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| VA BAP HOSP DIV CEN | 3300 RIVERMONT AVE LYNCHBURG, VA 24503 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 10/11/17 through 10/13/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow.<br><br>The census in this 166 certified bed facility was 97 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through #17 and Resident #21) and three closed record reviews (Residents #18 through #20). | F 000 | | |
| F 241 SS=E | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, family interview and group interview, the facility staff failed to ensure that residents throughout the facility were treated with dignity and respect.<br><br>Residents and families reported to the survey team that resident requests were not promptly responded to in a dignified manner. CNAs (Certified nursing assistants) were described as having "an attitude", being "rough", and "acting disgusted" when asked for help or assistance. One resident complained that she was put to bed in the early evening and was not checked on until | F 241 | 1- Discussion with affected residents was conducted immediately by the Administrator to discuss our zero tolerance policy for failure to treat residents with dignity and respect and that immediate notification to management was expected if occurred.<br><br>2- A 100% of all interviewable residents will be interviewed to determine if they feel they are being treated with dignity and respect by the DON or designee. | 11/24/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/25/2017

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

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| F 241 | Continued From page 1<br>3:00 a.m. She stated by that time her bed was wet and she was cold. She stated that when she rang her call bell the staff didn't always respond.<br><br>Residents interviewed are identified below.<br><br>Findings were:<br><br>A group interview was conducted on 10/11/2017 at 2:30 p.m., with seven cognitively intact residents. Three of the female residents spoke up regarding care at the facility. One of the residents stated, "When you ring you call bell or ask for help, they come in the room and act disgusted that you are asking them to do anything." Another resident stated, "It's rough around here sometimes, you ring the bell and you have to wait for them to take you to the bathroom... then they leave and you have to wait for them to come back and help you out of the bathroom." A third female resident spoke up and stated, "They just aren't quick enough when I ring the call bell sometimes... I have peed my pants waiting on them... some of the CNAs don't want to help you... one of them told me I needed to get myself up. I told her the other girls helped me and she said, you need to do more for yourself." None of the residents could provide names of the CNAs they were referring to. The residents were asked if the concerns voiced in the group meeting had been shared with the administrative staff. They all shook their heads no. The residents were asked why they had not addressed it. One of the residents spoke up and stated, " Maybe I'm speaking out of run, but I'm not doing it... if you say anything to one, they tell another, and they tell another, until it is all over the place and everyone knows you were complaining about them. Then you can't get anything done and they | F 241 | 3- Education will be provided to all staff on civility in the workplace and resident dignity by the Director of Nursing or designee.<br><br>4- A 100% of all residents will be interviewed weekly x 4weeks to determine if residents feel that they are being treated with dignity and respect by the DON or designee. A 10% random interview audit and 10% observation audit will be conducted on a monthly basis for 3 month by the DON or designee. If areas of concern are identified they will be investigated and corrected immediately. The findings and results will be reported to the Quality Assurance Performance Improvement Committee to ensure ongoing compliance.<br><br>5- 11/24/2017 | |

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| F 241 | Continued From page 2 | F 241 | | |

are mad at you." The other residents were asked if they were in agreement with that statement. They all shook their heads "Yes".

A private interview was conducted with Resident #9's family member on 10/12/17 at 4:30 p.m. The family member stated some of the certified nurses' aides (CNAs) caring for her mother reacted "with an attitude" if questioned about a care issue or concern. The family member stated she recently found Resident #9 sitting in the wheelchair with the lift pad "bunched up" behind her in the chair and in the bed with her legs crossed up. The family member stated when she asked the CNA about this the aide acted like she was not concerned and not an issue. The family member stated some of the aides "act like they think I am supposed to do it [provide care]." The family stated she had talked with the unit manager and director of nursing about the issue but had seen little change in the caregivers' attitudes.

Resident #8 was admitted to the facility on 09/29/17 with diagnoses including, but not limited to: Colon/Rectal Cancer with a Colon Resection, Hypertension, Nausea and Chronic Obstructive Pulmonary Disease.

