with orders to float heels and will observe the practice in place. An audit will be conducted of current residents with in house acquired pressure and residents who were admitted with pressure ulcers, skin assessments, measurements and current staging, and treatments. Any variances will be corrected and reported to the DON. Nursing administration will continue to monitor for heels floated by observation of the practice for residents with physician□s	

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F 314	Continued From page 57 in harm. * Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blancheable erythema of intact skin Intact skin with a localized area of non-blancheable erythema, which may appear differently in darkly pigmented skin. Presence of blancheable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including	F 314	orders weekly x 4 weeks. Current resident with in house acquired pressure ulcers, and new admissions admitted with pressure ulcers, or new areas will continue to be monitored by reviewing the care plan, physician notification, if the pressure ulcer has worsened, and orders for any treatment changes and or identify if a treatment needs to be changed. Any additional education and/or counseling will be provided as indicated. The DON will report any concerns to the quality assurance committee monthly until resolved. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

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2. The facility staff failed to implement pressure ulcer prevention interventions by not floating Resident #12 heels while in bed.

The findings include;

1. Resident #13 was admitted to the facility on 1/10/17 with diagnoses that included, but weren't limited to; GERD (gastroesophageal reflux disease), high blood pressure, high lipids in blood stream, and arthritis.

A review of Resident #13's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/18/17, coded Resident #13 as having a score of three, out of a possible 15, on the BIMS (brief interview for mental status). Resident #13 was also coded as requiring extensive assistance of one person for activities of daily living and had a stage 2 pressure ulcer that was not present on admission.

On 4/11/17 at 4:20 p.m. an interview was conducted with Resident #13's daughter who stated that her mother (Resident #13) had suffered a significant change in condition around the middle of February (2017), that she stopped trying to feed herself and would not get out of bed. Resident #13's daughter stated that the staff discovered a pressure ulcer on her mother's sacrum around this time.

On 4/12/17 at 9:50 a.m. LPN (licensed practical nurse) #9 was observed while providing wound care to Resident #13. LPN #9 was assisted by an aide to roll Resident #13 onto her right side,

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Resident #13 required extensive assistance and her eyes remained closed throughout the procedure and was non-verbal. LPN #9 stated that Resident #13 had a sacral wound. LPN #9 was asked who staged the wounds in the facility. LPN #9 stated that the wound doctor would stage the wound. When asked who would stage a wound if the wound doctor was not consulted, LPN #9 stated that RN (registered nurse) #3, the unit manager, would stage the wound. LPN #9 was asked if she was the wound nurse. LPN #9 stated that she was the wound treatment nurse today and was not always the one who did treatments. When asked how she knew what the specific treatments were for each resident with a wound, LPN #9 stated it was on the MAR (medication administration record) and/or the TAR (treatment administration record). LPN #9 further stated that there was a treatment book that contained the description of the wound being treated as well as the treatment. LPN #9 stated that she could also review (the name of the wound doctor's) notes. LPN #9 had prepared her clean area with the treatments to be applied to Resident #13's wounds; LPN #9 washed her hands and placed clean gloves on, then removed the existing dressing from Resident #13's sacral area. LPN #9 washed her hands and placed clean gloves on her hands. LPN #9 was asked to measure and describe Resident #13's sacral wound. LPN #9 stated that she didn't normally measure wounds and that the unit manager usually did that with the wound doctor. LPN #9 used a cotton bud and obtained the following measurements; Depth of wound 0.7 cm, width of wound 1.9 cm, length of wound 3.0 cm. The wound was open and was observed to with undermining around the circumference of the wound. When asked if there was tunneling

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and/or undermining in Resident #13's wound, LPN #9 stated that there was none. LPN #9 completed the cleansing of the wound and applied the wound dressing as ordered.

A review of Resident #13's admission assessments revealed, in part, the following documentation recorded on the facility document titled "Integumentary (skin) Assessment." A diagram of the front of the human body and back of the human body contained multiple hand drawn arrows describing areas of concern on the skin. One such arrow was drawn and pointed to the sacrum on the diagram of the back of the human body with "pink blancheable" hand written beside the arrow. Below the diagram a nursing note documented, in part, the following; "Buttocks, pink, blancheable (sic). No open areas. Skin intact." Signed and dated by the admitting nurse on 1/10/17.

A review of Resident #13's clinical record revealed, in part, the facility document, "Weekly Skin Assessments" which contained a diagram of feet, a diagram of the front and back of the body. The following dates contained entries on this document;
- "1/11/17 x2nd (second shift)" An arrow was drawn pointing to the right buttock and an illegible word was written beside the arrow.
- "1/11/17 x 3rd (third shift)" An arrow was drawn pointing to the sacrum and "blanch pink" was written beside the arrow. The box titled "Skin intact" was checked.
- "1/17/17" An arrow is drawn to the sacrum and "Pink blancheable Tx (treatment) - place) written beside the arrow. The box "Has existing (circled): wound condition/pressure ulcer" was checked and "wound condition" was circled.

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F 314	Continued From page 62 - "1/31/17" An arrow was drawn pointing to the sacrum and "pink blancha (blancheable)" was written beside the arrow. The box "Has existing (circled): wound condition/pressure ulcer" was checked and "wound condition" was circled. - "2/7/17" An arrow was drawn pointing to the sacrum and "pink" written beside the arrow. The box "Has existing (circled): wound condition/pressure ulcer" was checked and "wound condition" was circled. -"2/16/17" An arrow was drawn pointing to the sacrum and "pink blancheable" written beside the arrow. The box "Has existing (circled): wound condition/pressure ulcer" was checked and "wound condition" was circled. -"2/23/17" An arrow was drawn pointing to the sacrum and "pinkish area blancheable Tx in place" was written beside the arrow. "Has existing (circled): wound condition/pressure ulcer" was checked and "wound condition" was underlined. On 3/2/17, 3/9/17 and 3/16/17 the weekly skin assessments are completed and "treatment in place" was documented alongside an arrow pointing to the sacrum on the diagram and the box for an existing wound condition was checked. -"3/23/17" an arrow was drawn pointing to the sacrum and "p/u (pressure ulcer)" documented alongside the arrow. The box "Has existing (circled): wound condition/pressure ulcer" was checked and pressure ulcer was circled. -"3/30/17" an arrow was drawn pointing to the sacrum and "tx (treatment) in place" documented alongside the arrow. Pressure ulcer was underlined. - "4/6/17" an arrow was drawn pointing to the sacrum and "P/u" documented alongside the pressure ulcer. The box "Has existing (circled): wound condition/pressure ulcer" was checked	F 314		

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and both wound condition and pressure ulcer was circled.

Further review of Resident #13's clinical record revealed, a facility document titled "Pressure Ulcer Record" that revealed, in part, a diagram of the human body (front and back) with an arrow drawn to the sacrum. The line entry documentation was as follows:
- "Initial Wound Description: Describe location, size and appearance of pressure ulcer. Date 3/11/17. Site: Sacrum. Description: area open and cover (sic) (symbol for with) gray/yellow slough."
- "Date: 3/11/17. Stage: U (unstageable). Length/width/depth in cm (centimeters) 3x3x0.3. Tunneling: (a line drawn through clock face used as a tool to locate the tunneling). Undermining in cm: (a line drawn through this area). Odor: (a line drawn through this area). Drainage: S (serosanguineous [wound drainage most common in deep partial-thickness and full-thickness wounds [2]). Color: gray, yellow, pink. Comments: Santyl (an ointment used on wound beds to help break down dead skin [3])." Signed by a nurse.
- "Date 3/23/17. Stage: U. Length/Width/Depth in cm: 3x3x0.3. Tunneling: (a line drawn through the clock face). Undermining in cm: A line drawn through. Odor: 0 (none). Drainage: Scant. Color: yellow pink. Comments: Santyl." Signed by RN (registered nurse) #1, a floor nurse.
- "Date 3/31/17. Stage: IV (Stage 4). Length/Width/Depth in cm: 2.8 x 1.5 x 1.0. Tunneling: (A line drawn through the clock face). Undermining in cm: (A line drawn through). Odor: Foul. Drainage: mod (moderate) serous (serosanguinous). Color: red. Comments: Flagyl (an antibiotic [4]), Cipro (an antibiotic [5]), Dakin's

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(a type of wound cleanser [6])." Signed by RN #3, the unit manager.
- "Date: 4/7/17. Stage: IV. Length/Width/Depth in cm: 2.5 x 2.2 x 0.9. Tunneling: no entry. Undermining in cm: 4.2 (cm) at 12:00 (12 0'clock, the location of the undermining as compared to the clock face). Odor: 0 (zero). Drainage: Red serous. Color: Red. Comments: Flagyl, Dakins." Signed by RN #3.

A review of Resident #13's nursing progress notes revealed, in part, the following documented entries:
"2/27/116 10:49 a.m. Wound care done to sacral area." No description documented regarding the wound. Note signed by nurse.
"3/15/17 (no time provided). Wound care to sacrum completed, santyl applied and dry dressing." No description documented regarding the wound. Signed by hospice nurse.
3/20/17 11:45 a.m. Wound care completed by facility nurse." No description documented regarding the wound. Signed by nurse.

Further review of Resident #13's nursing progress notes revealed, in part, documentation for daily assessments that assessed all clinical systems; including skin. All daily nursing assessments dated 1/10/17 through 2/14/17 documented Resident #13's skin as "intact." On 2/16/17 the daily nursing assessment documented Resident #13's skin as "warm and dry." The following nursing notes documented skin as follows:
- 3/2/17 at 4:39 p.m. "Skin assessment completed. Writer informed by hospice nurse that hospice nurse completed treatment to resident sacrum."

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- 3/9/17 at 1:06 p.m. "LOOK BACK... Look Back Period: 7 (seven) days ....Skin Changes Since Last Assessment: No. Skin.... Skin WNL (within normal limits)."
- 3/11/17 10:04 p.m. "Late entry for 3/11/17 at 10 a.m., During am (morning) care aide noticed the guest excoriation (skin is scraped or abraded) to her sacrum, excoriation has opened, area now gray & (and) yellow, slough (shedding of dead tissue) to center, area measure's at 3x3x0.3 (centimeters), tx (treatment) change to santyl, rp (responsible party) and md (medical doctor) aware. will continue to for (sic) changes."
- 3/16/17 2:26 p.m. "SKIN ... Skin Intact .... Skin WNL .... Skin Warm / Dry. Wound: Yes .... Location: sacrum ... Wound Care: clean sacrum with NS (normal saline), apply santyl and cover with dry dressing."
- 3/31/17 4:27 p.m. "Guest daughter made aware of (name of wound doctor) evaluating and treatment changes he made to her mother's wound."
- 4/6/17 11:15 am. "SKIN ... Skin WNL .... Skin Warm / Dry. Wound: Yes .... Location: sacrum wound .... Wound Care: Flagyl crushed & applied to wound, then packed w (with)/Dakins soaked packing gauze (sic), cover w/dry dsg (dressing)."

A review of Resident #13's H&P (history and physical) progress notes documented, that Resident #13 had been seen/examined by a physician on the following dates: 1/19/17; 1/20/17; 1/24/17; 1/30/17; 2/1/17; 2/7/17; 2/27/17; 3/20/17 and 4/6/17. On the note dated 4/6/17 the physician documented, in part, the following; "DOS (date of service): 4/6/17. HPI (history of present illness): Seen for 60 days recert (recertification) for debility/weakness. Pt (patient) under Hospice care. Chart reviewed. Pt.

