STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 07/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/17/18 through 7/23/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/17/18 through 7/23/18. An extended survey was conducted 7/18/18 through 7/23/18. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity Level 4, then lowered to Level 3 Isolated, and which constituted Substandard Quality of Care. The Life Safety Code survey/report will follow. Seven complaints were investigated. The census in this 174 certified bed facility was 163 at the time of the survey. The survey sample consisted of 55 resident reviews.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F 565		9/5/18

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

Electronically Signed | 08/13/2018

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 565	Continued From page 1 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility staff failed to provide privacy for resident council meetings. During a resident council group interview on 07/18/18 at 02:22 PM, the group stated that they are not allowed privacy during resident council meetings. The group stated that staff are always present and that staff come in and out of the meeting. It should be noted that vending machines are located in the same area where the resident council meets. During the interview on 07/18/2018, staff were observed to come into the room, interrupting the group interview, and use	F 565	1. Administrator met with the President of Resident Council to notify of relocation on 8/08/2018. Administrator to ask to be invited to Resident Council a minimum of quarterly to receive feedback from Council. During Resident Council on 8/09/2018, members voiced that they did not want to relocate their Council meeting. 2. Quality review of Resident council meeting to ensure privacy of meeting. Follow up	

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F 565	Continued From page 2 the vending machines even though signs were posted that a meeting was in progress.	F 565	based on findings. 3. Staff re-educated by the Staff Development Coordinator/designee to ensure Residents have a location to hold Resident Council meetings, free from interruptions. 4. Administrator/designee to conduct quality monitoring to ensure Residents have a location to hold Resident Council meetings, free from interruptions, Monthly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated.	
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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 580		9/5/18

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F 580	Continued From page 3 (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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation, clinical and hospital record review, and in the course of a complaint deficiency, the facility staff failed to for one resident, Resident #611, in a survey sample of 51 residents, to notify the physician of a change in condition, resulting in harm.	F 580	1. Ad Hoc QAPI Committee Meeting conducted on 8/13/18. Root Cause Analysis (RCA) completed. Resident #611 no longer resides in the facility. 2. Director of Nursing/Designee	

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F 580	Continued From page 4 1. Resident #611's physician was not notified of the worsening of the resident's pressure wounds, resulting in wound infection, pain and resulted in both wounds deteriorating to stage 4 pressure ulcers. In addition, the physician was not notified of the inability of the facility to provide a wound vacuum for treatment. This resulted in harm. The findings included: 1. Resident #611's physician was not notified of the worsening of the resident's pressure wounds, resulting in wound infection, pain and resulted in both wounds deteriorating to stage 4 pressure ulcers. In addition, the physician was not notified of the inability of the facility to provide a wound vacuum for treatment. This resulted in harm. Resident #611 was admitted to the facility on 3/24/17 and discharged to the hospital on 2/12/18. Diagnoses included, but not limited to, Down's Syndrome, seizure disorder, unspecified sacral fracture before admission and hypothyroidism. Resident #611's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 1/16/18 coded Resident #611 with severe cognitive impairment. The MDS was completed as a quarterly assessment. The resident required extensive to total care with all ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was incontinent of bowel and bladder. There was one wound documented on the MDS which was coded as a stage 3 with the measurements of 4.5 cm (centimeters) by 3.3 cm with a depth of 0.3 cm. The wound bed had	F 580	completed a Quality Review of current facility residents□ skin condition utilizing the weekly skin check document. Director of Nursing/Designee completed a Quality Review of current facility residents□ preventative skin measures ensuring applicable to current skin condition. Director of Nursing/Designee completed a Quality Review of current wound treatments; (pressure and non-pressure). Follow up of each Quality Review based on findings. Regional Director of Clinical Services to validate findings and follow up. Regional Director of Clinical Services provided re-education for Clinical Management Team regarding wound/skin standards and physician notification of resident□s change in condition. 3. Regional Director of Clinical Services provided re-education for Interdisciplinary Team (IDT) regarding wound/skin standards and physician notification of resident□s change in condition. Director of Clinical Services/Designee provided re-education for Licensed Nurses regarding wound/skin standards and physician notification. 4. Director of Nursing/Designee to	

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F 580	Continued From page 5 slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous). During this look back period, according to the clinical record, the resident actually had two stage three pressure ulcers. The NPUAP (national pressure ulcer advisory panel) describes a stage 3 ulcer as a "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." NPUAP describes a stage 4 ulcer as a "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Review of the clinical record for the resident's right buttock, also documented as sacral and right ischial wound revealed the following: There was no wound tracking, weekly measurements, treatment documentation, wound care orders upon review of the clinical record. There was documentation of at least one time that the	F 580	complete Quality Improvement Monitoring of skin/wound management per standard, physician notification of resident□s change in condition utilizing the Morning Clinical Meeting Process 5x weekly x 12 weeks, 3x weekly x 4 weeks, weekly x 4 weeks, then monthly and as needed. Regional Director of Clinical Services/Designee to validate Quality Improvement Monitoring weekly x 4 weeks, bi-weekly x 2, monthly x 2 then as needed. Findings to be reviewed at monthly QAPI Committee.	

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F 580	Continued From page 6	F 580		

resident received a treatment that was ordered for the right posterior thigh. The physician was not notified of decline in the wound for a change in treatment.

On 12/13/17, the nurse's notes documented a "dressing change to right buttocks." There was no documentation that the physician was notified and orders given to treat the wound.

On 12/18/17, the nurse's notes read, "Treatment to right buttock (pressure). Area is stage 3... some yellow slough... NS, Alginate, Optifoam." Incidentally, this was the treatment for the right posterior upper thigh. There is no documentation that the MD was notified of the deterioration of the wound.

12/21/17, the nurse's notes read: "Wound is malodorous, and appears to have bloody drainage. Resident shouted in pain upon dressing application... resident is still grimacing and vocalized his pain." There was no documentation the physician was notified of the pain. Pain medication was ordered on 1-18-18.

On 12/27/17, the nurse's notes read: "Resident threw up after lunch." There is no documentation that the MD was notified.

On 12/28/17, the NP (nurse practitioner) recorded: "On assessment, patient had a dressing to his right hip, when uncovered, there was about 3.5 by 3.5 inch wound with bloody, purulent drainage noted.... Nurse called to bedside to assess the site." A culture and sensitivity was ordered, but was canceled on 1-2-18. Antibiotic therapy with Keflex was initiated.

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F 580	Continued From page 7 On 12/29/17, the nurse's notes read: "Treatment provided. Some discomfort... Area is improving, healing nicely. Measurements- inner dimensions 2.9 by 2.7." There is no indication which wound was being assessed and there is no depth recorded. There is no documentation that the MD was notified. On 1/3/18, the nurses notes read: "Wound has developed yellowish-gray slough on wound bed with an odor, however wound is reducing in size and depth." No measurements were taken and it is unclear which wound was being assessed. On 1/5/18, the nurse's notes read: "Treatment performed... Area is improving slowly, the area of the wound is hard to heal, in middle of buttock cheek, very close to anus." On 1/12/18, the nurses note read: "Treatment completed on sacral/right posterior buttocks. Measures 4.5 by 3.3 by 0.3." There is no documentation the physician was notified of the worsening of the wound. On 1/15/18, the nursing notes read: "Treatment completed, area is sore, there is stool in the wound, needs an irrigation with saline, to help clear wound." There is no documentation the physician was notified of the observation and no new physician orders. On 1/25/18, the notes read: "Sacral wound dressing changed, moderate drainage noted. Area malodorous." No measurements documented. There is no documentation that the MD was notified.	F 580		

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F 580	Continued From page 8 On 2/7/18 at 4:30 AM, "Resident O2 sat 88%, placed on O2 sat up to 95%." The resident did go out for an appointment with the wound clinic. The treatment orders per the wound care physician read: "Right ischial (hip) wound stage 3-4, measurements 4.3 cm by 3.0 cm with a depth of 3.8 cm. PT (physical therapy) wound care with pulsed lavage 1000 cc (cubic centimeters) 0.9 % NS 4.8 PSI (pounds square inch) 100 mm (millimeters) mercury wound vacuum treatment) to right ischial wound. Dressing medihoney, packed with Kaltostat, 4 by 4 and Mepilex border." There is no documentation that the wound treatment or PT referral was done as ordered. On 2/12/18, after the resident returned from the wound clinic (no wound documentation available), according to the nurse's notes, "Family came to the nurses and wanted resident to be sent to the ER (emergency room) for an evaluation because he is more lethargic to them. NP (nurse practitioner) present and assessed resident and stated that we could treat him here. But they still wanted to go." The resident was transferred to the hospital and did not return to the facility. Review of the care plan dated 2/21/18 revealed there was no documentation of the right buttock/sacrum/hip wounds. It also included to "notify the physician for change in condition." On 7/19/18 at 4:10 PM, the DON (director of nursing) stated, "The nurses should call the MD and get an order for wound treatments." She also stated there were no wound care minutes or weekly tracking. The DON and Administrator were notified of harm level deficiency.	F 580		