Resident #8's most recent MDS (minimum data set) was an Initial assessment with an ARD (assessment reference date) of 10/06/17. Resident #8 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

Resident #8 was interviewed on 10/11/17 at 3:35 p.m. regarding his stay and care at the facility. During this interview Resident #8 stated, "They [referring to CNA's (certified nursing assistants)]

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| F 241 | Continued From page 3<br>sometimes act flustered when answering my light, depending on how many times I need to go to the bathroom. Sometimes I just pass gas, but I don't know until I get in there."<br><br>Resident #16 was originally admitted to the facility on 06/25/15 and readmitted on 08/10/15 with diagnoses including, but not limited to: Diabetes, Congestive Heart Failure, Dementia, Glaucoma, Arthritis and Cerebrovascular Accident (CVA).<br><br>The most recent MDS was a quarterly assessment with an ARD of 09/06/17. Resident #16 was assessed as cognitively intact with a total cognitive score of 14 out of 15.<br><br>A resident interview was conducted with Resident #16 on 10/12/17 at 4:15 p.m. During this interview Resident #16 stated, "I go to bed at 7:30 [p.m.] every night, but the night shift never come to check on me and see if I am wet. Sometimes my clothes are wet, my bed is wet and I am cold. I call for help sometimes at night, but they don't always come. [Name-CNA] takes care of me when she comes in at 3:00 [a.m.]."<br><br>The above information was discussed with the administrator and the director of nursing on 10/13/2017 during a morning meeting.<br><br>No further information was obtained prior to the exit conference on 10/13/2017. | F 241 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. | F 278 | | 11/24/17 |

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| F 278 | Continued From page 4<br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility staff failed for one of 21 residents in the survey sample (Resident # 5) to ensure the resident had a complete and accurate Minimum Data Set. Resident # 5 was incorrectly identified on a Quarterly Minimum Data Set as having a Stage 1 pressure ulcer. | F 278 | 1- The MDS for resident #5 was immediately corrected to reflect the accurate staging of the wound.<br><br>2- A 100% audit of all resident MDS' with pressure ulcers will be conducted by the Lead MDS Coordinator to ensure that | |

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The findings were:

Resident # 5 in the survey sample, a 79 year-old female, was admitted to the facility on 4/15/16, and most recently readmitted on 3/20/17 with diagnoses that included congestive heart failure, anterior displaced Type II dens fracture, cardiomyopathy, chronic kidney disease, chronic obstructive pulmonary disease, cognitive communication deficit, constipation, difficulty walking, dysphagia, hypertension, hyperkalemia, hyperlipidemia, generalized muscle weakness, stage II sacral pressure ulcer, diabetes mellitus, displaced fracture of the second cervical vertebra, and vascular dementia. According to the most recent Minimum Data Set, a Quarterly Review with an Assessment Reference Date of 9/1/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15.

At Section M (Skin Conditions), Item M0300, Current Number of Unhealed Pressure Ulcers at Each Stage, under sub-heading A. Number of Stage 1 pressure ulcers, the resident was identified as having one (1) Stage 1 pressure ulcer.

A Stage 1 pressure ulcer is defined as, "An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin,

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their most recent MDS assessment was correctly coded for the pressure ulcer.

3- Education will be obtained through independent study of the regulations from the CMS.gov website by the MDS staff on accurate coding of pressure ulcers on the MDS assessment.

4- A 100% audit of all resident's due to have an MDS completed and have pressure areas will be audited weekly x4 weeks to ensure correct coding on the MDS by the Lead MDS Coordinator. A 10% random audit of MDS due for completion for residents who have pressure areas will be conducted on a monthly basis for 3 months by the Lead MDS Coordinator. The findings and results will be reported to the Quality Assurance Performance Improvement Committee to ensure ongoing compliance.

5- 11/24/17

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whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues." (Ref. CMS's RAI Version 3.0 Manual, Chapter 3, page M-7, September 2010.)

At 3:20 p.m. on 10/12/17, RN # 3 (Registered Nurse), one of the facility's MDS Coordinators, was interviewed regarding the identification of Resident # 5 as having a Stage 1 pressure ulcer. Asked what criteria was used to determine Resident # 5 had a Stage 1 pressure ulcer, RN # 3 showed the surveyor a copy of an Initial Encounter, dated 8/28/17, written by the Medical Director, and indicated it was the criteria that was used. The encounter document noted the following:

"Reason for visit - Left unstageable heel wound. Assessment and Plan: Left heel unstageable wound initial encounter."