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comfortable, pleasantly confused. D/w (discussed with) nursing hospice managing her (Resident #13's) sacral wound. Stage IV. Assessment and Plan: 5. Sacral wound. Cont (continue) wound care per Hospice." No further documentation was provided from the medical doctor regarding Resident #13's wound.

A review of Resident #13's physician orders revealed, in part, the following telephone order: "2/18/17 9 pm. 1. Cleanse pink, open area to sacrum with NS (normal saline), apply calmaFX (a brand of moisture barrier cream) and dry foam drsg (dressing) every 3 (three) days."

Further review of Resident #13's clinical record revealed, in part, the physician order sheet for "ACTIVE Orders (4/1/17 - 4/30/17)" and ACTIVE Orders (3/1/17 - 3/31/17)" that documented the following:

- "TRTM-TRTM (treatment) Start: 02-18-17 End: 02-27-17 Initial 02-18-17 TREATMENT clean open area to sacrum with n/s apply calmaFX moisture barrier ointment and dry foam dressing q (every) 3 (three) days at day (day) telephone order from (name of medical doctor) (name of nurse) noted on 02-18-17 11:40 pm by (name of nurse)." Signed and dated by medical doctor on 3/2/17.

- "Start 03-11-17 End 03-10-18 Initial 03-11-17 09:40 (am) SANTYL OINTMENT topically daily (day) cleanse sacrum with ns, apply santyl cover (sic) with dry drsg qd (every day) dx (diagnosis): wound wound (sic) healing telephone order from (name of medical doctor), taken by (name of nurse) noted on 03-11-17 9:40 pm by (name of nurse)." Signed and dated by medical doctor on

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3/13/17.

- "TRTM -TRTM (treatment) Start: 03-29-17 End: 03-28-18 Initial: 03-29-17 TREATMENT pack sacrum wound w/dakin soaked gauze, cover w/dry dsg. daily (day) telephone order from (name of medical doctor) taken by (name of RN #1) noted on 03-29-17 12:14 pm by (name of RN #1)." Signed and dated by medical doctor on 4/7/17.

A review of Resident #13's TAR (treatment admission record) dated 2/1/17 to 2/28/17 revealed, in part, the following order: "TREATMENT every three days at day for Start: 2/18/17 11:40 pm DC (discontinue): 3/11/17 9:41 pm Extended directions: clean open area to sacrum with n/s apply calmafx moisture barrier ointment ad dry foam dressing q 3 days." The TAR was initialed by a nurse as completed on 2/21/17; 2/24/17; 2/27/17; 3/2/17; 3/5/17; 3/8/17 and 3/11/17.

A review of Resident #13's TAR dated 3/1/17 to 3/31/17 revealed, in part, the following orders:
- "SANTYL OINTMENT daily: topically for wound healing Start: 03-11-17 09:40 pm
DC: 03-29-17 12:11 pm Extended Directions: cleanse sacrum with ns, apply santyl cover with dry drsg qd dx: wound." The TAR was initialed by a nurse as completed every day from 3/12/17 through 3/29/17.
- "TREATMENT daily for Start: 3/29/17 12:14 pm DC: 3/31/17 3:02 pm Extended Directions: pack sacrum wound w/dakin soaked gauze, cover w/dry drsg." The TAR was initialed by a nurse as completed on 3/29/17; 3/30/17 and 3/31/17.

A review of Resident #13's progress notes from

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ASM (administrative staff member) #4, the wound doctor revealed, in part, the following documentation:
- "Date 3/31/2017 HPI (history of present illness) Statement: At the request of (name of ASM #3, the medical doctor), this 91 year old female was seen and evaluated today. She presents with a stage 4 pressure wound of the medial sacrum of at least 1 days (sic) duration. There is moderate serous exudate (discharge). There is no indication of pain associated with this condition. FOCUSED WOUND EXAM. Etiology (quality): Pressure. MDS 3.0 Stage: 4 Duration: > (greater than) 1 (one) days. Wound Size (L x W x D): 2.8 x 1.5 x 1.0 cm. Thick Adherent Devitalized Necrotic Tissue: 85 % (percent). Granulation Tissue: 15 %. Assessment and Plan of Care Recommendations: Stage 4 Pressure Wound of the Medial Sacrum - Initial Evaluation: Add: FLAGYL crushed - Once Daily, 1/4 DAKINS moistened gauze - Once Daily, Dry protective Dressing - Once Daily. FOLLOW-UP: Evaluation by wound care specialist within 7 (seven) days with further intervention as indicated." Electronically signed by (name of wound care doctor) on 3/31/2017.
- "Date 4/7/2017 HPI Statement: She (Resident #13) presents with a stage 4 pressure wound of the medial sacrum of at least 7 days duration. There is light serous exudate. Wound Size: 2.5 x 2.2 x 0.9 cm. Undermining: 4.2 cm at 12 o'clock. Thick Adherent Devitalized Necrotic Tissue: 65 %. Granulation Tissue: 35 %. Wound progress: improved." Electronically signed by (name of wound care doctor) on 4/7/17.

A review of Resident #13's admission care plan dated 1/10/17 revealed, in part, the following

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directions; "3. Pressure Sores/ Skin Care. Goal: Prevent/heal pressure sores/ skin breakdown." The following boxes were checked: "Follow facility skin care protocol. Turn every 2 (two) hours and PRN (as needed). Immediately report any redness or skin breakdown to charge nurse / physician. Lift sheet for repositioning. A "Braden Scale - For Predicting Pressure Sore Risk" dated 1/10/17, documented Resident #13 was scored as a 17 indicating that Resident #13 was at risk. There were no other Braden Scale assessments completed for Resident #13 by the facility staff.

A review of Resident #13's comprehensive care plan dated 1/16/17 revealed, in part, the following documentation; "Onset/DC (discontinued) 6/30/17. Problems/Conclusions: URINARY: Risk for complications of frequently incontinent of bladder, occasionally incontinent of bowel r/t (related to) decreased physical mobility, weakness 2nd to (secondary to) thoracic spine compression fx (fracture) s/p (status post) fall and pneumonia. Approaches/Interventions: Apply moisture barrier / topical treatments per policy or MD (medical doctor) order. Start 1/19/17. Evaluate skin with each episode and report any redness, skin breakdown, rash, pain, burning, odorous urine, to nurse. Start 1/19/17. Provide skin care for each episode of incontinence. Start 1/19/17. Onset / DC: 3/17/17. Problems/Conclusions: Skin04: Risk for skin impairment r/t decreased physical mobility, weakness 2nd to thoracic spine compression fx. 4/6/17 Wound tx to sacrum: apply Flagyl 500 mg (milligrams) (crushed) to wound, pack with Dakins soaked packing strip and cover with dry dsg q day. Approaches/Interventions: Pressure reduction mattress on bed. Start 1/19/17. Braden Scale per protocol Start 1/19/17. Use

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draw sheet or pad prn to help move up in bed. Start 1/19/17. Provide incontinent care with each episode and apply moisture barrier. Start 1/19/17. Conduct weekly head to toe skin assessments, document and report abnormal findings to physician. Start 1/19/17."

On 4/12/17 at 2:50 p.m. an interview was conducted with ASM (administrative staff member) #4, the wound care doctor. ASM #4 was asked when he was first asked to look at Resident #13's sacral wound. ASM #4 stated that he learned about the wound at the end of March. ASM #4 was asked if he was made aware of an "open area" found on February 18, 2017. ASM #4 stated that he was not made aware. ASM #4 was asked who was responsible for notifying him of any open skin areas. ASM #4 stated, "It is different people, maybe the unit manager or the nurse. As a consultant I have to be invited to assess a resident's wounds." ASM #4 was made aware that Resident #13 had received an order to treat an open area on her sacrum on 2/18/17 with Santyl and dakins solution. ASM #4 was asked if that was an appropriate treatment. ASM #4 stated that was an appropriate treatment. ASM #4 was asked how frequently such a wound should be assessed and what should the assessment include. ASM #4 stated, "The wound should be assessed at least weekly, and the assessment should include a description of the wound base, drainage, surrounding tissue, the presence of any odor and whether or not it (the wound) is getting bigger or smaller, you need to measure it." ASM #4 was asked whether or not the facility staff had provided any information regarding the wound prior to his consultation and assessment on 3/31/17. ASM #4 stated, "No, but

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I don't usually ask, I like to do my own assessment."

On 4/12/17 at 3:21 p.m. an interview was conducted with RN #1, a floor nurse. RN #1 was asked to describe the process for the weekly skin assessments. RN #1 stated, "We do an assessment every week, it is assigned by the unit manager as to who does which ones. We assess the skin for any new areas of concern as well as old areas." When asked if the areas were measured, RN #1 stated that they were. RN #1 was asked where the measurements were documented. RN #1 stated that if it was a bruise or rash, non-pressure, the measurements would be documented on a skin and wound sheet. If the wound was a pressure wound then the wound would be measured and the information documented on the pressure ulcer report sheet. RN #1 was asked who was responsible for the skin assessment. RN #1 stated, "The nurse working with the resident when the skin assessment was due to be done and the nurse who finds a wound (pressure) will measure the wound and enter this onto the pressure ulcer record." RN #1 was asked whether or not the nurse would document anywhere other than the pressure ulcer record. RN #1 stated that the nurse just documents on the pressure ulcer record. RN #1 further stated, "Any new area would be noted in the nurse's notes and the note should include that the RP (responsible party) and MD (medical doctor) were notified."

RN #1 was asked at what point the wound care doctor would be asked to look at a wound. RN #1 stated, "Definitely if the wound is a stage 2." RN #1 was asked to review Resident #13's clinical

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record, specifically the telephone order written on 2/18/17 that described a "pink, open area" to the sacrum. RN #1 stated, "I don't know what happened on 2/18/17 I was on vacation. She (Resident #13) was on a different hallway on 2/16/17. The ball got dropped between 2/16/17 and 2/23/17, she was moved."

RN #1 was asked what a "pink, open area" on the sacrum signified. RN #1 stated, "That would be a pressure ulcer." RN #1 was asked where it should have been documented. RN #1 stated, "It should have been documented on the pressure ulcer record. There should have been measurements." RN #1 reviewed Resident #13's pressure ulcer record and stated, "There should have been measurements between 2/18/17 and 3/11/17. I would say that there are sheets missing." RN #1 was asked to review the entry on the pressure ulcer record dated 3/11/17. RN #1 was asked whether or not the entry on 3/11/17 described a worsening wound. RN #1 stated, "It was an unstageable wound so yes." RN #1 was asked if she entered the description on the pressure ulcer record dated 3/23/17, RN #1 stated that she did. RN #1 was asked who contacted the wound care doctor. RN #1 stated that she thought that the unit manager (name of RN #3) did sometime between 3/23/17 and 3/31/17.

RN #1 was asked how often a pressure ulcer should be assessed. RN #1 stated, "At least every week." RN #1 was asked whether or not the pressure ulcer found on Resident #13 was assessed weekly between 3/11/17 and 3/31/17. RN #1 stated, "Her weekly skin assessments were done but I don't know where the measurements are."

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On 4/12/17 at 3:58 p.m. an interview was conducted with LPN #4, a floor nurse. LPN #4 was asked to state the process for a weekly skin assessment. LPN #4 stated, "I look at the resident head to toe and document on the skin assessment sheet (using the diagrams). If we find anything new we call the doctor to get orders. If we find a pressure ulcer we complete both the skin assessment sheet and the pressure ulcer record. We also write a nurse's note and write that the RP and MD are aware."