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F 580	Continued From page 9 On 7/19/18 at 5:20 PM, the facility Regional Clinical Director stated, "We don't do wound vacs."	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		8/13/18

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F 582	Continued From page 10 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure one resident (Resident #561) of 51 sampled residents was given a form CMS-10055 before discharged from skilled nursing. The findings included: Resident #561 was discharged from skilled nursing on 05/15/2018. A review of the record showed no form CMS-10055 was provided to the resident. An interview was conducted with the Administrator on 07/23/2018 at approximately 12:43 PM. The Administrator confirmed that Resident #561 did not receive a form CMS-10055. The Administrator stated that the facility had identified the problem on 5/10/2018	F 582	Past noncompliance: no plan of correction required.	

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F 582	Continued From page 11 and had an in-service with the Business Office Manager on 05/10/2018 and the issue was taken to the Quality Assurance Committee on 05/21/2018. Two other residents were reviewed who discharged from skilled nursing after 05/21/2018 and there were no other issues with residents not receiving form CMS-10055. This qualifies as Past Non-Compliance.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		9/5/18

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F 584	Continued From page 12 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, complaint review and facility documentation review, the facility staff failed to 1) provide a safe homelike environment for 1 (Resident #38) of 51 sampled residents, 2) The facility failed to treat noticeable mold and mildew odor on 1 out of 5 units, in a hall alcove across from resident rooms, and 3) The shower room on wing one was in disrepair. Findings included: 1) The facility staff failed to provide a safe homelike environment for Resident #38. Resident #38 was admitted to the facility on 1/26/2017 with diagnoses: traumatic left arm amputation and traumatic paraplegia. The most recent comprehensive Minimum Data Set (MDS) assessment, dated 1/28/2018, shows a Brief Interview for Mental Status (BIMS) score of 15/15 indicating no cognitive impairment. It also shows the resident requires total staff assistance for transfers, and staff supervision to	F 584	1. Resident #38 interviewed on 7/25/2018, resident states he is provided a safe homelike environment. Facility repaired wallpaper identified on 200 hallway 7/18/2018, area is free from mold and mildew odor. Shower room located on wing one was repaired on 7/22/2018. 2. Quality review of current resident□s rooms by Maintenance Director/designee to ensure a safe homelike environment is provided. Quality review of facility by Maintenance Director /designee to ensure facility is free from mold and mildew odors. Quality review of shower rooms by Maintenance Director/designee to ensure shower rooms are	

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F 584	Continued From page 13 move about in the corridor. On 7/19/2018, at 9:15AM, an interview was conducted with Resident #38. Resident #38 described an incident that occurred between Admin A (the facility Administrator) and a certified nursing assistant (CNA) who had been terminated. Resident #38 stated that he had been "anxious and frightened" during and after the incident. He stated that "afterwards, I just stayed away from the administrator." The surveyor asked him if he still was frightened or felt unsafe, and the resident responded "No." When asked if he was still avoiding Admin A, the resident stated "No." When asked by the surveyor if he had any interactions with Admin A since the original incident, the resident stated that he had taken an unrelated problem to Admin A and that his concerns were resolved without issue. Resident #38 also stated "this is my home, and a man shouldn't be scared in his own home." On 7/19/2018 at 11 AM, the surveyor interviewed Admin A. Admin A described the altercation, and stated that he had "raised my voice" during the altercation. Admin A also described the incident as having inappropriate language, and that the altercation moved from his office out into the corridor and then into the facility front lobby. Admin A was asked if he had realized at the time that a resident observed the altercation, and Admin A stated that the resident liked to sit in the corridor between his office and the social services office. He stated that at the time of the altercation, he did not notice any reaction by the resident. Admin A also stated that he "became aware there was an issue" between himself and Resident #38 "a month or so" after the altercation, and that he had a meeting with the resident to ensure that	F 584	in good working order. Follow up based on findings. 3. Administrator re-educated by the Regional Vice President of Operations/designee to ensure residents are provided a safe homelike environment, facility is free from mold and mildew odor, and shower rooms are in good working order. Maintenance Director re-educated on completing facility rounds; weekly /monthly/quarterly/as needed repair and maintenance schedule. 4. Administrator/Maintenance Director /designee to conduct quality monitoring to ensure residents are provided a safe homelike environment, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Administrator/Maintenance Director/designee to conduct quality monitoring to ensure facility is free from mold and mildew odor, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Administrator / Maintenance Director/designee to conduct quality monitoring to ensure shower rooms are in good working order, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI	

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F 584	Continued From page 14 there were no negative outcomes for the resident. On 7/19/2018 at 1:30PM, an interview was held with Admin A and Admin D (the corporate nurse). When asked what the company policy was about terminations and altercations, Admin D replied "it should have been behind closed doors." Admin A agreed and stated "it was my first day in this job, and I wasn't thinking about how it would look to the residents." A review of the clinical record revealed an Interdisciplinary Note dated 3/2/2018 where Admin A interviewed the resident to determine if he had any concerns with Admin A. The note states "Resident stated that he had previous issues when writer came aboard as new ED. Resident states he no longer has concerns w/writer." The surveyor requested that the facility provide a description of their standard of practice for dealing with termination of staff. The facility provided a letter, dated 7/18/2018 and signed by Human Resources that stated: For disruptive employees, our Standards of Practice are to: 1. Escort employee from the area for the safety of residents, guests, and staff No further information was provided prior to exit. 2) The facility failed to treat noticeable mold and mildew odor on 1 out of 5 units, in a hall alcove across from resident rooms.	F 584	committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 584	Continued From page 15 On 7/17/18 at 11:56 a.m. during initial tour of the facility, surveyors observed an alcove in the 200 hall with wallpaper hanging off the wall, revealing dark colored mold underneath. Surveyors noted a strong odor of mold/mildew in the hall by the alcove. Facility staff provided surveyors with documents related to a mold inspection the facility had set up following a recent incident of flooding. The first document was a Laboratory Report prepared by [LABORATORY] for [MOLD REMEDIATION COMPANY] and was dated 7/2/18. This document contained analysis of samples taken by [MOLD REMEDIATION COMPANY] onsite at the Facility. The second document was an analysis of that report, titled "Indoor Air Quality Investigation, written by [MOLD REMEDIATION COMPANY] and dated 7/6/18. The Air Quality Report states, among other findings, the following: "The visual inspection showed the walls downstairs outside the shower room were wet and crumbling." "The Ceiling and pipes/pipe insulation in the basement were wet and presenting with signs of microbial growth." "Although the levels are tremendously high, the conditions are optimal for microbial organisms to flourish." The report goes on to suggest "a list of items that should be addressed to assure that the microbial levels do not climb even higher than they currently are." Item #2 on the list is "The water damaged/wet sheetrock needs to be removed as well as any insulation inside the walls." On the morning of 7/18/18, surveyors noted that the wallpaper in the alcove was no longer hanging from the wall.	F 584		

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F 584	Continued From page 16 The Administrator and the Director of Nursing were informed of the findings at the end of day meeting on 7/18/18. No further information was provided. 3) The shower room on wing one was in disrepair. During a group interview on 07/18/2018 at approximately 2:22 pm, the group stated that the shower room on wing one was in disrepair. On 07/19/18 at approximately 01:24 PM, the shower room on wing one was inspected with the administrator. The shower had four 5x5 tiles missing, caulking around shower stall window was stained with an unknown substance, the window was open but had no screen. In addition, a light bulb was out in one light, one light was completely out, and one light had a cover missing. The administrator stated that the facility has no maintenance director and the shower room is on a list of items to be done. The facility was informed of the findings during a meeting on 07/19/18 at 04:16 PM	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		9/5/18