After reading the Medical Director's Initial Encounter report, the surveyor advised RN # 3 that by definition, an unstageable wound was not a Stage 1 pressure ulcer and as such, the identification of Resident # 5 as having a Stage 1 pressure ulcer was incorrect.

The incorrect assessment was discussed during a meeting held at 4:00 p.m. on 10/12/17, that included the Administrator, Director of Nursing, and the survey team.

F 279 SS=D 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS — F 279 — 11/24/17

483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15

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months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the

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resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive plan of care for two of 21 residents in the survey sample. Resident #4 had no care plan developed regarding dental issues and Resident #12 had no care plan developed regarding impaired cognition.

The findings include:

1. Resident #4 had no care plan developed regarding dental issues.

Resident #4 was admitted to the facility on 9/8/16 with diagnoses that included dementia, high blood pressure, protein-calorie malnutrition, vitamin deficiency and anemia. The minimum data set (MDS) dated 9/15/17 assessed Resident #4 with severely impaired cognitive skills.

Resident #4's clinical record documented a

1- The care plans for resident #4 and resident #12 were immediately corrected to reflect the accurate assessment by the MDS Coordinator.

2- 100% audit of all resident's last comprehensive assessment will be conducted by the Lead MDS Coordinator or designee to ensure all triggered CAAs have been marked for care planning have been care planned.

3- Education will be obtained through independent study of the regulations from the CMS.gov website by the MDS staff on care planning CAA's resulting from the MDS assessment.

4- After the initial audit, a 10% audit will be conducted by Lead MDS Coordinator of Comprehensive Assessments due to

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dietary assessment dated 6/13/17 indicating the resident had "obvious or likely cavity or broken natural teeth" and a lower partial plate. The annual MDS dated 6/13/17 included dental issues as a triggered problem in the care area assessment summary requiring a care plan. The 6/13/17 MDS indicated the facility decided to include dental issues as part of the resident's comprehensive care plan.

Resident #4's plan of care (print date 10/12/17) included no problems, goals and/or interventions regarding the resident's dental problems.

On 10/12/17 at 9:35 a.m. registered nurse (RN) #3 responsible for MDS assessments and care plan development was interviewed about a dental care plan for Resident #4. RN #3 stated it was listed under nutrition to check for the condition of the teeth but there were not specific problems, goals and/or interventions on the plan concerning potential problems with the resident's teeth.

These findings were reviewed with the administrator and director of nursing during a meeting on 10/12/17 at 11:00 a.m.

2. Resident #12 had no plan of care developed regarding impaired cognition and/or dementia.

Resident #12 was admitted to the facility on 1/19/16 with a re-admission on 3/15/16. Diagnoses for Resident #12 included difficulty swallowing, cognitive communication deficit, dementia, glaucoma, cervical stenosis and osteoarthritis. The minimum data set (MDS) dated 8/13/17 assessed Resident #12 with severely impaired cognitive skills.

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be completed to ensure that all CAA Triggers marked have been care planned monthly x 3 months. The findings and results will be reported to the Quality Assurance Performance Improvement Committee to ensure ongoing compliance.

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| F 279 | Continued From page 10<br><br>Resident #12's MDS dated 8/13/17 documented the resident was assessed with severely impaired cognitive skills indicated by a score of 0 out of 15 on the brief interview for mental status. This score was a decline in cognitive function as compared to the previous MDS dated 2/20/17 that assessed the resident with moderately impaired cognitive skills (score of 8 out of 15 on the brief interview for mental status). The annual MDS dated 2/20/17 included cognitive loss/dementia as a triggered problem in the care area assessment summary requiring a plan of care. The facility indicated cognitive loss/dementia was included in the care plan.<br><br>Resident #12's plan of care (print dated 10/12/17) included no problems, goals and/or interventions regarding the resident's dementia or cognitive loss.<br><br>On 10/12/17 at 10:20 a.m. the registered nurse (RN #2) responsible for care plan development was interviewed about Resident #12. RN #2 reviewed the care plan and stated she did not see entries regarding the resident's cognitive impairment or decline. RN #2 stated the facility social worker usually completed the cognitive assessment and added the care plan entries for dementia and cognitive loss. RN #2 stated the social worker that assessed Resident #12 was out on leave and not available for interview.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 10/12/17 at 11:00 a.m. | F 279 | | |
| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES | F 314 | | 11/24/17 |