LPN #4 was asked to review her skin assessment dated 2/23/17 for Resident #13. LPN #4 stated, I can't remember what it (the wound) looked like then, I was new and didn't know then that I had to put an open area on the pressure ulcer record." LPN #4 continued to review the skin assessment sheets that she had completed and further stated, "On 3/2/17 I did a skin assessment and I don't see any measurements. I definitely should have documented measurements." LPN #4 was asked whether or not an assessment should have been completed between 3/11/17 and 3/23/17. LPN #4 stated, "Yes, the measurements should have been done on 3/16/17 when I did the assessment. I can't really say that I learned about the pressure ulcer records until a couple of weeks ago."

On 4/12/17 at 4:15 p.m. an interview was conducted with ASM #5, the medical doctor. ASM #5 was asked how he would know about a skin issue. ASM #5 stated that the nursing staff would do their assessment then call him. ASM #5 was asked what would happen at that point,

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ASM #5 stated that he would provide orders and that there should be a plan of care put into place for every wound. ASM #5 further stated, "I can generally manage a stage 1 pressure ulcer and a stage 2, but once we get to the stage 3 or higher then I defer to (name of wound care doctor) as he is the specialist. Also if a plan of care to treat a wound was found to not be working then I would expect (name of the wound care doctor) to be called in. Most of the wounds in the building are managed by the wound care doctor." ASM #5 was asked about Resident #13's plan of care for the wound that she developed on her sacrum. ASM #5 stated, "I cannot answer why there was no plan of care following the initial evaluation when the staff noted skin breakdown. Some of this is on me as I did not follow up after I gave an order to treat the open area initially." ASM #5 further stated, "If there is no evaluation provided in the nurse's notes then it should be in the communication book for me to review. If I am not informed and there is no info (information) then I would not have a plan of care. The staff does work very hard to make sure that things happen quickly. An evaluation should be documented. I was not aware that this wound was progressing so rapidly, we should definitely have had a plan of care." ASM #5 was asked whether or not he was aware that the wound care doctor was not asked to assess the wound until the end of March. ASM #5 stated that he was not aware and that he counted on the nursing staff to contact the wound care doctor.

On 4/12/17 at 5:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the concern for harm. ASM #1 and ASM #2 were asked to provide any

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information that would evidence that Resident #13's sacral pressure ulcer was monitored for the impact of interventions following initiation and changes in treatment. A policy / protocol for wound identification and management was requested at this time.

On 4/12/17 at 5:15 p.m. an interview was conducted with RN #3, the unit manager. RN #3 was asked to describe the process for weekly skin assessments. RN #3 stated, "The skin assessments are assigned weekly to a nurse. They are done weekly but not always by the same nurse. The nurse documents what she sees and if there is a skin condition she puts on the skin condition sheet, rashes, bruises, surgical wounds and skin tears would be documented as skin conditions."

RN #3 was asked where a pressure ulcer would be documented, RN #3 stated, "On the pressure ulcer report." RN #3 was asked what is documented on the pressure ulcer report. RN #3 stated, "The size, stage and what it (the wound) looks like in general." RN #3 was asked if anyone reviewed the pressure ulcer report. RN #3 stated, "I do, every day. If I see a new pressure ulcer documented I go look at it on the resident and make sure that the treatment is appropriate and notify the wound doctor." RN #3 was asked if she documented her assessment. RN #3 stated, "If I look at the wound and decide to change the treatment, the change in the treatment is my documentation. I do not document my findings, but if I have new findings I will document those on the pressure ulcer report." RN #3 was asked if all the nurses had received wound care education. RN #3 stated, "They (the

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nursing staff) get it (wound care education) at orientation, then we have in-services from time to time." When asked when the last in-service was for pressure ulcer identification and management, RN #3 stated that she did not remember, then further stated, "Maybe March?" RN #3 was asked whether or not she would document when she contacted the wound care doctor. RN #3 stated that she would not.

RN #3 was asked to review the telephone order dated 2/18/17 for Resident #13 that described a "pink, open area." RN #3 was asked to state what a "pink, open are" to the sacrum indicated. RN #3 stated, "It is telling us that there is an open area to sacrum, it is not necessarily a pressure ulcer. I looked at it and it was nothing." RN #3 was asked where she documented her assessment. RN #3 stated, "I did not do any documentation."

RN#3 was asked to review the weekly skin assessments from 2/18/17 to 3/11/17 for Resident #13. RN #3 was asked whether or not there should have been measurements documented for the "pink, open area" being treated at that time. RN #3 stated, "The order is inconsistent with the skin assessment, measurements were not necessary." RN #3 was asked whether or not there should have been a description of the wound other than "pink, blancheable." RN #3 stated, "I probably should have followed up."

RN #3 was asked to review the note on the pressure ulcer record for Resident #13 dated 3/11/17. RN #3 stated, "I did look at it (the wound) and I looked at the treatment. I spoke to the hospice nurse about changing the treatment.

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I did not document that I spoke to the wound care doctor. I should have reassessed on 3/18 rather than on 3/23/17." RN #3 was asked to provide evidence that measurements were obtained and that the wound was assessed for its response to the treatment put in place on 3/11/17. RN #3 stated, "I should have followed up. The treatment was appropriate." RN #3 was made aware that the wound care doctor stated he had not been asked to look at the wound until 3/31/17, when he was in the building. RN #3 stated, "Okay." RN #3 was asked whether the wound had worsened between 2/18/17 and 3/11/17, RN #3 did not respond. RN #3 was asked whether the wound had worsened between 3/11/17 and 3/31/17. RN #3 did not respond.

On 4/13/17 at 10:45 a.m. an interview was conducted with ASM #2, the director of nursing, along with another surveyor. ASM #2 stated that she wanted to discuss the question of harm as she did not agree that harm had occurred with the management of Resident #13's pressure ulcer. ASM #2 stated, "Going through (name of Resident #13's) records I see that she had a weekly skin assessment every week. There was also a hospice consult order on 2/13/17 and a hospice evaluation on 2/18/17." ASM #2 was asked who identified the wound initially on 2/18/17. ASM #2 stated that the nurse who obtained the order on 2/18/17. The nurse in question was not available for interview. ASM #2 was asked if she had documentation of the description of the wound other than on the telephone order, and if she had any monitoring or tracking of the wound when it was found on 2/18/17. ASM #2 stated that she did not. ASM #2 was asked if there should have been ongoing monitoring and documentation of the wound.

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ASM #2 stated that it should have been documented on the skin sheets.

ASM #2 was asked whether or not the description documented on 3/11/17 on the pressure ulcer record indicated that the wound had declined since the description of the wound in the 2/18/17 telephone order. ASM #2 stated, "We obtained a new order." ASM #2 was asked when, between 2/18/17 and 3/11/17 did the sacral wound develop slough. ASM #2 stated, "I see what you're saying, I know they (the nursing staff) were looking at the skin weekly. There is no documentation." ASM #2 was asked to define "looking at the skin." ASM #2 stated, "Assess the wound for color, odor, size and drainage." When asked if that was included in the documentation, ASM #2 stated that it was not. When asked if the wound was worsening between 2/18/17 and 3/11/17, ASM #2 stated, "I cannot say if the wound was worsening, I did not see it. I do feel like the staff was looking at the wound, I do not have the documentation. There are definitely some education opportunities."

On 4/13/17 at approximately 11:00 am a nurse/cna (certified nursing assistant) sign-in sheet for "In-service Program Attendance" was presented. The in-service title was "Pressure Ulcer Prevention." Attached to the sign in sheets was a document titled "Pressure Ulcer Prevention and Wound Care." The document revealed, in part, the following instruction: "DOCUMENTATION: Assessments, interventions, topical agents and guest's response to therapy. At least weekly in the medical record document: Wound type, location, size - length, width, depth, undermining and tunneling, stage - for pressure ulcers, drainage,

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appearance of the wound bed - epithelium, granulation, slough, necrotic or eschar, condition of surrounding skin, guest's response to treatment; progress, current treatment plan."

The facility document titled "Pressure Ulcer Identification and Treatment Protocols" revealed, in part, the following; "Stage II: Partial thickness skin loss of dermis presenting as a shallow, open ulcer with a red pink wound bed, without slough. Intervention: 8. Evaluate wound during each dressing change and/or treatment. Document site, stage, length, width, depth, (cm), color, treatment, and progress at least weekly and if the condition of the wound changes."

The facility document titled "Pressure Ulcer Record" revealed, in part, the following; "Policy: All pressure ulcers are to be documented on the pressure ulcer record weekly. Procedure: 1. Initiate the form when a pressure ulcer is identified. 4. Record the date and site when first identified. Document in the description the location and appearance of the pressure ulcer. 5. Document the wound stage. 6. Measure the wound in centimeters and record the length, width and depth. 7. Enter the location of any tunneling or undermining with the 12 o'clock at the head by placing an "x" in the location. 9. Document the odor, drainage, and color. 14. Continue to measure and document the wound every seven days. Monitoring Healing: Nurses will use clinical judgement to assess signs of healing. If a wound does not show progress toward healing within a two week period, the guest's treatment plan should be reviewed with the attending physician. Any signs of deterioration should be addressed immediately. General signs of healing may include decrease in length, width or depth.

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The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8 concerning pressure ulcer assessment, "Asses the pressure ulcer initially and re-assess it at least weekly, documenting findings...A 2-week period is recommended for evaluating progress toward healing. However, weekly assessments provide an opportunity for the health care professional to detect early complications and the need for changes in the treatment plan." Page 9 of this reference states, "With each dressing change, observe the pressure ulcer for developments that may indicate the need for a change in treatment (e.g., wound improvement, wound deterioration, more or less exudate, signs of infection, or other complications)...Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue type (s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)...Signs of deterioration should be addressed immediately." (8)

No further information was provided prior to the end of the survey process.

[1] Necrotic tissue is described as dead tissue resulting from inadequate local blood supply. This information was obtained from the following website;
http://www.medscape.com/viewarticle/459733_5

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[2] Serosanguineous drainage features added plasma, which makes the run-off appear pink in color. Serosanguineous exudate is usually indicative of damage to blood vessels and capillaries. This information was obtained from the following website; https://www.advancedtissue.com/common-types-of-wound-drainage/

[3] Santyl ointment is used for: Removing dead skin from wounds and burned areas. Santyl ointment is an enzymatic debriding ointment. It works by breaking down dead skin. This information was obtained from; https://www.google.com/#q=santyl&spf=1

[4] A broad spectrum antibiotic. This information was obtained from the following website; http://www.healthline.com/drugs/metronidazole/oral-tablet#Highlights1

[5] An antibiotic used to treat bacterial infections. This information was obtained from the following website: http://www.healthline.com/drugs/ciprofloxacin/oral-tablet#Highlights1

[6] Abroad-spectrum topical antimicrobial solution, effective bacteria, viruses, molds, fungi and yeast. Also used for odor control. This information was obtained from the following website: http://www.woundsource.com/product/dakins-solution-quarter-strength-0125

[7]The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably

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score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. A lower Braden Scale Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development. This information is taken from the website

https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN/
[8] This information was obtained from: National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline. Washington, DC: National Pressure Ulcer Advisory Panel, Second edition published 2014.

2. The facility staff failed to implement pressure ulcer prevention interventions by not floating Resident #12 heels while in bed.