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F 600	Continued From page 17 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and facility documentation, staff interview and in the course of a complaint investigation, the facility staff failed to for two Residents, Resident #611 and Resident #361, in a survey sample of 51 residents, to prevent neglect, resulting in harm for both residents. In addition, the facility staff maintain supplies needed for resident care. 1) Resident #611 sustained a sacral wound that was discovered at a stage 3, was not treated or monitored, which progressed to a stage 4, requiring hospitalization. The resident also acquired a stage 3 pressure ulcer to the right posterior upper thigh which progressed to a stage 4 and became infected. This is harm 2) For Resident #361, the facility staff failed to ensure neglect did not occur. Treatments were not done as ordered by the physician. Resident #361 was transported to the hospital with maggots in his wounds. This is harm 3) The facility failed to maintain supplies needed for resident care. The findings included: 1) Resident #611 sustained a sacral wound that was discovered at a stage 3, was not treated or monitored, which progressed to a stage 4,	F 600	1. Ad Hoc QAPI Committee Meeting conducted on 8/13/18. Root Cause Analysis (RCA) completed. Resident #361 no longer resides in facility. Resident #611 no longer resides in the facility. Resident #31 continues to refuse showers after multiple attempts to offer a shower. 2. Director of Nursing/Designee has completed a Quality Review of current facility residents physician ordered treatment stock for adequate supply. Director of Nursing/Designee completed a Quality Review of current facility residents to ensure treatment completed/in place as per physician□s order. Regional Director of clinical Services/Designee to validate results of Quality Review. Follow up based on findings. 3. Regional Director of Clinical Services/Designee completed re-education with facility Clinical Management Team regarding obtaining/ maintaining supplies for provision of	

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F 600	Continued From page 18 requiring hospitalization. The resident also acquired a stage 3 pressure ulcer to the right posterior upper thigh which progressed to a stage 4 and became infected. This is harm. Resident #611 was admitted to the facility on 3/24/17 and discharged to the hospital on 2/12/18. Diagnoses included, but not limited to, Down's Syndrome, seizure disorder, unspecified sacral fracture before admission and hypothyroidism. Resident #611's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 1/16/18 coded Resident #611 with severe cognitive impairment. The MDS was completed as a quarterly assessment. The resident required extensive to total care with all ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was incontinent of bowel and bladder. There was one wound documented on the MDS which was coded as a stage 3 with the measurements of 4.5 cm (centimeters) by 3.3 cm with a depth of 0.3 cm. The wound bed had slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous). During this look back period, according to the clinical record, the resident actually had two stage three pressure ulcers. The NPUAP (national pressure ulcer advisory panel) describes a stage 3 ulcer as a "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by	F 600	resident care and services as well as ensuring residents are provided treatment as ordered by physician. Director of Nursing/Designee completed re-education for facility Licensed Nurses on process for obtaining supplies to perform resident care and services and completing treatments as ordered by physician. Executive Director/Designee provided re-education for current facility staff regarding Abuse/Neglect as it relates to provision of resident care and services; i.e. (maintaining adequate supply/performing treatments as ordered by physician). 4. Director of Nursing/Designee to conduct Quality Improvement Monitoring of resident□s receiving treatments per physician□s order utilizing Morning Clinical Meeting Process and random observation 5x/week x 8 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Executive Director/Designee to conduct Quality Improvement Monitoring of resident treatments to ensure adequate supply on hand 5x/week x 8 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and as	

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F 600	Continued From page 19 anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." NPUAP describes a stage 4 ulcer as a "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Review of the closed clinical record revealed on 8-27-17 an SBAR-Situation/Background/Evaluation/ Appearance/Review revealed "a red, irritated area to buttock, likely related to soiled pamper." Barrier cream was applied. Review of the clinical record revealed on 11/22/17: ""Assess resident right upper thigh for bleeding. Minimal bleeding noted. Appears to be excoriation and has been a recurring incident. RP/MD (responsible party/physician) notified. On 12/6/17, the treatment was changed to Bacitracin and a dry dressing. On 12/8/17, the treatment was changed to cleaning the wound with normal saline, skin prep, Alginate, cover with Optifoam. The wound was documented as a "stage 2-3." The area measured 4 cm by 4 cm with a 0.3 depth. There	F 600	needed. Regional Director of Clinical Services/Designee to validate Quality Improvement Monitoring findings weekly x 4 weeks, then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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were no further notes or wound tracking of this wound until 2-1-18. The treatment remained the same until 1-17-18.

On 1/10/18 a low air loss mattress was in place.

On 1/17/18, the nurses notes documented, "Right lower posterior thigh... area tender to touch, resident cringes when touched..measures 3.5 cm by 2 cm with a depth 1.4 cm... wound has an odor.. drainage covers 80 % of dressing." The treatment was changed to Maxsorb, Alginate (for drainage) and Santyl (to debride dead tissue).

On 1/18/18, the resident received an order for Ultracet (pain medication) every four hours for "pain of wound."

On 1/22/18, there was a new physician's order for Bactrim DS (an antibiotic) diagnosis wound infection" of the right posterior thigh.

On 2/1/18, the nurse's notes documented "went out to the wound clinic for consult right thigh. VS (vital signs) 97.4, 82, 12 (respirations), blood pressure 92/50. Oxygen (O2) saturation 87 % (normal above 92 %). Staff called the wound clinic to recheck oxygen sats 87%. MD notified , new order for oxygen 2 liters per minute via nasal cannula for O2 less than 95%." The wound treatment was changed to cleanse right thigh with 1/4 strength Dakins, rinse with NS (normal saline) apply Medihoney, Kaltostat 4 by 4 and ABD (absorbent dressing)." The pain medication orders were changed to Oxycodone 5 mg (milligrams) every six hours for pain.

On 2/7/18 at 4:30 AM, "Resident O2 sat 88%, placed on O2 sat up to 95%." The resident did go

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F 600	Continued From page 21 out for an appointment with the wound clinic. On 2/10/18, the nurses notes read: "Wound care provided. Facial grimacing noted during wound care." On 2/12/18, after the resident returned from the wound clinic, according to the nurse's notes, "Family came to the nurses and wanted resident to be sent to the ER (emergency room) for an evaluation because he is more lethargic to them. NP (nurse practitioner) present and assessed resident and stated that we could treat him here. But they still wanted to go." The resident was transferred to the hospital and did not return to the facility. Review of the clinical record for the resident's right buttock, also documented as sacral and right ischial wound revealed the following: There was no wound tracking, weekly measurements, treatment documentation, wound care orders upon review of the clinical record. There was documentation of at least one time that the resident received treatment that was ordered for the right posterior thigh. The physician was not notified of decline in the wound for a change in treatment. On 12/13/17, the nurse's notes documented a "dressing change to right buttocks." On 12/18/17, the nurse's notes read, "Treatment to right buttock (pressure). Area is stage 3... some yellow slough... NS, Alginate, Optifoam." Incidentally, this was the treatment for the right posterior upper thigh. 12/21/17, the nurse's notes read: ""Wound is	F 600		

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malodorous, and appears to have bloody drainage. Resident shouted in pain upon dressing application... resident is still grimacing and vocalized his pain." There was no documentation the physician was notified of the pain. Pain medication was ordered on 1-18-18.

On 12/27/17, the nurse's notes read: "Resident threw up after lunch." There is no documentation that the MD was notified.

On 12/28/17, The NP recorded: "On assessment, patient had a dressing to his right hip, when uncovered, there was about 3.5 by 3.5 inch wound with bloody, purulent drainage noted.... Nurse called to bedside to assess the site." A culture and sensitivity was ordered, but was canceled on 1-2-18. Antibiotic therapy with Keflex was imitated.

On 12/29/17: The nurse's notes read: "Treatment provided. Some discomfort... Area is improving, healing nicely. Measurements- inner dimensions 2.9 by 2.7." There is no indication which wound was being assessed and there is no depth recorded.

12/31/17: Nurses notes recorded: "Resident's wound to right buttock showing signs of improvement." There were no measurements.

On 1/3/18, the nurses notes read: "Wound has developed yellowish-gray slough on wound bed with an odor, however wound is reducing in size and depth." No measurements were taken and it is unclear which wound was being assessed.