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| F 314 | Continued From page 11<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(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<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff interview, and observations, the facility staff failed for one of 21 residents in the survey sample (Resident # 5) to accurately assess an area on the resident's left heel. The area on Resident # 5's left heel was variously identified as a Stage 1 pressure ulcer, as a deep tissue injury, and as an unstageable pressure ulcer.<br><br>The findings were:<br><br>Resident # 5 in the survey sample, a 79 year-old female, was admitted to the facility on 4/15/16, and most recently readmitted on 3/20/17 with diagnoses that included congestive heart failure, anterior displaced Type II dens fracture, cardiomyopathy, chronic kidney disease, chronic obstructive pulmonary disease, cognitive communication deficit, constipation, difficulty | F 314 | 1- The record for resident #12 was corrected to reflect accurate assessment of the pressure area.<br><br>2- A 100% chart audit will be conducted of all residents with pressure ulcers to ensure accurate assessment of the pressure area by the DON or designee.<br><br>3- Education will be provided to nursing staff on accurate assessment and staging of pressure areas by the DON or designee.<br><br>4- A 100% chart audit of all residents with pressure areas will be conducted weekly for 4 weeks by the DON or designee to ensure accurate assessment. A 10% random audit will be conducted on a | |

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| VA BAP HOSP DIV CEN | 3300 RIVERMONT AVE LYNCHBURG, VA 24503 |

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| F 314 | Continued From page 12<br>walking, dysphagia, hypertension, hyperkalemia, hyperlipidemia, generalized muscle weakness, stage II sacral pressure ulcer, diabetes mellitus, displaced fracture of the second cervical vertebra, and vascular dementia. According to the most recent Minimum Data Set, a Quarterly Review with an Assessment Reference Date of 9/1/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15.<br><br>Review of Resident # 5's Electronic Health Record (EHR) noted the following series of Progress (Nurses) Notes:<br><br>8/25/17 - "This nurse was called to patient's room this evening at approximately 2015 (8:15 p.m.) due to bloody area noted on bed linens at foot of bed. Upon entering patient's room, this nurse observed left foot resting on wash cloth, with small amount of blood noted from left inner aspect of heel. Upon observation this nurse noted a darkened area that is soft to touch with complaint of tenderness reported by patient upon palpation. Small pinpoint area noted at bottom of darkened area with blood noted when area was cleaned with saline. 4 x 4 pads (3) were place over area for cushion, then wrapped with Kling. Left foot was elevated on pillow x 1 to reduce pressure to area. Will continue to monitor."<br><br>8/28/17 - "MD in to see resident concerning left heel. Area noted to be dark and soft on right side of heel...Order received for Venelex to be applied twice daily to heels. Heelz-up to be in place...." (NOTE: This entry was added as a late entry on 9/4/17.) | F 314 | monthly basis for 3 months by the DON or designee. If inaccurate assessment and/or staging is identified, it will be corrected immediately. The findings and results will be reported to the Quality Assurance Performance Improvement Committee to ensure ongoing compliance.<br><br>5- 11/24/17 | |

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9/4/17 - "Resident with dark area on left heel. Area non-tender. Area measures 4.5 x 4 cm (centimeters). Venelex applied as ordered. Heelz-up in place while resident is in bed." (NOTE: Venelex is a Balsam Peru, Castor Oil, Glyceryl Monostearate and White Petroleum ointment that helps to..."deodorize and protectively cover pressure wounds and...provides a moist wound environment conducive to healing...." Ref. Product Instruction sheet from Status Pharmaceuticals.)

9/11/17 - "Resident with dark area on left heel. Area non-tender. Area measures 4.5 x 4.1 cm. Venelex applied as ordered. Heelz-up in place while resident is in bed."

9/12/17 - "...Resident with...unstageable dark area to left heel...."

9/18/17 - "Resident with dark area on left heel. Area non-tender. Area measures 4.5 x 4.1 cm. Venelex applied as ordered. Heelz-up in place while resident is in bed."

9/26/17 - "Resident with dark area on left heel. Area non-tender. Area measures 4.5 x 4 cm. Saf-gel applied and area covered with gauze, Kerlix and secured with Medipore tape as ordered."