Resident #12 was admitted to the facility on 8/1/16 with diagnoses that included but were not limited to Alzheimer's Disease, Dementia, COPD

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(Chronic obstructive pulmonary disease), and high blood pressure. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/18/17. Resident #12 was coded as being severely impaired of cognition scoring 02 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring extensive assistance with one staff member for bed mobility and extensive assistance with two or more staff for transfers. Section M "Skin Conditions" of the 01/08/17 MDS documented Resident #12 as being a high risk for developing pressure ulcers. Resident #12 was coded in Section O "Special Treatments, Procedures, and Programs," as receiving hospice services.

Review of Resident #12's wound documentation revealed that Resident #12 was admitted on 8/1/16 with a stage two pressure ulcer [1] to his left inner buttock, a left heel intact blister, and a right heel DTI (deep tissue injury [2]). All areas were documented as resolved on 9/23/16 on the Weekly Skin Assessment Sheets.

Review Resident #12's most recent Braden Score for Predicting Pressure Sore Risk [3] dated 1/18/17, documented Resident #12 as being as being at high risk for developing pressure sores scoring a "17." The following was documented, "Total Score: Total score of 17 or less indicates that the individual is AT RISK."

Review of Resident #12's care plan dated 8/18/16 and updated 1/23/17 documented the following under the area of Skin: "Potential for impaired skin integrity related to mobility, cognitive impairments, and incontinence (r/t (related to)

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advanced stages of Alzheimer's Dementia. Measurable Goals: Skin will remain intact with no further signs of breakdown through next review. Approaches...Float heels while in bed."

On 4/11/17 at 2:26 p.m., an observation was made of Resident #12. He was sleeping in bed. His lower extremities and heels were flat on the bed.

On 4/11/17 at 3:30 p.m., an observation was made of Resident #12. He was sleeping in bed. His lower extremities and heels were flat on the bed.

On 4/11/17 at 4:30 p.m., an observation was made of Resident #12. He was sleeping in bed. His lower extremities and heels were flat on the bed.

On 4/11/17 at 4:45 p.m., an interview was conducted with LPN (licensed practical nurse) #3, the nurse assigned to Resident #12 that shift. When asked how often nurses round on their residents, LPN #3 stated that nurses including CNAs (Certified nursing assistants), should be rounding on residents every two hours. When asked how nursing staff know resident needs as far as skin preventive measures, LPN #3 stated that she would look at the treatment orders for each resident or look at the care plan. When asked if CNA's had access to the care plan, LPN #3 stated that CNAs had access to the care plan and also used a Care Card that is created from the care plan for each resident. When asked what Resident #12 needed to protect his skin, LPN #3 stated that he received skin protectant to his sacrum, skin prep to heels, and his heels needed to be floated while in bed. When asked

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what heels floated meant, LPN #3 stated, "Heels should not be touching the surface of the bed, the heels need to be alleviated from pressure." When asked how the heels are floated, LPN #3 stated, "With pillows or boots." When asked if Resident #12's heels were floated, LPN # 3 stated that she was not sure. This writer followed LPN #3 to Resident #12's room. LPN #3 stated, "No they are not floated." When asked if his heels should be floated, LPN #3 stated, "Yea. He's in bed." LPN #3 walked out of Resident #12's room. Resident #12's heels were still not floated at that time. LPN #3 was asked if nursing was following the care plan to "float heels" for Resident #12. LPN #3 stated that the care plan was not being followed.

On 4/11/17 at 4:50 p.m., an interview was conducted with CNA (certified nursing assistant) #1, the CNA assigned to Resident #12. When asked how CNAs determine residents' needs in regards to skin preventive measures, CNA #1 stated that she would look at the care plan. When asked how often she rounded on her residents, CNA #1 stated that she rounded constantly. CNA #1 stated, "I can't say I'll be there every one to two hours, sometimes it's longer than that." When asked what it meant to float heels, CNA #1 stated, "Something is placed under the heels to prevent the heels from rubbing." When asked when she had rounded on Resident #12 last, CNA #1 stated that she had rounded on Resident #12 when she first arrived to the facility. When asked if his heels were floated, CNA #1 stated, "I can look." This writer followed CNA #1 to Resident #12's room. CNA #1 lifted up the blankets and stated, "Don't look floated." When asked if his heels should be floated, CNA #1 stated that she was not sure.

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Resident #12's heels were observed flat directly on the surface of the mattress. There were no pillows under the Resident's legs. CNA #1 put the blankets back in place and left the room stating that she would get to him next.

On 4/12/17 at 7:37 a.m. (the following morning), an observation was made of Resident #12. He was sleeping in bed and his heels did not appear to be floated. His knees and feet were flat on the mattress surface.

On 4/12/17 at 7:38 a.m., an interview was conducted with CNA #2, a CNA who was assigned to Resident #12. When asked how CNAs determined residents' needs for skin preventive measures, CNA #2 stated that she received a little paper documenting the Resident's needs or she used the care card. When asked if Resident #12's heels should be floated, CNA #2 stated, "Not that I know of." When asked to see the paper or care card, CNA #2 pulled out a list of residents with their needs documented. CNA #2 stated, "I am missing the sheet with his name. I can try to go find it."

On 4/12/17 at 8:04 a.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse assigned to Resident #12 that shift. When asked how she would determine residents' needs in regards to skin preventive measures, LPN #4 stated that she would look at the TAR (treatment administration record) for treatment orders, and look in the ADL records. LPN #4 stated that she would also verify with the unit manager and care plan. LPN #4 stated that she was a new nurse to the facility and didn't know many residents. When asked if Resident #12 needed his heels floated while in bed, LPN #4

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stated that she would check the TAR. The TAR did not address the need for Resident #12's heels to be floated. When asked if Resident #12's heels were currently floated, LPN #4 stated that she could check. This writer followed LPN #4 to Resident #12's room. LPN #4 lifted up Resident #12's blanket and stated "They are not floated." Resident #12's heels were flat on the mattress with no pillow in place. This writer requested to see Resident #12's heels. Resident #12's heels were observed with no skin issues. Resident #12's heels were intact and his skin was blanachable. LPN #4 stated, "I'll float his heels before I leave." LPN #4 was then observed floating Resident #12's heels.

On 4/12/17 at approximately 9:00 a.m., the care card was presented. Review of Resident #12's most current "Nursing Care Card" documented the following: "...Float heels."

On 4/13/17 at 7:36 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated that all nursing staff had access to the care plan and that CNAs could use the care card to determine residents' needs. ASM #2 stated that she prefers residents to have orders or interventions on the care plan that states "float heels as tolerated" because so many residents do not keep their heels floated on the pillow. When ASM #2 was informed that Resident #12 did not have a pillow underneath his legs or around his legs to evidence staff were attempting to float his heels, ASM #2 stated that nursing should have been floating his heels. When asked if facility staff were following Resident #12's care plan, ASM #2 stated that nursing staff were not following the care plan.

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F 314	Continued From page 88 On 4/13/17 at 7:36 a.m., ASM #2, the DON was made aware of the above concerns. Facility policy titled, "Prevention Matrix" documents the following: "This section of the Wound Management Program has provided guidance on prevention of wounds. The prevention matrix will continue to be a guidance tool to utilize when dealing with the six (6) risk factors associated with prevention. Along with the risk factors, there are accompanying recommendations for each. Risk assessment factors: Lack of sensory perception: Recommendations: Utilize a pressure reducing mattress. It is required that each guest who has a Braden Scale of 17 or below be on a pressure relieving/reducing mattress. The lower the Braden scale, the greater the need for higher quality pressure reducing mattress...Turn and reposition every two (2) hours...assess pain and response interventions...For guests with red/and mushy heels- "float the heels"- Place a pillow or similar object under the Achilles' tendon so that the heels are not receiving pressure from any source...Friction and Shear:...Keep skin-to-skin and bony prominences from direct contact." No further information was presented prior to exit. According to Lippincott Manual of Nursing Practice, Eighth Edition, part 2, unit 1, section 9, special health problems of the older adult, page 187, "nursing and patient care considerations in prevention and healing of pressure ulcers; relieve	F 314		

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the pressure by: reposition every two hours, using special devices to cushion specific areas such as the heels."

[1] Stage II: 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. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

[2] Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use

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F 314	Continued From page 90 DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. [3] The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. A lower Braden Scale Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development. This information is taken from the website https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN/	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		5/19/17

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F 323	Continued From page 91 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to ensure an environment free of hazards on one of 3 nursing units, the Washington unit. On the Washington unit, the floor in the "Coffee Room" was observed with buckling and cracks and there was also a large crack with buckling in the tile from one corner to halfway across the hallway in the Tavern "Breezeway", creating tripping hazards for residents. The findings include: On 4/13/17 at approximately 8:00 a.m., a tour of	F 323	Ftag 323 The floor in the Coffee room has been repaired. The floor in the Tavern Breezeway has been repaired. All residents have the potential to be affected by this practice. NHA will educate the Maintenance department and department managers on the identification of repairs needed during rounds on the	

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F 323	Continued From page 92 the facility was conducted with OSM (Other Staff Member) #3 the director of maintenance. The following issues were observed: Near the front end of the Washington unit, was a "Coffee Room" which was a small space where residents could sit at tables and drink coffee. This was across from the main dining room. The floor to the entrance of the Coffee Room was observed with buckling and cracks, which could cause a resident to trip and fall. Near the back end of the Washington unit, was an open living room area at a hall crossways. This area was identified as the "Tavern Breezeway". There was a large crack in the tile from one corner to halfway across the hallway, and buckling of the tile at the crack, which could cause a resident to trip and fall. On 4/13/17 at 8:34 a.m., in an interview with OSM #3, he stated that staff complete work orders when they see something that needs repairing, and he collects the work orders several times a day. He was not able to provide evidence of having received a work order for these areas. A policy was requested for the routine maintenance of the facility. He stated he did not have one. On 4/13/17 at 9:00 a.m., the administrator was made aware of the findings. No further information was provided by the end of the survey.	F 323	units and the process for communication and repair requests. Director of Maintenance or designee will complete an audit of hallways and ancillary rooms for floors that require repairs. Director of Maintenance will make repairs and/or arrange for repairs to be completed with outside services as appropriate. NHA and Director of Maintenance will continue to monitor hallway and ancillary room floors. Any concerns identified will be corrected and reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any concerns.	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility	F 328		5/19/17

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and good foot health, the facility must:

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

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

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

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

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

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal

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F 328	Continued From page 94 suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and clinical record review, it was determined that the facility staff failed to provide respiratory care services per professional standards for two of 26 residents in the survey sample, Resident #3 and Resident #7. 1. The facility staff failed to administer Resident #3's oxygen as ordered by the physician. 2. For Resident #7, facility staff failed to maintain nebulizer equipment in a sanitary manner. The findings include: 1. Resident #3 was admitted to the facility on 5/11/15 and readmitted on 3/7/16 with diagnoses that included but were not limited to: high blood pressure, stroke, dementia and headaches. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 3/10//17 coded the resident as having a 15 out of 15 on the BIMS (brief interview	F 328	Ftag 328 Resident # 3: No negative outcomes occurred as a result of this practice. Oxygen is in place as ordered. Resident #7: No negative outcomes occurred as a result of this practice. Resident□s nebulizer mask has been stored appropriately in a bag. The DON or designee will educate licensed nursing staff about maintaining oxygen settings as ordered by a physician, appropriately storing nebulizer masks when not in use, and the process for supervision during nebulizer treatments if residents do not self-medicate. Nursing administration will conduct an audit orders and settings for current guests receiving oxygen to ensure they	