On 1/5/18, the nurse's notes read: "Treatment performed... Area is improving slowly, the area of

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F 600	Continued From page 23 the wound is hard to heal, in middle of buttock cheek, very close to anus." On 1/8/18, "Area on right posterior buttocks measures 2.4 by 1.9 by 0.2." On 1-10-18, a low air loss mattress was ordered. On 1/12/18, the nurses note read: "Treatment completed on sacral/right posterior buttocks. Measures 4.5 by 3.3 by 0.3." There is no documentation the physician was notified of the worsening of the wound. On 1/15/18, the nursing notes read: "Treatment completed, area is sore, there is stool in the wound, needs an irrigation with saline, to help clear wound." There is no documentation the physician was notified of the observation and no new physician orders. On 1/17/18, in the nurse's notes: "New order to culture right lower buttocks, do aerobe (sic) and anerobic and do surgical consult on right lower buttock pressure." On 1/22/18, the nurse's notes revealed: "New order for Bactrim DS (antibiotic)." On 1/25/18, the notes read: "Sacral wound dressing changed, moderate drainage noted. Area malodorous." No measurements documented. On 2/7/18 at 4:30 AM, "Resident O2 sat 88%, placed on O2 sat up to 95%." The resident did go out for an appointment with the wound clinic. The treatment orders per the wound care physician read: "Right ischial (hip) wound stage 3-4,	F 600		

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measurements 4.3 cm by 3.0 cm with a depth of 3.8 cm. PT (physical therapy) wound care with pulsed lavage 1000 cc (cubic centimeters) 0.9 % NS 4.8 PSI (pounds square inch) 100 mm (millimeters) mercury to right ischial wound. Dressing medihoney, packed with Kaltostat, 4 by 4 and Mepilex border." There is no documentation that the wound treatment or PT referral was done as ordered.

On 2/12/18, after the resident returned from the wound clinic (no wound documentation available), according to the nurse's notes, "Family came to the nurses and wanted resident to be sent to the ER (emergency room) for an evaluation because he is more lethargic to them. NP (nurse practitioner) present and assessed resident and stated that we could treat him here. But they still wanted to go." The resident was transferred to the hospital and did not return to the facility.

Review of the care plan dated 2/21/18 revealed there was no documentation of the right buttock/sacrum/hip wounds. It also included to "notify the physician for change in condition."

Review of the skin evaluations done by nursing from 10/3/17 to 1/6/18 revealed no markings on the body diagram or notations of the right buttock/sacral/ wound.

The facility policy (clinical guideline) was reviewed. The policy read:
* Licensed nurse to complete skin evaluations weekly and document in the clinical record.
* CNA (certified nursing assistant) to complete skin observations and report changes to Licensed nurse.
* Licensed nurse to document presence of skin

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F 600	Continued From page 25 impairment/ new skin impairment when observed and weekly until resolved. * Licensed nurse to report changes in skin integrity to the physician/ practitioner and resident/responsible party and document in the medical record * Develop individualized goals and interventions and document on care plan and the CNA Kardex * Monitor resident's response to treatment and modify treatment as indicated * Refer to therapy as indicated * Evaluate the effectiveness of interventions and progress towards goals during the care management meeting and as needed. On 7/19/18 at 4:10 PM, the DON (director of nursing) stated, "The nurses should call the MD and get an order for wound treatments." She also stated there were no wound care minutes or weekly tracking. The DON and Administrator were notified of harm level deficiency. On 7/19/18 at 5:20 PM, the facility Regional Clinical Director stated, "We don't do wound vacs." 2) For Resident #361, the facility staff failed to ensure neglect did not occur. Treatments were not done as ordered by the physician. Resident #361 was transported to the hospital with maggots in his wounds. This is harm. Resident #361 was admitted to the facility on 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included	F 600		

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F 600	Continued From page 26 but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral Arterial Disease. Review of the Resident # 361's closed clinical record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder. Review of the FRI (Facility Reported Incident submitted to the state agency on 2/15/2018 reported an allegation of neglect that occurred on 9/18/17. The FRI stated a nurse LPN (Licensed Practical Nurse) H failed to provide wound care to Resident # 361 resulting in resident being sent to the Emergency Room for further evaluation. It was noted that maggots were in his wound located on his right heel. The hospital sent resident back to the facility on 9/19/17 and requested that the resident have a wound consult. Resident did return with orders for antibiotic treatment. Resident was sent back to hospital on 9/20/17 and did not return. LPN H was suspended and during the investigation, LPN H verbally admitted that she did not provide wound care as ordered by the physician during her assigned shift. She was terminated and she was reported to the Department of Health Professions-Enforcement Division.	F 600		

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F 600	Continued From page 27 Review of the closed clinical record was conducted on 7/18/2018 and 7/19/2018. Review of the Physicians Orders revealed orders written on 8/31/2017 for: Cleanse right heel with Normal Saline apply Santyl and dry dressing every day and PRN (as needed). Cleanse left heel with Normal Saline apply Santyl and dry dressing every day and PRN (as needed). Review of the TAR (Treatment Administration Record) for September 2017 revealed documentation of treatments to the right heel and left heel being signed off as having been administered every day in September 2017 from 9/1/2017-9/18/2017. There were no missing signatures or circled signatures indicating treatments had not been administered. Review of the Facility Investigation and Sworn Statement revealed that when questioned by the Director of Clinical Services about whether treatments had been completed over the weekend of 9/16-9/17/2017, the nurse, LPN (Licensed Practical Nurse) H, admitted that she did not do treatments on Resident # 361 on 9/16/2017 and 9/17/2017. When the Director of Clinical Services asked why the treatments had not been completed, LPN H stated Resident # 361 told her he was not in the mood on that Saturday, 9/16/17 and Sunday someone came and got him by the time I went back in there he was already gone." (sic) LPN H stated "no, I probably did not " when asked if she told another nurse that the wound care needed to be completed. LPN H admitted that it was	F 600		

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F 600	Continued From page 28 "possible" she "signed off" the treatments on the TAR because "I do sign my stuff and then go to the patient". Review of the September TAR in the Investigation packet had yellow highlights on those two dates: September 16, 2017 and September 17, 2017. Review of the hospital Emergency Room notes dated 9/18/17 at 5:23 PM revealed documentation of "Chronic ulcerations to bilateral heels. Left heel has maggot visible in wound. Left heel ulceration appears to reach the bone." Review of the facility policy on Abuse, Neglect, Exploitation and Misappropriation dated 11/30/2014 and revision date 11/28/2017 stated "Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." During the end of day debriefing on 7/19/2018, the facility Administrator, Director of Nursing and Corporate Consultant were informed of the findings. All stated that nurses should follow physicians orders. No further information was provided. COMPLAINT DEFICIENCY 3) The facility failed to maintain supplies needed for resident care. Resident #31 was admitted to the facility on 10/10/2012. Her most recent Minimum Data Set	F 600		

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F 600	Continued From page 29 (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/23/2018. Her active diagnoses included, but were not limited to, Anemia, Congestive Heart Failure, Hypertension, Diabetes Mellitus, Hip Fracture, and Depression. The Brief Interview for Mental Status (BIMS) assessed her at 15, indicating no impairment. Resident #31 required extensive assistance of two persons for transfers and bed mobility, required extensive assistance of 1 person for dressing and hygiene, and was totally dependent on 1 person for toileting. On 7/17/18 an initial tour of the facility was conducted. During the tour, at 12:30p.m., an interview was conducted with Resident #31 in her room. Resident #31 was asked how long she had been living at the facility, and she replied "about 7 years". Resident #31 was asked to describe her time at the facility. Resident #31 stated that she felt the facility had "gone downhill" during her time there. When asked to explain what she meant, Resident #31 offered several examples. She offered several examples of issues that she stated had gotten more common over time. These included a lack of supplies for staff to provide care, such as linens, towels, gowns, and washcloths. Resident #31 stated that sometimes residents with soiled linens have to wait linens to be washed before they are cleaned up because there are no clean linens available. In addition, Resident #31 stated that she has asked for a shower, only to be told she has to wait because no towels are available. On 7/18/18 at 2:00p.m., a meeting was conducted with the Resident Council. When	F 600		

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F 600	Continued From page 30 asked about concerns related to having enough linens or other supplies, 4 residents stated that there were frequently not enough linens or towels. When asked to elaborate, the Residents stated that sometimes when they asked for a bath or shower, staff would tell them they had to wait for laundry to finish, because there were not enough clean towels. On 7/18/2018 at 2:25p.m., an interview was conducted with Employee A, the Environmental Services Manager. He was asked to describe how each unit is stocked with linens. Employee A stated that each unit has both a linen cart, located in the hall, as well as a linen closet. He went on to state that nursing staff will first check the linen cart for needed supplies, then check the unit closet. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 7/18/18. No further information was provided.	F 600		
F 607 SS=G	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		9/5/18