10/2/17 - "Resident with dark area on left heel. Part of eschar had fallen away leaving red granulating tissue. Total area measures 4.5 x 4 cm. Saf-gel applied and area covered with gauze, Kerlix and secured with Medipore tape as ordered." (NOTE: Eschar is defined as "Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may

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appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound." Ref. CMS's RAI Version 3.0 Manual, Chapter 3, page M-15, September 2010.)

10/9/17 - "Resident with dark area on left heel. Most of eschar has fallen away, leaving red granulating tissue. A thin layer of eschar remains from 8 o'clock to 11 o'clock (on the wound). Total area measures 4.5 x 4 cm."

Review of Resident # 5's EHR also revealed the following Skin Documentation notes:

8/30/17 - "Left foot has dark, soft area present on inner lateral aspect of left heel."

9/13/17 - "Necrotic area on left heel being treated with Venelex every shift."

At 8:15 a.m. on 10/12/17, LPN # 1 (Licensed Practical Nurse), the Unit Manager on the unit where Resident # 5's room was located, was interviewed regarding the resident's foot wound. LPN # 1 said, "I never saw the pinpoint wound on the heel. I was unable to see it." LPN # 1 also said she never saw any eschar on the resident's heel. "Venelex will dry the skin and it will flake off. Maybe that's what other staff thought was eschar," she said.

Asked if the resident had sustained any injury to her feet, LPN # 1 said "No." When asked how the resident moved about the facility, LPN # 1 said, "She wears gripper socks and will use her feet to scoot around in her wheelchair."

At 8:30 a.m. on 10/12/17, CNA # 1 (Certified

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Nursing Assistant), who is also a Restorative Aide, was interviewed regarding Resident # 5. Asked if the resident had ever sustained an injury to her feet, CNA # 1 said "No." CNA # 1 went on to say that, "She (the resident) has a pair of white shoes, but she complains they are too heavy, so she usually just wears gripper socks."

At approximately 11:30 a.m. on 10/12/17, two surveyors and LPN # 1 went to Resident # 5's room to observe the left heel wound. At the time of the observation, the resident was dressed in street clothes and was seated in her wheelchair which was located next to her bed.

After obtaining permission to observe the wound, LPN # 1 removed the gauze wrapping and a foam heel pad that was on the resident's left heel. The wound area was clean and the skin was light pink. There were no open areas, although there was a small tear-drop shaped area within the wound area near the bottom aspect of the heel that LPN # 1 said was, "...her natural skin color and not an open area." While there was some flaking skin around the area of the wound, there was no eschar visible either on or about the wound area.

Further review of Resident # 5's Quarterly Minimum Data Set revealed that at Section M (Skin Conditions), Item M0300, Current Number of Unhealed Pressure Ulcers at Each Stage, under sub-heading A. Number of Stage 1 pressure ulcers, the resident was identified as having one (1) Stage 1 pressure ulcer.

A Stage 1 pressure ulcer is defined as, "An observable, pressure-related alteration of intact skin, whose indicators as compared to an

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adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues." (Ref. CMS's RAI Version 3.0 Manual, Chapter 3, page M-7, September 2010.)

At 3:20 p.m. on 10/12/17, RN # 3 (Registered Nurse), one of the facility's MDS Coordinators, was interviewed regarding the identification of Resident # 5 as having a Stage 1 pressure ulcer. Asked what criteria was used to determine Resident # 5 had a Stage 1 pressure ulcer, RN # 3 showed the surveyor a copy of an Initial Encounter, dated 8/28/17, written by the Medical Director, and indicated it was the criteria that was used. The encounter document noted the following:

"Reason for visit - Left unstageable heel wound. Assessment and Plan: Left heel unstageable wound initial encounter."

During two separate meetings, one at 4:00 p.m. on 10/12/17, and a second at 9:20 a.m. on 10/13/17, that included the Administrator, Director of Nursing, and the survey team, the lack of a definitive assessment and identification of Resident # 5's heel wound was discussed. Both the Administrator and the Director of Nursing indicated that while nursing staff look at wounds, the staging is done by the wound team. Both also indicated that the Unit Managers do wound observations and then report those observations to the wound committee (team)