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F 328	Continued From page 95 for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as receiving oxygen. Review of Resident #3's care plan initiated on 3/30/17 documented, "Problems/Conclusions. RESP (respiratory) DIF (difficulty): Potential for Breathing difficulty (sic) r/t (related to Pulmonary disease...Oxygen use...Approaches/Interventions. Administer O2 (oxygen) as ordered." Review of the physician's orders dated April 2017 documented, "OXYGEN: HUMIDIFIED 3l (liters)/min (minute) via nasal cannula (1) continuous (day, eve, night)...Start 03/07/16." Review of the April 2016 treatment administration record documented, "OXYGEN-HUMIDIFIED via nasal cannula; continuous for 3l/min." The oxygen was documented as being administered every shift during April 2017. An observation was made on 4/11/17 at 11:35 a.m. of Resident #3. The resident was lying in bed, she was awake and alert. She had oxygen on via nasal cannula connected to an oxygen concentrator. The concentrator was observed set at four and 1/2 liters. An observation was made on 4/12/17 at 8:24 a.m. of Resident #3. The resident was in bed with the oxygen set on two and 1/4 liters via nasal cannula. An interview was conducted on 4/12/17 at 8:29 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked about the process	F 328	are on the appropriate settings. An audit of current residents with nebulizer orders will be conducted and room rounds on all residents to assure that the nebulizer masks are properly stored. Any variances will be corrected and additional education and/or counseling will be provided as needed. Nursing administration will continue to monitor conducting weekly rounds x 4 weeks of nebulizer masks to assure they are appropriately bagged and weekly rounds x 4 weeks of oxygen to assure the appropriate settings are in place and oxygen is functional. The DON will report any concerns to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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staff follows for checking a resident's oxygen, LPN #4 stated, "When we make rounds, we basically overview the whole thing to see if anything is out of order." When asked if she had checked Resident #3's oxygen that day, LPN #4 stated she had. LPN #4 was asked to check Resident #3's oxygen. LPN #4 stated, "It's between two and three." LPN #4 then adjusted the oxygen to three liters/minute. When asked what the prescribed oxygen rate was, LPN #4 stated, "Three liters per minute." When asked why it was important to give the oxygen as ordered, LPN #4 stated, "It pretty much depends on their diagnosis. They need to get enough oxygen in their lungs."

An interview was conducted on 4/12/17 at 8:40 a.m. with LPN #1, the unit manager. When asked about the process staff follows for checking resident's with oxygen, LPN #1 stated, "They should do it at least when they sign it off (on the treatment administration record), at least once a shift." When asked if it was important to administer the oxygen as ordered, LPN #1 stated it was. When asked how the oxygen was set, LPN #1 stated, "The metal ball has to be centered on the line."

On 4/13/17 at 11:15 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the manufacturer's operating manual documented on page 26, "NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Now, center the ball on the L (liter)/min. line prescribed."

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No further information was provided prior to exit.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

(1) A nasal cannula consists of two small plastic tubes, or prongs, that are placed in both nostrils. Taken from http://www.nhlbi.nih.gov/health/health-topics/topics/oxt/howdoes

2. For Resident #7, facility staff failed to maintain nebulizer equipment in a sanitary manner.

Resident #7 was admitted to the facility on 3/30/15 with diagnoses that included but were not limited to head injury, aortic aneurysm, osteoporosis, high blood pressure, arthritis, diabetes, and heart disease. Resident #7's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 1/3/17. Resident #7 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #7 was coded as requiring supervision only with most ADL (activities of daily living).

On 4/11/17 at 2:30 p.m., an observation of

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Resident #7's room was conducted. Her nebulizer mask was sitting upright in between the nebulizer machine handle. It was not stored in a plastic bag.

On 4/11/17 at 3:30 p.m., an observation of Resident #7's room was conducted. Her nebulizer mask was sitting upright in between the nebulizer machine handle. It was not stored in a plastic bag.

On 4/13/17 at 7:29 a.m., an observation of Resident #7's room was conducted. Her nebulizer mask was sitting upright in between the nebulizer machine handle. It was not stored in a plastic bag.

Review of Resident #7's most recently signed physician orders dated 3/10/17 revealed the following order: "Albuterol [1] 0.083% Sol (solution) 3 ML (milliliters) inhalation every 4 hours (1:00 a.m., 5:00 a.m., 9:00 a.m., 1:00 p.m., 5:00 p.m., 9:00 p.m.) shortness of breath." This order was initiated on 6/15/16.

On 4/13/17 at 7:30 a.m., an interview was conducted with LPN (licensed practical nurse) # 2, the nurse assigned to Resident #7 on 11-7 shift. When asked how nebulizer equipment should be stored when not in use, LPN #2 stated, "It should be cleaned after use and placed in a plastic bag." LPN #2 stated that the mask should be placed in the bag for cleanliness. When asked if Resident #7 had received her 1 a.m., and 5 a.m. breathing treatments, LPN #2 stated, "Yes." When asked if her nebulizer mask was in a plastic bag, LPN #2 stated, "She holds the mask in front of her face and sometimes she forgets to put the mask in the bag when it is

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completed." When asked if Resident #7 could determine when to shut off the machine and place the mask in the bag, LPN #2 stated, "Yes and she sometimes forgets to bag the mask. She will put the mask on the desk when it is done."

On 4/13/17 at 7:32 a.m., an interview was conducted with LPN #3. When asked about the process staff follows when a resident completes a nebulizer treatment, LPN #3 stated, "Nurses are supposed to wait there while the treatment is being done and then the nurse will bag the mask when it is completed." When asked why a nebulizer mask should be placed in a plastic bag, LPN #3 stated it was for infection control.

On 4/13/17 at 7:36 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked how nursing should store a nebulizer mask when a treatment is completed, ASM #2 stated that the nebulizer mask should be placed in a plastic bag for infection control. When asked if it was ok for the nurse to leave a resident with a breathing treatment in place, ASM #2 stated, "The nurse should be going back and checking to see if all the medication was completed and then should be placing the mask in a plastic bag."

On 4/13/17 at 7:36 a.m., ASM #2, the DON was made aware of the above concerns.

Facility policy titled "Aersol treatment" documents in part, the following: "The respiratory therapist/nurse shall administer treatments per physician order. Nebulizers are to be rinsed and shaken after each use and stored in a plastic bag."

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F 328	Continued From page 100 No further information was presented prior to exit. [1] Bronchodilator used to treat bronchospasm in patients with asthma, COPD and other lung disease. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008848/?report=details.	F 328		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F 329		5/19/17

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F 329	Continued From page 101 (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure the medication regimen one of 26 residents in the survey sample, Resident #2, was free of unnecessary medications. The facility staff failed to monitor the Resident #2's blood pressure prior to administering blood pressure medications on multiple dates from January 2017 through April 2017. The physician ordered Resident #2's blood pressure medications to be held if the resident's blood pressure was below specific parameters. The findings include: Resident #2 was admitted to the facility on 10/14/16. Resident #2's diagnoses included but were not limited to: diabetes, high blood pressure and Parkinson's disease. Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/17, coded the resident as being cognitively intact. Review of Resident #2's clinical record revealed a	F 329	Ftag 329 Resident #2: No negative outcome occurred as a result of this practice. BP parameters and medications have been reviewed by the physician. Residents with a diagnosis of hypertension and receiving blood pressure medication have the potential to be affected by this practice. The DON or designee will educate licensed nursing staff on following physician□s orders regarding blood pressure medication parameters and obtaining vital signs as ordered as well as entering prompts into the electronic health record that indicate parameters as a cue to the staff. Nursing administration will complete an audit of current residents receiving medication for hypertension and MAR□s for parameters being followed. The DON will continue to monitor through	

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F 329	Continued From page 102 physician's order dated 12/29/17 that documented, "HOLD Coreg (1) & lisinopril (2) & lasix (3) for SBP (systolic blood pressure) < (less than) 120 DBP (diastolic blood pressure) < 70" and a physician's order dated 1/6/17 that documented, "Hold BP (blood pressure) meds (medications) if SBP <110." Further review of Resident #2's clinical record (including the electronic medication administration record and nurses' notes) failed to reveal documentation that Resident #2's blood pressure was monitored prior to the administration of blood pressure medications each day from 1/1/17 through 4/12/17 except on the following dates: 1/3/17 1/6/17 1/7/17 1/13/17 1/16/17 1/17/17 1/21/17 1/27/17 2/3/17 2/10/17 3/10/17 3/17/17 3/23/17 3/24/17 3/31/17 4/7/17 4/10/17 4/12/17 Resident #2's comprehensive care plan revised on 1/23/17 documented, "Orthostatic hypotension (low blood pressure) with med (medication) changes. ER (Emergency room) visit < (less than) 30 last month for c/o (complaint of) chest pains...Obtain vital signs as ordered & as	F 329	review of new admissions and new and/or changed orders to blood pressure medications and MAR□s for parameters followed. Monitoring will occur 5 x weekly x 4 weeks. Additional education and/or education will be provided as indicated. The DON will report concerns to the quality assurance committee monthly until resolved. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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needed..."

On 4/12/17 at 8:51 a.m., an interview was conducted with RN (registered nurse) #3. This surveyor reviewed the above physician's orders with RN #3 and asked how nurses knew when to hold the blood pressure medications. RN #3 stated, "They should take the blood pressure before they give the medication." RN #3 was asked if the blood pressures were to be documented and if so where. RN #3 stated, "It's preferable that it is. They (blood pressures) should be documented in the medication administration record notes or the nurses' notes." Resident #2's medication administration record/notes and nurses' notes were reviewed with RN #3. RN #3 confirmed there was no evidence that Resident #2's blood pressure was monitored each day from January 2017 through April 2017. RN #3 was asked how this surveyor would know if Resident #3's blood pressure was monitored each day. RN #3 stated, "Well if it's not anywhere it's kind of hard to know unless they have a personal record somewhere."

On 4/12/17 at 10:10 a.m., this surveyor asked ASM (administrative staff member) #1 (the administrator) for a policy regarding blood pressure monitoring.

On 4/12/17 at 4:50 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above findings. ASM #1 stated the facility did not have the requested policy.

No further information was provided prior to exit.