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F 607	Continued From page 31 by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to implement abuse policies on preventing neglect for one resident (Resident # 361) in a survey sample of 51 Residents resulting in harm. For Resident # 361, the facility staff failed to implement the policies on reporting abuse/neglect Findings: Resident #361 was admitted to the facility on 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral Arterial Disease. Review of the Resident # 361's closed clinical record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder. Review of the closed clinical record was conducted on 7/18/2018 and 7/19/2018. An interview was conducted with the	F 607	1. Ad Hoc QAPI Committee Meeting conducted on 8/13/18. Root Cause Analysis (RCA) completed. Resident #361 no longer resides in facility. 2. Executive Director/Designee conducted Quality Review of grievances/concerns for the last 60 days for potential reportable allegations. Social Services director/Designee to conduct resident /family (responsible party) interviews of residents receiving wound treatment services for satisfaction with provision of care. Follow up based on findings. 3. Executive Director/Designee provided re-education for current facility staff regarding Abuse/Neglect reporting policy/standard/ regulation. 4. Executive Director/Designee to conduct Quality Improvement Monitoring of Abuse/Neglect Allegations reported per policy/standard/ regulation weekly x 12 weeks, every other week x 6 weeks, then monthly and as needed. Regional Vice President of Operations/ Designee to validate findings of Quality Improvement Monitoring monthly x 2 months, then as needed. Findings to be reviewed	

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F 607	Continued From page 32 Administrator on 7/18/2018 regarding reporting the allegation of neglect for Resident # 361. The Administrator stated that he heard rumors about the allegation of neglect soon after he was employed at the facility in February 2018. He stated he searched but could not find any documentation that the allegation of neglect had been reported to the State Agency by the previous administrator so he completed the FRI (Facility Reported Incident). The Administrator stated it was the right thing to do. Review of the FRI showed the incident happened on 9/18/2017 and was reported on 2/15/218 by the new administrator. Review of the FRI (Facility Reported Incident submitted to the state agency on 2/15/2018 reported an allegation of neglect that occurred on 9/18/17. The FRI stated a nurse LPN (Licensed Practical Nurse) H failed to provide wound care to Resident # 361 resulting in resident being sent to the Emergency Room for further evaluation. It was noted that maggots were in his wound located on his right heel. The hospital sent resident back to the facility on 9/19/17 and requested that the resident have a wound consult. Resident did return with orders for antibiotic treatment. Resident was sent back to hospital on 9/20/17 and did not return. LPN H was suspended and during the investigation, LPN H verbally admitted that she did not provide wound care as ordered by the physician during her assigned shift. She was terminated and she was reported to the Department of Health Professions-Enforcement Division. Review of the closed clinical record was	F 607	at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 607	Continued From page 33 conducted on 7/18/2018 and 7/19/2018. The DON stated that she would report to the state agency immediately but no later than 2 hours after the allegation is made. The facility abuse policy "Abuse: Prohibition, Reporting, and Investigation of Resident Abuse, Neglect, And Mistreatment" was reviewed. Page 3, bullet 5 read "As soon as possible, but within no more than twenty-four (24) hours of the suspected abuse, neglect or mistreatment, the Administrator shall notify the Office of Health Care Quality and the local police department (as appropriate) of the suspected abuse, neglect or mistreatment." On 7/19/18 at 4:00 p.m., the Administrator and DON were asked to submit any information they would like to have reviewed regarding the issue. Both stated that no other information was able to be found. The Administrator and DON were not employed at the facility at the time of the allegation of Neglect. No further information was provided.	F 607		
F 609 SS=G	COMPLAINT DEFICIENCY Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		9/5/18

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F 609	Continued From page 34 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review the facility staff failed for 1 resident (Resident #361) of 51 residents in the survey sample to report an allegation of Neglect to the state agency. Resident #361 did not receive treatments as ordered by the physician for two consecutive days 9/16/2017 and 9/17/2017. Maggots were found in the wounds on his heels. The nurse signed the Treatment Administration Record indicating the treatments were done. The nurse later admitted she did not do the treatments to the heels for those two days. A FRI (Facility Reported Incident) was not submitted until a new administrator was hired in February 2018.	F 609	1. Ad Hoc QAPI Committee Meeting conducted on 8/13/18. Root Cause Analysis (RCA) completed. Resident #361 no longer resides in facility. 2. Executive Director/Designee conducted Quality Review of grievances/concerns for the last 60 days for potential reportable allegations. Social Services director/Designee to conduct resident /family (responsible party) interviews of residents receiving wound treatment services for	

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F 609	Continued From page 35 The findings included: Resident #361 was admitted to the facility on 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral Arterial Disease. Review of the Resident # 361's closed clinical record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder. Review of the closed clinical record was conducted on 7/18/2018 and 7/19/2018. Review of the FRI (Facility Reported Incident submitted to the state agency on 2/15/2018 reported an allegation of neglect that occurred on 9/18/17. The FRI stated a nurse LPN (Licensed Practical Nurse) H failed to provide wound care to Resident # 361 resulting in resident being sent to the Emergency Room for further evaluation. It was noted that maggots were in his wound located on his right heel. The hospital sent resident back to the facility on 9/19/17 and	F 609	satisfaction with provision of care. Follow up based on findings. 3. Executive Director/Designee provided re- education for current facility staff regarding Abuse/Neglect reporting policy/standard/ regulation. 4. Executive Director/Designee to conduct Quality Improvement Monitoring of Abuse/Neglect Allegations reported per policy/standard/ regulation weekly x 12 weeks, every other week x 6 weeks, then monthly and as needed. Regional Vice President of Operations/ Designee to validate findings of Quality Improvement Monitoring monthly x 2 months, then as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 609	Continued From page 36	F 609		

requested that the resident have a wound consult. Resident did return with orders for antibiotic treatment. Resident was sent back to hospital on 9/20/17 and did not return. LPN H was suspended and during the investigation, LPN H verbally admitted that she did not provide wound care as ordered by the physician during her assigned shift. She was terminated and she was reported to the Department of Health Professions-Enforcement Division.

Review of the closed clinical record was conducted on 7/18/2018 and 7/19/2018.

An interview was conducted with the Administrator on 7/18/2018 regarding reporting the allegation of neglect for Resident # 361.

The Administrator stated that he heard rumors about the allegation of neglect soon after he was employed at the facility in February 2018. He stated he searched but could not find any documentation that the allegation of neglect had been reported to the State Agency by the previous administrator so he completed the FRI (Facility Reported Incident). The Administrator stated it was the right thing to do.

The Administrator stated that once an allegation was made, he would report to the State Agency immediately and begin the investigation.

The DON stated that she would report to the state agency immediately but no later than 2 hours after the allegation is made.

The facility abuse policy "Abuse: Neglect, Exploitation and Misappropriation, Under Reporting/Response" was reviewed. Page 7,

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F 609	Continued From page 37 read " Any employee is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause thee allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials in accordance with State law.." On 7/19/18 at 4:00 p.m., the Administrator and DON were asked to submit any information they would like to have reviewed regarding the issue. Both stated that no other information was able to be found. The Administrator and DON were not employed at the facility at the time of the allegation of Neglect. The nurse was terminated on 9/18/2017. No further information was provided.	F 609		
F 656 SS=G	COMPLAINT DEFICIENCY Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 656		9/5/18

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F 656	Continued From page 38 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 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 facility documentation and clinical record review, and in the course of a complaint investigation, the facility staff failed to for three residents (Resident #611, #612, #361) in a survey sample of 51 residents in the survey sample, to develop a care plan. 1. Resident #611 sustained a sacral wound that was discovered at a stage 3,that was not care	F 656	1. Ad Hoc QAPI Committee Meeting conducted on 8/13/18. 2. Root Cause Analysis (RCA) completed. Resident #361 and 611 no longer reside in facility. Resident□s # 612□s care plans have been reviewed and updated	