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| F 314 | Continued From page 17<br><br>Regarding the Medical Director's Initial Encounter documentation of Resident # 5's heel dated 8/28/17, the Administrator said, "Dr. [name] assessment was incorrect and she has added an addendum to the Initial Encounter of 8/28/17." The Administrator provided a copy of the Medical Director's addendum, dated 10/11/17, which noted the following, "Upon further evaluation, the wound on her heel appears to be a deep tissue injury due to the character of it being soft, yet dark." | F 314 | | |
| F 364 SS=E | 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>(d) Food and drink<br><br>Each resident receives and the facility provides-<br><br>(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, group interview and staff interview, facility staff failed to ensure food served was palatable and at the preferred temperature for residents.<br><br>Facility staff failed to serve food at an appetizing temperature for residents in the facility on all three nursing units. The food was served cold.<br><br>Findings included:<br><br>A group interview was conducted on 10/11/2017 | F 364 | 1- Education was provided to Resident #16 and Interviewed Family Member of Resident during survey to notify staff immediately if the food is not palatable or to preferred temperature and it will be correctly immediately.<br><br>2- A 100% resident interview will be conducted to determine if any other residents voice concern of food not being served at preferred temperature or not palatable by the Nutrition Services | 11/24/17 |

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| F 364 | Continued From page 18<br>at 2:30 p.m., with seven cognitively intact residents. The residents were representative of all three floors/units at the facility. During the interview the residents were asked about food at the facility. All of the residents stated that the food was cold when served. They were asked if one meal was colder than the other. The residents agreed that all the meals were cold when served. When asked if they had asked to have the food reheated, one of the residents stated, "No ma'am...I'm scared of what they gonna say...they might tell me 'I brought it to you once, I'm not bringing it to you again." The residents also stated that the meat was tough and the vegetables were hard.<br><br>On 10/12/17 at 11:00 a.m. food temperatures were observed as lunch was placed on the steam table and kitchen staff prepared lunch trays for the residents. The temperature of the pepper steak was 178 degrees, mashed potatoes and gravy was 180 degrees. The first resident lunch tray was plated at 11:20 a.m. and placed on the food cart. When all lunch trays had been plated for the first floor, cardiac unit, this surveyor asked for an additional tray to be added to the lunch cart. The cart with the resident lunch trays left the kitchen and was on the nursing unit at 11:44 a.m. The first lunch tray was served at 11:46 a.m. and the last tray was served at 11:56 a.m. At 11:59 a.m. the Dietary Manager (DM) took the extra tray off of the lunch cart and food temperatures were obtained. The pepper steak temperature was 122 degrees, a drop of 56 degrees and the mashed potatoes and gravy was 142 degrees, a drop of 38 degrees. The DM and this surveyor then tasted the pepper steak and mashed potatoes and gravy. The DM stated regarding the pepper steak, "Delicious" and | F 364 | Manager or Designee.<br><br>3- A new dietary Camduction system was installed to ensure that food is being served at preferred temperatures on 11-20-2017.<br><br>4- A 10% random audit of meal temperatures will be conducted weekly x 4 weeks by the Nutrition Services Manager or Designee and then monthly x 3months to ensure appropriate food temperatures alternating breakfast, lunch and dinner. The findings and results will be reported to the Quality Assurance Performance Improvement Committee to ensure ongoing compliance<br><br>5- 11/24/17 | |

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regarding the mashed potatoes and gravy, "A little bland, but of course we can't use salt. We could maybe add a little butter." This surveyor agreed with the DM regarding palatability of the food. The DM stated regarding the drop in temperatures, "The potatoes should not drop that much. It is hard to keep the steak up to temp after plating. We have already asked for a new system for the kitchen." The current plating system in the kitchen included metal pellet inserts for the hard, plastic plate covers. The actual plates were kept in a warmer until food was served.

A resident interview was conducted with Resident #16 on 10/12/17 at 4:15 p.m. During this interview Resident #16 stated, "I eat in my room. The food is tough and cold. Hamburger is tough. My pepper steak today was tough. String beans are tough and cold. The rice is cold."

A family interview was conducted on 10/12/2017 at approximately 4:30 p.m. During the interview the family member was asked about meals at the facility. She stated, "They are cold...always cold...My husband got soup the other day that I know was dumped right out of the can. I stuck my finger right in it, it had never been heated...I see the trays when they get on the floor and the aids get them out pretty quick, it's just not hot enough when it comes from the kitchen."

The above findings were discussed with the Administrator and DON (director of nursing) during a morning meeting with the survey team on 10/13/17. No further information was received prior to the exit conference at 10:30 a.m.