(1) Coreg is used to treat high blood pressure. This information was obtained from the website:

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F 329	Continued From page 104 https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=fdb12700-116b-4203-8d74-9a94b9401fe6 (2) Lisinopril is used to treat high blood pressure. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=27ccb2f4-abf8-4825-9b05-0bb367b4ac07 (3) Lasix is used to treat high blood pressure. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=eadfe464-720b-4dcd-a0d8-45dba706bd33	F 329		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		5/19/17

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documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

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F 334	Continued From page 106 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to implement the flu and pneumococcal vaccination policies for four out of 26 residents in the survey sample; Residents #4, #2, #19, and #11. 1. The facility staff failed to provide Resident #4 and/or their responsible party, with annual or periodic education and offer of the flu vaccination and pneumococcal vaccine. 2.a. The facility staff failed to offer Resident #2 the influenza vaccine. b. The facility staff failed to provide education regarding the pneumonia vaccine to Resident #2 prior to administering the vaccine to the resident. 3. The facility staff failed to provide education regarding the influenza vaccine to Resident #19 and/or the resident's responsible party prior to administering the vaccine to the resident. 4. The facility staff failed to provide evidence that Resident #11 (or Resident #11's responsible party) had been offered the influenza vaccination during the 2016/2017 flu season. The findings include:	F 334	Ftag 334 Resident #4: No negative outcome occurred from this practice. It is not currently flu season; therefore, a flu vaccination will not be offered. The facility has offered a pneumovac vaccination to the resident representative. Resident # 2: No negative outcome occurred from this practice. It is not currently flu season, therefor a flu vaccination will not be offered. Resident #19: No negative outcome occurred from this practice. It is not currently flu season therefore a flu vaccination will not be offered. Resident #11: No negative outcome occurred from this practice. It is not flu season; therefore, a flu vaccine will not be offered. All residents have the potential to be affected by this practice. DON or designee will educate licensed nursing staff and the admissions department about obtaining consent upon admission, offering education, and appropriately documenting in the medical	

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F 334	Continued From page 107 1. For Resident #4, the facility staff failed to provide the resident and/or their responsible party, with annual or periodic education and offer of the flu vaccination and pneumococcal vaccine. Resident #4 was admitted to the facility on 11/3/10 and readmitted on 3/25/17 after a brief hospitalization. The resident was admitted with the diagnoses of but not limited to: dementia, osteomyelitis, asthma, stroke, small bowel obstruction, depression, cataracts, and spinal fusion. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) 2/1/17. The resident was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing, dressing, and eating; extensive assistance for transfers and hygiene; and was coded as incontinent of bowel and bladder. A review of the above MDS, "Section O - Special Treatments, Procedures, and Programs" documented under "O0250 - Influenza Vaccine" and under O0300 Pneumococcal Vaccine" that the resident did not receive the flu vaccine in the most recent flu season, nor had received at any time the pneumococcal vaccine. The reason documented for each was because it was not offered. A review of the clinical record revealed the "Immunization Record." There was no documentation that the resident had received any flu vaccines since admission in 2010. An "Acknowledgement of Receipt of Vaccine	F 334	record. In addition, education will be provided regarding offering, educating, and providing a new consent annually regardless of past declinations. Nursing administration will conduct an audit of immunization records for residents currently in the facility for consents, declines, last education, and last received vaccination as applicable. Additional education and/or counseling will be provided as indicated. The DON will continue to monitor through the daily clinical meeting, new admissions and immunizations 5 x week x 4 weeks. Corrections will be completed as needed and concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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Information Sheet (VIS) documented, "My signature(s) as noted affirms that I have received the VIS for each of the vaccine(s) listed below on the date(s) specified. It also affirms that I understand the information contained in the VIS and have had the opportunity to have any questions answered to my satisfaction before any injection is given." Under this was an area to consent or refuse the Pneumococcal Vaccine and the Inactive Influenza Vaccine. Each was marked as "declined" and dated 11/5/10. There was no evidence after the year 2010 that the resident and/or responsible party had been offered, educated, and refused these vaccines annually or periodically.

On 4/12/13 at 11:38 a.m., in an interview with RN #3 (Registered Nurse) the unit manager, RN #3 stated that she had no evidence that annual or periodic offerings and education of the vaccines were provided. She stated that "we were told that it only had to be offered once (at admission) and if they refused, we did not have to pursue it any further. We were told it was only a onetime thing."

A review of the policy for "Flu Vaccine" documented, "The facility will provide education and offer the flu vaccine to guests upon admission and annually thereafter to protect guests and to prevent an outbreak of influenza. The vaccine will be offered to all guests unless immunization is medically contraindicated."

A review of the policy for "Pneumococcal Vaccination" documented, "10. If the guest/family/legal representative chooses to exercise the right to decline the vaccination, the choice with benefit and risk review will be

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re-offered periodically."

On 4/12/17 at 5:45 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.

2.a. The facility staff failed to offer Resident #2 the influenza vaccine.

Resident #2 was admitted to the facility on 10/14/16. Resident #2's diagnoses included but were not limited to: Parkinson's disease, diabetes and high blood pressure. Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/18/17, coded the resident as being cognitively intact. Section O documented Resident #2 was not offered the influenza vaccine.

Review of Resident #2's clinical record failed to reveal the resident was offered the influenza vaccine. A form titled, "Acknowledgement of Receipt of Vaccine Information Sheet (VIS)" was blank with a line drawn across the form.

On 4/12/17 at 8:51 a.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated the admissions department was responsible for offering the influenza vaccine and having the paperwork signed on admission. RN #3 stated after the admissions department finishes the paperwork, nurses are responsible for administering the vaccine. RN #3 was shown Resident #2's clinical record and confirmed there was no evidence that Resident #2 was offered the influenza vaccine.

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On 4/12/17 at 9:58 a.m., an interview was conducted with OSM (other staff member) #2 (an employee from the admissions department). OSM #2 stated prior to admission, she calls the resident or the resident's family and explains the paperwork required for admission. OSM #2 stated after the resident is admitted, she has the resident or family signs all the admission paperwork including the "Acknowledgement of Receipt of Vaccine Information Sheet (VIS)" that offers the influenza vaccine.

On 4/12/17 at 4:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "FLU VACCINE" documented, "The facility will provide education and offer the flu vaccine to guests upon admission and annually thereafter to protect guests and to prevent an outbreak of influenza..."

No further information was provided prior to exit.

b. The facility staff failed to provide education regarding the pneumonia vaccine to Resident #2 prior to administering the vaccine to the resident.

Review of Resident #2's clinical record revealed the resident was administered the pneumonia vaccine on 12/15/16. Further review of the resident's clinical record failed to reveal the resident was provided education regarding the benefits and potential side effects of the immunization. A form titled, "Acknowledgement of Receipt of Vaccine Information Sheet (VIS)"

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was blank with a line drawn across the form.

On 4/12/17 at 8:51 a.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated the admissions department was responsible for offering the pneumonia vaccine and having the paperwork signed on admission. RN #3 stated after the admission department finishes the paperwork, nurses are responsible for administering the vaccine. RN #3 was shown Resident #2's clinical record and confirmed there was no evidence that Resident #2 was provided education prior to receiving the pneumonia vaccine.

On 4/12/17 at 9:58 a.m., an interview was conducted with OSM (other staff member) #2 (an employee from the admissions department). OSM #2 stated prior to admission, she calls the resident or the resident's family and explains the paperwork required for admission. OSM #2 stated after the resident is admitted, she has the resident or family sign all the admission paperwork including the "Acknowledgement of Receipt of Vaccine Information Sheet (VIS)" that documents the resident has been provided vaccine education.

On 4/12/17 at 4:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "PNEUMOCOCCAL VACCINATION" documented, "5. Provide education to the guest and/or legal representative on the benefits and potential side effects of the pneumococcal conjugate vaccine..."

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F 334	Continued From page 112 No further information was provided prior to exit. 3. The facility staff failed to provide education regarding the influenza vaccine to Resident #19 and/or the resident's responsible party prior to administering the vaccine to the resident. Resident #19 was admitted to the facility on 6/28/06. Resident #19's diagnoses included but were not limited to: heart failure, high blood pressure and major depressive disorder. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/17/17, coded the resident's cognition as moderately impaired. Section O documented Resident #19 received the influenza vaccine on 10/27/16. Review of Resident #19's clinical record revealed the resident was administered the influenza vaccine on 10/27/16. Further review of the resident's clinical record failed to reveal the resident/responsible party received education regarding the benefits and potential side effects of the immunization. On 4/12/17 at 4:36 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (unit manager). LPN #1 was asked if residents/responsible parties were provided education each year prior to receiving the influenza vaccine. LPN #1 stated she didn't provide education each year and her understanding was that the employee at the front desk mails the education to responsible parties. At this time, LPN #1 was asked to provide evidence that Resident #19 and/or her	F 334		

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responsible party was provided education prior to the resident receiving the influenza vaccine on 10/27/16.

On 4/12/17 at 4:45 p.m. an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 was asked if residents/responsible parties were provided education each year prior to receiving the influenza vaccine. ASM #1 stated the education is sent out to residents' responsible parties each year and she believed the former assistant director of nursing (no longer employed at the facility) was responsible for that.

On 4/12/17 at 4:50 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was provided prior to exit.

4. The facility staff failed to provide evidence that Resident #11 (or Resident #11's responsible party) had been offered the influenza vaccination during the 2016/2017 flu season.

Resident #11 was admitted to the facility on 4/24/16 with diagnoses that included, but were not limited to, low red blood cell count, heart failure, high blood pressure, elevated lipids in the blood stream, elevated potassium levels in the blood stream, anxiety, depression, psychosis and an irregular heartbeat.

Resident #11's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/16/17. Resident #11 was coded as scoring a 0 (zero) out of a possible score of 15 on the BIMS (brief

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interview for mental status) indicating that Resident #11 is severely impaired with decisions for daily living. In Section O, Special Treatments, Programs and Procedures, Resident #11 was coded as not having received the influenza vaccine in this facility for this year's influenza season and was further coded indicating that the influenza vaccine was not offered.

A review of Resident #11's clinical record revealed the facility document "Immunization Record Page 1" that revealed, in part, the following documentation; "Influenza Vaccination. Date: 3/22/13 Mfg (manufacturer): (not provided). Lot #: (not provided). Vaccine Given: (not provided). By Whom: (a line drawn through the entry box)." Across all boxes was written, "per hospital documentation."

Further review of Resident #11's clinical record revealed the facility document with a fax date stamp at the very top of the form of 4/9/2013, titled "Immunization Record Page 2 Acknowledgement of Receipt of Vaccine Information Sheet (VIS)" that revealed, in part, the following documentation; "Guest's Name: (Resident #11's name). Date of Birth: (Resident #11's date of birth). My signature (s) as noted affirms that I have received the VIS for each of the vaccine (s) listed below on the date (s) specified. It also affirms that I understand the information contained in the VIS and have had the opportunity to have any questions answered to my satisfaction before any injection is given. Inactive Influenza Vaccine VIS Publication Date 8-2012. Influenza Vaccine: (a box for accepted and a box for declined) Declined is checked. Guest's Representative: (A signature was on this line) Relationship: Guardian." There was no date

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to indicate when this document was signed and there was no evidence that this document was provided to Resident #11 and/or the responsible party at any other time.

A review of the facility document "Flu and Pneumonia Tracking Log 2016 - 2017" did not contain Resident #11's name on the log to indicate that she had been administered the flu vaccination.

On 4/12/17 at 4:35 p.m. an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what the procedure was each year to determine who would and who would not receive the flu vaccination. LPN #1 stated, "On admission the resident will sign a document stating that they wish to receive the flu vaccination or they wish to decline the vaccination. We do not aske anymore; if the resident or family members change their minds then we will have them sign a new form."

On 4/13/17 at 7:45 a.m. an interview was conducted with RN (registered nurse) #3, the unit manager. RN #3 was asked about the process followed by staff for resident flu vaccinations on her unit. RN #3 stated, "We ask the residents (or their RP) at the time of admission, we determine who has permission each year by going through the clinical records and then we obtain an order and administer the vaccination." At this time RN #3 was asked to provide evidence that the flu vaccination was offered to Resident #11 for the flu season starting in 2016 into 2017.