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F 656	Continued From page 39 planned for the treatment, continued assessment, interventions and evaluation of the acquired stage 3, resulting in infection and deterioration of the wound to a stage 4. This is harm. 2. Resident #612's history of fecal impaction was not care planned. The resident had no documentation of no bowel movements (BM) for 4 days, resulting in nausea and distended abdomen. At autopsy, the resident had both the large and small intestine distended with air, and the large intestine contained an abundant amount of stool. 3. For Resident # 361, the facility staff failed to ensure a comprehensive care plan included the focus of refusal of care. The findings included: 1. Resident #611 sustained a sacral wound that was discovered at a stage 3,that was not care planned for the treatment, continued assessment, interventions and evaluation of the acquired stage 3, resulting in infection and deterioration of the wound to a stage 4. This is harm. Resident #611 was admitted to the facility on 3/24/17 and discharged to the hospital on 2/12/18. Diagnoses included, but not limited to, Down's Syndrome, seizure disorder, unspecified sacral fracture before admission and hypothyroidism. Resident #611's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 1/16/18 coded Resident #611 with severe cognitive impairment. The MDS was	F 656	ensuring current resident conditions are present/ addressed within the comprehensive care plan. 3. MDS Coordinator/Designee completed a Quality Review of current facility residents with identified pressure ulcers, potential for fecal impaction, and those who refuse care for individualized comprehensive care plan. 4. Regional MDS Coordinator to validate Quality Review findings. Follow up based on findings. Regional MDS Coordinator completed re-education	

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F 656	Continued From page 40	F 656		

completed as a quarterly assessment. The resident required extensive to total care with all ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was incontinent of bowel and bladder. There was one wound documented on the MDS which was coded as a stage 3 with the measurements of 4.5 cm (centimeters) by 3.3 cm with a depth of 0.3 cm. The wound bed had slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous). During this look back period, according to the clinical record, the resident actually had two stage three pressure ulcers.

The NPUAP (national pressure ulcer advisory panel) describes a stage 3 ulcer as a "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable."

NPUAP describes a stage 4 ulcer as a "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers

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F 656	Continued From page 41 can be shallow. 12/31/17: Nurses notes recorded: "Resident's wound to right buttock showing signs of improvement." There were no measurements. On 1/3/18, the nurses notes read: "Wound has developed yellowish-gray slough on wound bed with an odor, however wound is reducing in size and depth." No measurements were taken and it is unclear which wound was being assessed. On 1/5/18, the nurse's notes read: "Treatment performed... Area is improving slowly, the area of the wound is hard to heal, in middle of buttock cheek, very close to anus." On 1/8/18, "Area on right posterior buttocks measures 2.4 by 1.9 by 0.2." On 1-10-18, a low air loss mattress was ordered. On 1/12/18, the nurses note read: "Treatment completed on sacral/right posterior buttocks. Measures 4.5 by 3.3 by 0.3." There is no documentation the physician was notified of the worsening of the wound. On 1/15/18, the nursing notes read: "Treatment completed, area is sore, there is stool in the wound, needs an irrigation with saline, to help clear wound." There is no documentation the physician was notified of the observation and no new physician orders. On 1/17/18, in the nurse's notes: "New order to culture right lower buttocks, do aerobe (sic) and anerobic and do surgical consult on right lower buttock pressure."	F 656		

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F 656	Continued From page 42 On 1/22/18, the nurse's notes revealed: "New order for Bactrim DS (antibiotic)." On 1/25/18, the notes read: "Sacral wound dressing changed, moderate drainage noted. Area malodorous." No measurements documented. On 2/7/18 at 4:30 AM, "Resident O2 sat 88%, placed on O2 sat up to 95%." The resident did go out for an appointment with the wound clinic. The treatment orders per the wound care physician read: "Right ischial (hip) wound stage 3-4, measurements 4.3 cm by 3.0 cm with a depth of 3.8 cm. PT (physical therapy) wound care with pulsed lavage 1000 cc (cubic centimeters) 0.9 % NS 4.8 PSI (pounds square inch) 100 mm (millimeters) mercury to right ischial wound. Dressing medihoney, packed with Kaltostat, 4 by 4 and Mepilex border." There is no documentation that the wound treatment or PT referral was done as ordered. On 2/12/18, after the resident returned from the wound clinic (no wound documentation available), according to the nurse's notes, "Family came to the nurses and wanted resident to be sent to the ER (emergency room) for an evaluation because he is more lethargic to them. NP (nurse practitioner) present and assessed resident and stated that we could treat him here. But they still wanted to go." The resident was transferred to the hospital and did not return to the facility. Review of the care plan dated 2/21/18 revealed there was no documentation of the right buttock/sacrum/hip wound.	F 656		

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F 656	Continued From page 43 2. Resident #612's history of fecal impaction was not care planned. The resident had no documentation of no bowel movements (BM) for 4 days, resulting in nausea and distended abdomen. At autopsy, the resident had both the large and small intestine distended with air, and the large intestine contained an abundant amount of stool. Resident #612 was admitted to the facility on 10/20/17 and discharged to the hospital on 10/29/17, where he expired. Diagnoses included, but not limited to, Pernicious anemia (Vitamin B 12 deficiency) legal blindness, seizure disorder and a history of fecal impaction. Resident #612's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 10-27-17 coded Resident #612 with no cognitive impairments. The MDS was completed as an admission assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was frequently incontinent of bowel and bladder. The resident was coded as having a weight loss not prescribed by the physician. Review of the closed record revealed: On 10-24-17: The resident was admitted to the facility. Zofran 4 mg (milligrams) for nausea was ordered and stat chest X-Ray. Complained of nausea at 10:54 PM and on the 7-3 shift. No documentation of Zofran being administered for nausea.	F 656		

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F 656	Continued From page 44 On 10-25-17: All shifts charted lungs clear. No complaints of nausea or vomiting documented. The physician note read: "Admitted to (name of hospital) after being admitted for hematuria, fecal impaction." On 10/27/17, the physician notes for this day documented "moderate distention (abdomen), hypoactive bowel sounds, non tender, no guarding." Review of Resident #612's care plan dated 1/24/17 revealed no care plan for history of fecal impaction and nausea or interventions to address bowel function and nausea. An autopsy was done 10/29/17. The results were: Final anatomic diagnosis: "Acute bronchopneumonia of lungs, bilateral. Pleural effusion, bilateral. Focal active colitis, with acute and chronic inflammation and focal degeneration of bowel wall. Probable early acute appendicitis is seen. Thoracic cavities were filled with approximately 1000 ml (one liter) of serosanguinous fluid in both the left and right sides. The large and small intestine were both distended with air, and the large intestine contains an abundant amount of stool." The microscopic examination revealed "acute and chronic inflammation of the large intestine (acute colitis). Vermiform appendix shows autolysis of appendiceal mucosa with focal early acute appendicitis." 3. For Resident # 361, the facility staff failed to ensure a comprehensive care plan included the focus of refusal of care. Resident #361 was admitted to the facility on	F 656		

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F 656	Continued From page 45 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral Arterial Disease. Review of the Resident # 361's closed clinical record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder. Review of the closed clinical record was conducted on 7/18/2018 and 7/19/2018. Review of an interdisciplinary note dated 9/14/17 revealed documentation of bilateral heel unstageable pressure ulcers deteriorated per wound report 9/13. Discussed with unit manager who reports refusal of care. Notably resident reports 'not feeling well' per nurse note 9/13, although no fever no pain.....Resident refused to be weighed for weekly weights, however last week weight 201 pounds, stable since admission, BMI (Body Mass Index) 22. Recommend d/c (discontinue) Cardiac restriction to encourage adequate intake for wound healing. Will continue to monitor and f/u (follow up) per protocol"	F 656		

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F 656	Continued From page 46 Review of Nurses Notes revealed documentation: 9/12/2017 (no time written) Resting upon rounds combative at times, refuses care at times. Chart check 9/12/17 1505 (3:05 PM) LOA (Leave of Absence) with friend in manual wheelchair no skin issues noted at this time-can be uncooperative 9/13/2017 2:15 PM ... Resident stated 'He didn't want to get up doesn't feel well,' Writer asked what wrong (sic) Resident stated 'Lady leave me alone. I just don't feel well. Resident has new order to obtain Complete Blood count, comprehensive Metabolic Profile and urinalysis and culture and sensitivity 9/14/18 Review of the care plan revealed focus areas of "At risk for impaired skin integrity, Has an infection Urinary tract infection, Altered bladder elimination, impaired cognition and/or thought processes related to Parkinson, impaired decision making, potential for alteration in pain/discomfort, actual and potential ADL (Activities of Daily Living) deficits, Potential for injury related to decrease mobility, fluid imbalance, Activities, Rehab potential , Full Code, Mood State, Nutritional Status, Psychosocial Well being, Potential for imbalanced nutrition related to Hypertension .... Thorough review of the care plan revealed no documentation of the concern or focus of "refusal of care" along with measurable objectives and interventions to reach a goal. During the end of day debriefing on 7/19/18, the facility Administrator, Director of Nursing and	F 656		

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F 656	Continued From page 47 Corporate Consultant stated care plans should reflect the residents' focus areas along with objectives, interventions and goals. No further information was provided.	F 656		
F 657 SS=D	COMPLAINT DEFICIENCY Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		9/5/18

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F 657	Continued From page 48 by: Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to revise the care plan for 1 resident (Resident #37) of 51 residents in the survey sample. Resident #37's care plan was not revised to include new interventions after each fall. The findings included: Resident #37, a 64 year old, was admitted to the facility on 9/4/17. Her diagnoses included dementia, dysphagia, and pica. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/28/18. Resident #37 was coded with severely impaired cognitive skills. She required extensive assistance with activities of daily living. Resident #37 fell on 12/10/17 requiring an emergency room visit and sutures to the head. She fell again without injury on 3/16/18 as a result of being left unattended in a standing position by staff. She fell a third time on 6/7/18 requiring an emergency room visit and sutures to the head. 1. 12/10/17 fall The "Fall Root Cause Investigation Report" read, "-Breakfast up to floor @ 10 AM- resident in day room -Approx 11 AM CNA (certified nursing assistant) informed writer resident on floor in day room - Resident on knees in floor with head on floor trying to bite cord to box fan beside her blood noted on side of fan probably hit her head on side	F 657	1. Resident #37 Fall Care Plan reviewed/ revised 7/20/2018. 2. Quality review of current residents with a fall in the last 90 days by Regional Director of Nursing/designee to ensure Care Plan was revised with new intervention post incident. Follow up based on findings. 3.MDS Coordinator re-educated by the Regional MDS/designee to ensure Care Plans are revised timely with new interventions post incidents. 4. Regional MDS/designee to conduct quality monitoring to ensure Care Plans are revised timely with new interventions post incidents, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 657	Continued From page 49 of fan. w/c (wheelchair) over backside of resident locked. - Blood (fresh) from laceration to forehead + L (left) temple appears to need stitches- area cleansed + bandage applied- resident put in w/c and ambulance called- No RP (responsible party)- NP (nurse practitioner) (name) called + informed- resident out to ER (emergency room) @ 11:15 AM". 12/10/17 "Discharge Instructions" from the ER visit read, "Sutured Wound Care" "Your cut has been cleaned and closed with stitches." The instructions also read, "Wound Care- Facial Laceration" "You have been treated for a laceration on your face. A laceration is a cut through the skin. This will usually require stitches if it is deep." A "Weekly Skin Integrity Review" form was included in the clinical record. On 12/15/17, documentation in the "Current skin condition" section read, "6 sutures to forehead". The care plan was not updated after this fall. 2. 3/16/18 fall The "Fall Root Cause Investigation Report" documented that the resident was "toileting" prior to the fall or at the time of the fall. Attached was a witness statement which read, "I, (name), was assigned to (resident name): I was in the process of changing her: she had been playing in feces: I stood her up and she held on to the night table: I went to the sink to wet a towel to clean her up: before I got back to her she lost her Balance and Feel (sic): (she slightly hit her left side of head on her wheel chair."	F 657		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 50 The most recent Minimum Data Set assessment completed prior to the fall had an assessment reference date of 12/28/17. She was coded as a 4/3 (total assistance/ 2 persons) for "Transfers" between surfaces and standing position. On 3/16/18, a "Fall Risk Evaluation" was completed. Resident #37 scored a 10, indicating "high risk" for potential falls. The care plan was not updated after this fall. 3. 6/7/18 fall 6/7/18, 3:10 p.m. nursing note read, "Resident was found on the floor in her bedroom. Before the event occur the resident was lying bed. The resident have a deep laceration to the L (left) forehead. The laceration was cleaned a dressing was applied. Resident was sent out to (hospital) for eval." 6/7/18, 8:00 p.m. nursing note read, "Call ER (emergency room to get information on how many sutures, wasn't in the chart @ the hospital on how many. Upon assessment it look to be 3 sutures on the left side of forehead." The hospital emergency provider report "stated complaint" read, "Head Pain". Diagnostic tests included CT (computerized tomography) scan of the head and spine. Both had negative findings. The hospital discharge summary read, "suture care". The care plan was not updated after this fall. Resident #37's care plan initially dated 9/7/17 was reviewed. There was no focus area specific to fall prevention. The focus "(Resident name) has	F 657		

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	495327	A. BUILDING _____ B. WING _____	C 07/23/2018

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F 657	Continued From page 51 the potential for injury r/t (related to) pica, dementia, poor communication/ comprehension, poor safety awareness, impaired mobility" included safety interventions. Interventions included 9/15/17 revised 5/4/18: be sure call light is within reach 9/15/17 revised 5/4/18: ensure appropriate footwear 9/15/17 revised 5/4/18: Follow facility fall protocol 9/7/17: keep needed items, water, etc, in reach The care plan interventions were not reviewed and revised after each fall. On 7/19/18 at the end of day meeting, Resident #37's falls with injury and lack of supervision were reviewed with the Administrator and Director of Nursing. They were also notified that the care plan interventions were updated. All information regarding the falls was accepted and reviewed. No information was provided about the care plan.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review and in the course of a complaint investigation, the facility staff failed to follow professional standards of documentation for two residents (Resident # 361 and #49) in a survey sample of 51 residents.	F 658	1. Resident #361 was discharged from facility on 9/20/2017. Resident #49 receives medications per Physician order. Late entry documentation for 7/16/2018 for	9/5/18

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F 658	Continued From page 52 1) For Resident # 361, failed to document properly on the Treatment Administration Record regarding not administering treatments as ordered by the physician. 2) For Resident #49, the facility staff failed to document the administration of medication. Findings included: 1) For Resident # 361, failed to document properly on the Treatment Administration Record regarding not administering treatments as ordered by the physician. Resident #361 was admitted to the facility on 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral Arterial Disease. Review of the Resident # 361's closed clinical record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder.	F 658	medication administered was completed on 7/17/2018. 2. Quality review of current resident□s medication administration record (MAR) and treatment administration record (TAR) was completed by Divisional Director of Nursing and Divisional Clinical Quality Specialist to ensure medications and treatments were administered per Physician order with documentation. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to ensure medications and treatments are documented post administration. 4. DON/UM/designee to conduct quality monitoring of MAR/TAR for omissions, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 658	Continued From page 53 Review of the closed clinical record was conducted on 7/18/2018 and 7/19/2018. Review of the Physicians Orders revealed orders written on 8/31/2017 for: Cleanse right heel with Normal Saline apply Santyl and dry dressing every day and PRN (as needed). Cleanse left heel with Normal Saline apply Santyl and dry dressing every day and PRN (as needed). Review of the TAR (Treatment Administration Record) for September 2017 revealed documentation of treatments to the right heel and left heel being signed off as having been administered every day in September 2017 from 9/1/2017-9/18/2017. There were no missing signatures or circled signatures indicating treatments had not been administered. Review of the Facility Investigation and Sworn Statement revealed that when questioned by the Director of Clinical Services about whether treatments had been completed over the weekend of 9/16-9/17/2017, the nurse, LPN (Licensed Practical Nurse) H, admitted that she did not do treatments on Resident # 361 on 9/16/2017 and 9/17/2017. When the Director of Clinical Services asked why the treatments had not been completed, LPN H stated Resident # 361 told her he was not in the mood on that Saturday, 9/16/17 and Sunday someone came and got him by the time I went back in there he was already gone." (sic) LPN H stated "no, I probably did not " when asked if she told another nurse that the wound care needed to be	F 658		

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F 658	Continued From page 54	F 658		

completed. LPN H admitted that it was "possible" she "signed off" the treatments on the TAR because "I do sign my stuff and then go to the patient".
Review of the September TAR in the Investigation packet had yellow highlights on those two dates: September 16, 2017 and September 17, 2017.

The nurse was terminated on 9/18/2017.