On 4/13/17 at 11:20 a.m. a meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of

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F 334	Continued From page 116 nursing. The administrative staff were made aware of the above findings. No further information was provided prior to the end of the survey process.	F 334		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 356		5/19/17

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F 356	Continued From page 117 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to post the required staff posting. The findings include: On 4/12/17 at 4:40 p.m., an observation was made in the main lobby of the staff posting. The 7am-3pm shift was still posted. The posting had not been updated to include the 3pm-11pm shift. On 4/12/17 at approximately 5:00 p.m., an interview was conducted with CNA #5 (Certified Nursing Assistant), the staffing coordinator. She stated that she does not post it (staff posting) until she is provided with census information for the shift. When asked when the staffing should be posted, she stated that she posts 7am-3pm staffing around 730 am; and the 3pm-11pm shift around 4:00 p.m., and the 11pm-7am shift does	F 356	Ftag 356 Staffing hours are now posted on all 3 shifts at this start of each shift. All residents have the potential to be affected by this practice. DON or designee will educate the staffing coordinator, and licensed nursing staff on staffing hours, how to correct hours as needed, posting locations, and that they are to be posted at the beginning of each shift. DON or designee will audit the last 30 days of staffing posting hours for all three shifts. The DON or designee will continue to monitor staffing hours posted in addition	

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F 356	Continued From page 118 not get posted because she is not at the facility during those hours. She states she completes the staffing information for the 11pm-7am shift the next morning. She stated that the night shift staffing never actually gets posted; just the information is completed on the form the next morning. At this time a policy was requested. CNA #5 provided the regulation as the facility policy, which documented, "The facility must post nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift." When asked if the policy was followed regarding postings at the beginning of each shift, CNA #5 stated, it was not. On 4/12/17 at approximately 5:45 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.	F 356	weekly x 4 weeks to assure that posting is being completed and accurate. Additional education and/or counseling will be provided as indicated. The DON will report any concerns to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	
F 360 SS=B	483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, clinical record review, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to honor food preferences for three of 26 residents in the survey sample, Residents # 16, # 17, and # 19.	F 360	Ftag 360 Resident # 16: No negative outcome occurred as a result of this practice. Resident□s food preferences have been updated.	5/19/17

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F 360	Continued From page 119 The facility staff failed to ask Resident # 16, # 17 and # 19 what food item they would have preferred before serving a substitute turkey patty for lunch. The findings included: During the observation of the facility's kitchen on 04/11/17 at 11:15 a.m. to approximately 12:50 p.m. OSM (other staff member) # 8, the cook, was observed plating lunch for the facility's residents in the presence of OSM # 1, the dietary manager. The residents' lunch consisted of roasted sliced turkey breast, stuffing, mixed vegetables, dinner roll, fruit cup, milk and beverage of choice (coffee, tea, juice). At approximately 12:30 p.m. OSM # 1 was observed frying several patties in a frying pan on the stove. At approximately the same time observation of the food service tray line revealed the pan that contained the roasted sliced turkey breast was empty. OSM # 8 asked OSM # 1 to bring the frying pan containing the patties to the steam table. OSM # 8 then prepared the last three resident lunch trays which included one fried patty, stuffing, mixed vegetables, dinner roll, fruit cup, milk and beverage of choice. When asked to identify the patty, OSM # 1 and OSM # 8 stated the patty was a turkey patty. The last three resident lunch trays were placed in the meal cart with several other resident lunch trays and sent to the floor to be delivered to the resident's rooms. When asked who was receiving the lunch trays with the turkey patties, OSM # 8 stated, "(Resident #16), (Resident # 17), and (Resident # 19). Resident # 16 was admitted to the facility on	F 360	Resident #17: No negative outcome occurred as a result of this practice. Resident□s food preferences have been updated. Resident # 19: No negative outcome occurred as a result of this practice. Resident □s food preferences have been updated. All residents have the potential to be affected by this practice. NHA or designee will educate the dietary manager and dietary department on honoring resident choice and preferences, and notification to affected residents of substitutions so the residents can make an informed decision. DON or designee will educate licensed nursing staff and certified nursing assistants on offering and communicating alternate meals and resident choice. Dietary Manager or designee will audit the last 30 days of the substation log. Dietary manager will update the substitution log to reflect not only substituted items but residents that substitution will affect and documentation that substitution was discussed and offered. Dietary manager will add alternate meals to the daily menu in addition to the always available meals already posted in the facility. Signage will be posted on guest bulletin boards as a reminder to ask staff for alternate choices if they do not wish to	

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F 360	Continued From page 120 05/13/16 with diagnoses that included but were not limited to: diabetes mellitus (1), hypothyroidism (2) and convulsions (3). Resident # 16's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/19/17, coded Resident # 16 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for making daily decisions. Resident # 16 was coded being independent with eating and requiring set up only of one staff member. Resident # 17 was admitted to the facility on 12/27/16 with diagnoses that included but were not limited to: depression, diabetes mellitus (1), hypertension (4) and anxiety (5). Resident # 17's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/30/17, coded Resident # 17 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact for making daily decisions. Resident # 17 was coded being independent with eating and requiring set up only of one staff member. Resident # 19 was admitted to the facility on 06/20/06 with diagnoses that included but were not limited to: hypertension (4), heart failure, thrombocytopenia (6) and chronic kidney disease (7). Resident # 19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/17/17, coded Resident # 19 as scoring a nine on the brief interview for mental status (BIMS) of a score of 0 - 15, nine being moderately impaired of cognition for making daily decisions. Resident # 19 was coded being independent with eating and	F 360	eat what is being served. The activities department will announce on the overhead paging system the meals and alternates daily with a reminder to speak with the staff if they would like something different. A resident group meeting will be held to discuss the new processes in place. The dietary manager will continue to monitor the substitution log weekly x 4 weeks. Interviews will be conducted with the residents at random weekly x 4 weeks. Additional education and/or counseling will be provided as indicated. The dietary manager will report concerns to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facilities quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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requiring set up only of one staff member.

On 04/11/17 at approximately 1:00 p.m. an observation and interview was conducted with Resident # 16 in their room. Resident # 16 was sitting on the edge of her bed with her lunch tray on the over the bed table in front of her. An observation of Resident # 16's lunch tray revealed one fried patty, stuffing, mixed vegetables, dinner roll, fruit cup, milk and beverage. When asked if she could identify the patty on the lunch plate Resident # 16 stated, "I don't know what it is. It might be a substitute." When asked if anyone informed her of what was on her lunch plate, Resident # 16 stated, "No."

On 04/11/17 at approximately 1:05 p.m. an observation and interview was conducted with Resident # 17 in their room. Resident # 17 was sitting up in her bed with her lunch tray on the over the bed table next to her bed. Resident # 17 stated she was waiting for a staff member to set her up for lunch. An observation of Resident # 17's lunch tray revealed one fried patty, stuffing, mixed vegetables, dinner roll, fruit cup, milk and beverage. When asked if she could identify the patty on the lunch plate, Resident # 17 stated, "I don't know what it is." When asked if anyone informed her of what was on her lunch plate Resident # 17 stated, "No."

On 04/11/17 at approximately 1:10 p.m. an observation and interview was conducted with Resident # 19 in their room. Resident # 19 was sitting on the edge of her bed with her lunch tray on the over the bed table in front of her. An observation of Resident # 19's lunch tray revealed one fried patty, stuffing, mixed vegetables, dinner roll, fruit cup, milk and

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beverage. When asked if she could identify the patty on the lunch plate, Resident # 19 stated, "I don't know what it is. I probably won't eat it." When asked if anyone informed her of what was on her lunch plate Resident # 19 stated, "No."

On 04/11/17 at approximately 1:20 p.m. an interview was conducted with OSM # 1 and OSM # 8. When asked to identify the patty that was served on Resident # 16's # 17's and # 19's lunch tray, OSM # 8 stated, "It's a turkey patty." When asked why a turkey patty was served to Residents # 16, # 17 and # 19, OSM # 1 and # 8 stated that they had run out of the roasted turkey breast. When asked if they had informed Residents # 16, # 17 and # 19 of the change or substitute in the menu, OSM # 1 and # 8 stated, "No." When asked if Residents # 16, # 17 and # 19 were asked if they would have liked the turkey patty or if they were given a choice of another food item for lunch, OSM # 1 and # 8 stated, "No." OSM # 8 further stated, "I know the residents and they'll eat that [turkey patty]."

On 04/12/17 at 2:00 p.m. a group interview was conducted with six residents who resided in the facility. When asked if they are served what is printed on the facility menu, resident's stated, "Not always. It's wrong as much as right." When asked if they are informed when there is a change in the menu or when the facility runs out of a particular food item, the resident's stated, "No. A lot of the time we don't know what's being changed, often get something entirely different." When asked if they are offered their preferred food item the resident's stated, "No."

On 04/12/17 at 5:35 p.m. an interview was conducted with Resident # 17. When asked if her

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food preferences are honored, Resident # 17 stated, "No." When asked about the turkey patty she was served for lunch the previous day, Resident # 17 stated, "I didn't eat it yesterday."

On 04/12/17 at 5:45 p.m. an interview was conducted with Resident # 19. When asked if her food preferences are honored, Resident # 19 stated, "No." When asked about the turkey patty she was served for lunch the previous day, Resident # 19 stated, "I didn't know what it was."

On 04/13/17 at 7:45 a.m. an interview was conducted with OSM # 1, the dietary manager. When asked to describe the process to ensure they don't run out of a food item, OSM # 1 stated, "I look at the servicing per resident and plan accordingly." When asked to describe the process that is followed if he does run out of a specific food item, OSM # 1 stated, "I try to replace it with a similar product, then go talk to the residents who are not going to receive the menu item and ask them what they would like to have and offer them choices or whatever their preference is." When asked if he gave Residents # 16, # 17 and # 19 the opportunity to express their preferences for lunch on 04/11/17, OSM # 1 stated, "No, I didn't at the time. It was the first time I've run out of food." When asked to describe how he determines a resident's food preference, OSM # 1 stated, "I use a preference sheet. It's completed within 48 hours of admission, I also talk to residents and rely on nursing, resident council and the food committee to make changes to the resident's food preferences or dietary restrictions." When asked to comment about serving Residents # 16, # 17 and # 19 a turkey patty, not informing them that they had run out of the roasted turkey breast and

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not asking them what their preference would have been, OSM # 1 stated, "I should have talked to the residents or sent my staff to find out what they would have preferred." When asked about OSM # 8's comment that because she knew the residents they would be okay with eating the turkey patty, OSM # 1 stated, "That's not an acceptable practice. She shouldn't assume what the residents like."

The facility's policy "Accommodation of Food Preferences" documented, " Policy: Alternate menu items shall be available to reasonably accommodate individualized guest allergies, intolerances, and food preferences, including religion, ethnic and cultural food preferences and restrictions as well as input from Resident Council. Procedure: 1. A record of guest's food preferences and/or restrictions shall be obtained as a component of the nutrition assessment process using the Guest Interview/Food Preferences form. Guest's food preferences shall be listed on the guest's tray card and/or Cardex card either manually or via computer."

On 04/13/17 at 9:10 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

Complaint deficiency

References:

(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(3) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(6) A disorder in which there is an abnormally low amount of platelets. Platelets are parts of the blood that help blood to clot. This condition is sometimes associated with abnormal bleeding. This information was obtained from the website: https://medlineplus.gov/ency/article/000586.htm.

(7) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/chronickidneydisease.html.

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F 364	Continued From page 126	F 364		
F 364 SS=B	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, it was determined that the facility staff failed to serve food at a palatable temperature for residents. The facility staff failed to serve food at a palatable temperature for the dinner meal on 04/12/17. The findings include: A resident council meeting was held on 04/12/17 at 2:00 p.m. with six residents. When asked about the food temperature and quality, the residents stated that the food was cold and the taste could be better. An observation of the dinner tray preparation was made on 04/12/17 at 4:41 p.m. Food temperatures were taken by the kitchen staff in the presence of OSM (other staff member) #1, the dietary manager and were as follows: macaroni and cheese 145 degrees; pureed macaroni and cheese 160 degrees; sliced ham 141 degrees; whole peas 187 degrees; diced ham 172 degrees; pureed ham 175 degrees;	F 364	Ftag 364 No negative outcome occurred as a result of this practice. Meals are being served at the appropriate temperature. All residents have the potential to be affected by this practice. Dietary manager or designee will educate the dietary department on appetizing food temperatures and test trays. Resident interviews at random will be conducted weekly x 4 weeks. DON or designee will educate licensed nursing staff and certified nursing assistants on food temperatures and keeping food carts closed to maintain the appropriate temperature. Dietary manager will conduct test trays 2x day for 5 days on every cart. Additional education and/or counseling will be provided as indicated.	5/19/17

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F 364	Continued From page 127 mashed potatoes 162 degrees; pureed peas 180 degree. On 04/12/17 at 5:45 p.m. the last food cart was loaded with residents' trays, a request was made to OSM #1 to prepare a test tray. The food cart was followed to the unit by OSM #1 and two surveyors. At 6:05 p.m. all of the residents' trays had been delivered and residents had begun eating. At that time the test tray food temperatures were re-checked by OSM #1. The food temperatures on the test tray were as follows: macaroni and cheese 145 degrees; pureed macaroni and cheese 118 degrees; sliced ham 149 degrees; whole peas 146 degrees; diced ham 133 degrees; pureed ham 133 degrees; mashed potatoes 148 degrees; pureed peas 151 degrees. OSM #1 and the two surveyors tested the food. OSM #1 stated that the pureed peas were too cool and should be above 130 degrees. OSM # 1 agreed that the pureed peas were not warm enough. Review of the "Resident Council Meeting Minutes" dated October 2016 through March 2017 failed to evidence documentation of food temperature concerns. Review of the "Food Committee Meeting Minutes" dated October 2016 through March 2017 failed to evidence documentation of food temperature concerns. Review of the facility's policy titled, "RECORDING HOLDING FOOD TEMPERATURES & GUIDELINES" documented, "5. The temperature of the food as it is served to the guest shall be	F 364	Dietary manager will continue to monitor through test trays rotating carts, meals, and texture 3 x a week for 4x weekly. Resident interviews at random will be conducted weekly x 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported to the quality assurance committee monthly until resolved.	

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F 364	Continued From page 128 palatable per guest preference. The cognitive status of the guest shall also be considered for safety reasons (e.g., hot beverages that may be spilled). 10. Food that is not held in the acceptable holding range (greater or equal to135 (degrees) F for hot food and less than or equal to 41(degrees) F for cold food) at the end of the meal service shall be discarded. Acceptable Serving Line Holding Temperatures: Vegetables/Starch greater or equal to135 (degrees) F." On 4/13/17 at 9:120 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 364		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		5/19/17

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F 371	Continued From page 129 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. 1. The storage shelf located above the two-compartment sink that stored clean measuring pitchers and the clean work bowl of the food processor, was observed with food debris present. 2. The facility staff failed to implement the use of hair nets during the food preparation service. The findings included: 1. The storage shelf located above the two-compartment sink that stored clean measuring pitchers and the clean work bowl of the food processor, was observed with food debris present. Observation of the facility's kitchen was conducted with OSM (other staff member) # 1, the dietary manager on 04/11/17 at 11:15 a.m. Observation of a eight foot long by 12 inch deep stainless steel shelf located above a two-compartment sink revealed six measuring pitchers turned upside down resting on the shelf and the work bowl of a food processor turned	F 371	Ftag 371 No negative outcome occurred as a result of this practice. The storage shelf has been cleaned and is free of food debris. Employees in the kitchen are wearing hairnets. All residents have the potential to be affected by this practice. NHA or designee will educate the Dietary manager and dietary department on sanitation and storage of food preparation and serving tools and wearing hairnets at all times when in the kitchen. NHA will educated department managers on wearing hairnets at all times if they are in the kitchen. The Dietary manager will audit the last 4 weeks of cleaning schedules and make adjustments and changes as appropriate and will audit availability of hairnets visible and in place.	

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F 371	Continued From page 130 upside down resting on the shelf. Further review of the stainless steel shelf revealed food debris present across the length of the shelf. OSM # 1 was asked if the six measuring pitchers turned upside down resting on the shelf and the work bowl of a food processor turned upside down resting on the shelf were cleaned and ready for use. OSM # 1 stated, "Yes." OSM # 1 was asked to examine the stainless steel shelf. When asked if the shelf was clean, OSM # 1 stated, "No." When asked if he agreed with the finding of food debris across the length of the stainless steel shelf, OSM # 1 stated, "Yes." OSM # 1 then removed the six measuring pitchers and the work bowl of a food processor to be rewashed and stated he would get the shelf cleaned. 2. The facility staff failed to implement the use of hair nets during the food preparation a service. During the observation of the facility's kitchen on 04/11/17 at 11:15 a.m. to approximately 12:50 p.m. OSM # 1, the dietary manager, was observed in and around the food service line, preparing turkey patties in a frying pan on the stove then carrying them to and placing them on the food service line. Further observation revealed OSM # 1 was not wearing a hair net. OSM # 1's head was characterized by baldness from the right and front temples, over the top of the head to the crown, (the area at the upper back of the skull). The sides of his head around to the back of the head revealed short cropped hair. On 04/11/17 at 1:30 p.m. OSM # 7, housekeeping and laundry supervisor, was observed in the facility's kitchen talking with OSM # 1. Further	F 371	NHA and dietary manager will continue to monitor sanitation through weekly kitchen rounds x 4 weeks and weekly review of cleaning schedules for dietary staff and dietary manager initials/signature to assure completion. Additional education and/or counseling will be provided as indicated. Concerns will be reported to the quality assurance committee monthly until resolved. Dietary manager will audit hairnets being in place on staff in the kitchen weekly x 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored thought the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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observations of OSM # 1 and # 7 revealed neither of the staff was wearing a hair net. When OSM # 7 was asked if he was wearing a hair net OSM # 7 stated, "No." When asked if OSM # 7should have been wearing a hair net, OSM # 1 and OSM # 7 stated, "Yes."

On 04/13/17 an interview was conducted with OSM # 1 regarding the use of hair nets. OSM # 1 stated that everyone in the kitchen or who enters the kitchen should be wearing a hair net. When asked why he was not observed wearing a hair net during the days of the survey, OSM # 1 stated that he didn't think he was required to wear a hair net because he was partially bald.

The facility's policy "EMPLOYEES-LIMITED ACCESS" documented, "Procedure: 1. Only authorized personnel shall be permitted access to the Dietary Department. Authorized personnel may include but is not limited to: Dietary Staff; Maintenance Staff and Administrator. 2. Unauthorized personnel shall wait at the Dietary Department door to receive or deliver trays, nourishments, ice, water pitchers, etc. 3. The Dietary Manager shall restrict visits with guests' families and other staff to the Dietary Manager's office or to an area outside of the Dietary Department. 4. Authorized personnel entering the Dietary Department shall abide by all the rules and regulations of the Dietary Department, (e.g., wash their hands and wear a hair net)."

On 04/13/17 at 9:120 a.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

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F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, it was determined	F 514	Ftag 514	5/19/17

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that the facility staff failed to ensure a complete and accurate clinical record for two of 26 residents in the survey sample; Resident #4 and Resident #23.

1. The facility staff failed to ensure the Durable Do Not Resuscitate Order (DNR or DDNR) form for Resident #4 was properly completed.

2. Resident #23 was transferred from the facility to the emergency room on 3/14/17 and admitted to the hospital. The facility staff failed to document in the clinical record that a bed hold notice was provided at the time of this transfer.

The findings include:

1. Resident #4 was admitted to the facility on 11/3/10 and readmitted on 3/25/17 after a brief hospitalization. The resident was admitted with the diagnoses of but not limited to dementia, osteomyelitis, asthma, stroke, small bowel obstruction, depression, cataracts, and spinal fusion. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) 2/1/17. The resident was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing, dressing, and eating; extensive assistance for transfers and hygiene; and was coded as incontinent of bowel and bladder.

A review of the clinical record revealed the Durable Do Not Resuscitate Order form, dated 3/24/17. This form documented the following:

Resident #23: Resident no longer resides at the facility, and did not return after discharge to the hospital.

All residents have the potential to be affected by this practice.

DON or designee will educate licensed nursing staff on the bed hold policy, offering a bed hold, and the appropriate documentation in the medical record. NHA or designee will educate the admissions department about documenting any bed hold acceptances or declinations for hospitalized residents.

DON or designee will audit that last 30 days of hospital discharges for documentation on offered bed hold.

The DON will continue to monitor discharges and bed hold offering and appropriate documentation in daily clinical meeting x 4 weeks. Additional education and/or counseling will be provided as indicated. The DON will report concerns to the quality assurance committee monthly until resolved.

Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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"Physician's Order" with a statement that read: "I, the undersigned state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify: [must check 1 or 2]:

1. The patient is CAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course or medical treatment. (Signature of patient is required).

2. The patient is INCAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision."

Box 2 was checked.

The second part of the form documented:

"If you checked 2 above, check A, B or C below:

A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

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B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf" is required).

C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf" is required)."

None of these areas (A, B, or C) were checked.

The bottom of the document contained the signature and printed name of the physician.

On 4/12/17 at 1:00 p.m., an interview was conducted with RN (Registered Nurse) #1. She looked at the form and stated that under item 2, a box (A, B, or C) should have been checked.

On 4/12/17 at 1:02 p.m., in an interview with RN #3 the unit manager, when she was shown the form, she was unable to identify that it was not accurately completed. When asked how often she audits charts for completeness and accurateness of the record, RN #3 stated at admission and maybe quarterly. The resident was readmitted on 3/25/17 with this new form completed, as the resident was a Full Code prior to the recent hospitalization. She had not identified that the form was not accurately completed.

On 4/12/17 at approximately 5:45 p.m., the

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Administrator was made aware of the findings. No further information was provided by the end of the survey.

2. Resident #23 was admitted to the facility on 2/24/17 and discharged to the hospital on 3/14/17. The resident did not return to the facility. Resident #23 was admitted with the diagnoses of but not limited to high blood pressure, morbid obesity, and intracranial hemorrhage. The Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/3/17, coded the resident as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing, hygiene, transfers, dressing, and toileting; supervision for eating; and was coded as occasionally incontinent of bladder.

A review of the clinical record revealed a nurse's note dated 3/15/17 at 12:18 a.m., that documented, "Guest c/o (complains of) N/V (nausea and vomiting) and pain to head, not relieved by PRN (as needed) meds (medications). Guest requests to be sent to ER (emergency room). RP (responsible party) at bedside, in agreement with guest. EMTs (emergency medical technician) called and Guest sent to ER for further evaluation at 11:30PM."

Further review of the clinical record failed to reveal any evidence a bed hold notice was provided to Resident #23 at the time of transfer.

On 4/12/17 at 1:29 p.m., in an interview with OSM #2 (Other Staff Member) the Admissions staff,

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she stated that when a resident is discharged to the hospital, she follows up with them or their responsible party the next day to see if they wanted a bed hold. She was not employed at the facility at the time of this discharge and was unable to state if the previous admissions person followed up. OSM #2 stated that if a resident does not want a bed hold, she typically does not document it.

On 4/12/17 at 4:56 p.m., in an interview with LPN #7 (Licensed Practical Nurse) she stated that she gave the resident (Resident #23) a bed hold policy as part of a discharge package, but she did not document that one was provided.

A review of the facility policy "Bed Hold and Return to Facility" documented, "The facility will provide written information to the guest or guest's representative of this bed hold policy upon leaving for hospitalization or a therapeutic leave."

On 4/12/17 at 5:45 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.