Review of the hospital Emergency Room notes dated 9/18/17 at 5:23 PM revealed documentation of "Chronic ulcerations to bilateral heels. Left heel has maggot visible in wound. Left heel ulceration appears to reach the bone."

During the end of day debriefing on 7/19/2018, the facility Administrator, Director of Nursing and Corporate Consultant were informed of the findings. All stated that nurses should follow physicians orders and should document accurately. The Director of Nursing cited Potter-Perry as the professional guidance used by the facility.

Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary.

No further information was provided.

COMPLAINT DEFICIENCY

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F 658	Continued From page 55 2) For Resident #49, the facility staff failed to document the administration of medication. Resident #49 was a 74 year old who was admitted to the facility on 1/30/18. Resident #49's diagnosis included Diabetes Mellitus Type 2, Acute Kidney Failure, and Hypertension. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 5/11/18, coded Resident #49 as having A Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. She was also coded as requiring insulin injections for 7 out of 7 days during the assessment period. On 7/18/18 a review was conducted of Resident #49's clinical record, revealing a lab test dated 5/31/18. It read, "Glucose 150 (High). Reference range 70 - 105." Resident #49's Care Plan read, :"6/7/18. At Risk for Metabolic Complications r/t (related to) Diabetes. Medications as ordered." Resident #49's signed Physician Order read, "Humalog 100 Unit. Inject subcutaneously per sliding scale before meals and at bedtime; If 141-180 = Give 4 Units Subq; 181-220= Give 6 Units 221-260= Give 8 Units 261-300 = Give 10 Units 301-350 = Give 12 Units 351-400 = Give 16 Units Greater than 401 Give 16 Units and Call MD (medical doctor)." Resident #49's clinical record contained a Medication Administration Record that did not contain documentation of a Blood Sugar level, or	F 658		

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F 658	Continued From page 56	F 658		

medication administration of insulin on 7/16/18 at 7:30 A.M. In addition, the Interdisciplinary Progress Notes did not contain any entries on 7/16/18.

Guidance for professional standards for documentation of medication administration was identified. "Document all medications administered in the patient's MAR or EMAR. If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions." Lippincott Solutions "Safe Medication Administration Practices, General" 10/02/2015.

On 7/18/18 a review was conducted of facility documentation, revealing a Medication Administration Policy dated September, 2016 that read, "It is the policy that the resident can expect safe and accurate administration of medication. Chart on MAR (Medication Administration Record)." The facility also submitted an Oral Administration of Medications Policy dated 9/22/17. It read, "Chart on Medication Administration Record immediately following when medication is given and before proceeding to the next resident."

On 7/18/18 at approximately 3:00 P.M. an interview was conducted with the Director of Nursing (Administration B) in the conference room. She stated, "The nurse should notify the physician and assess the resident, and document on the MAR. That shows we followed thru with the physician's order. Initials should be circled and a nurse's note put on back of the MAR. Blood sugar should be on the MAR." When asked about the importance of implementing the physician's

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F 658	Continued From page 57 orders, the Director of Nursing stated, "The physician gave the orders, that's the way we monitor whether or not we should give insulin. That's the physician's communication to us to determine if the quantitative value he set for the resident is correct. It it was hyperglycemic or hypoglycemic I would expect them to tell me what was done for the resident."	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on Observation, Resident Interview, and Staff Interview, facility staff failed to properly assist with activities of daily living for 2 residents Resident #31 and #1 in a survey sample of 51 residents. 1) The facility failed to bathe Resident #31 when requested. 2) The facility failed to shower Resident #1. The findings included: 1) Resident #31 was admitted to the facility on 10/10/2012. Her most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/23/2018. Her active diagnoses included, but were not limited to, Anemia, Congestive Heart Failure, Hypertension, Diabetes Mellitus, Hip Fracture, and Depression. The Brief Interview for	F 677	1. Resident #31 continues to refuse shower after multiple attempts to offer a shower. Resident #1 received a shower on 8/07/2018. 2. Quality review of current resident□s activity of daily living record (ADLs) to ensure residents received a shower per schedule and resident choice. ADLs reviewed in Morning Clinical Meeting to validate residents offered/received shower. Follow up based on findings. 3. Licensed nurses/ certified nursing assistants re-educated by the Staff Development Coordinator /designee to ensure residents receive a	9/5/18

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F 677	Continued From page 58 Mental Status (BIMS) assessed her at 15, indicating no impairment. Resident #31 required extensive assistance of two persons for transfers and bed mobility, required extensive assistance of 1 person for dressing and hygiene, and was totally dependent on 1 person for toileting. On 7/17/18 an initial tour of the facility was conducted. During the tour, at 12:30p.m., an interview was conducted with Resident #31 in her room. Resident #31 was asked how long she had been living at the facility, and she replied "about 7 years". Resident #31 was asked to describe her time at the facility. Resident #31 stated that she felt the facility had "gone downhill" during her time there. When asked to explain what she meant, Resident #31 offered several examples. She offered several examples of issues that she stated had gotten more common over time. These included a lack of supplies for staff to provide care, such as linens, towels, gowns, and washcloths. Resident #31 stated that sometimes residents with soiled linens have to wait linens to be washed before they are cleaned up because there are no clean linens available. In addition, Resident #31 stated that she has asked for a shower, only to be told she has to wait because no towels are available. Resident #31 also stated that she felt like there were not enough staff. When asked to elaborate, she stated "it takes a long time for them to answer the call bell." When asked how long it usually takes, Resident #31 stated it was frequently "over 30 minutes." On 7/18/18 at 2:00p.m., a meeting was conducted with the Resident Council, attended by 10 residents. When asked about concerns	F 677	shower per schedule and resident choice. 4. DON/UM/designee to conduct quality monitoring of ADLs to ensure resident□s receive a shower per schedule and resident choice, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 677	Continued From page 59 related to having enough linens or other supplies, there was a general consensus that there were frequently not enough linens or towels. When asked to elaborate, the Residents stated that sometimes when they asked for a bath or shower, staff would tell them they had to wait for laundry to finish, because there were not enough clean towels. 2) During a group interview on 07/18/2018 at approximately 2:22 pm, Resident #1 stated that she did not receive any showers since April. A review of Resident #1's clinical record was conducted. The review showed Resident #1 had one shower since April of 2018. The facility was informed of the findings during a meeting on 07/19/18 at 04:16 PM .	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the	F 684	1. Resident #65 skin re-assessed and treatment	9/5/18

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F 684	Continued From page 60 facility staff failed to ensure the highest practicable well being for 1 resident (Resident #65) in a survey sample of 51 residents. For Resident #65, the facility staff failed to ensure treatment in accordance with the comprehensive person-centered care plan. Findings included: Resident # 65 was admitted to the facility on 7/29/2015. He was readmitted to the facility on 11/29/2017 with diagnoses of cerebrovascular disease with resultant hemiplegia and hemiparesis (affecting his dominant side) and history of necrotizing fasciitis with prior skin grafts. The most recent Minimum Data Set (MDS) was a Quarterly Assessment done for 5/16/2018. This assessment showed the resident to have a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. This MDS recorded that the resident had no rejection of care in field E0800. On 7/17/2018 at 12:30PM, this surveyor introduced herself to a table of residents in the dining area. Resident # 65 stated "I have something you need to look at! they won't do my dressings!" Resident # 65 pulled back his lap robe a few inches to expose his left thigh. There was blood on his lap robe, and no dressing in place. His thigh had healed scarring and redness over an approximately 3 inch by 6 inch area. This reddened, scarred area had multiple small open areas, some of which were bleeding. The resident stated "I am supposed to have my dressing changed every day, and I remind them, but they	F 684	administered per Physician order. 2. Quality review of current resident□s Treatment Administration Record (TAR) was completed by Divisional Director of Nursing and Divisional Clinical Quality Specialist to ensure treatments were administered per Physician order with documentation. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to ensure treatments are administered per Physician order and documented post administration. 4. DON/UM/designee to conduct quality monitoring of TARs for omissions, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 684	Continued From page 61 don't do it half the time." On 7/17/2018 at 1:30PM, the surveyor reviewed the Treatment Administration Record (TAR) for Resident # 65. The TAR showed that dressings were to be done for the resident's left thigh, right thigh, and buttock wound. All these dressings were initialed by staff, indicating they had been done for 7/17/2018. A copy was obtained of this TAR. The medical record described the resident's thigh wounds as the site of prior skin grafts. At 4:00PM on 7/17/2018, this surveyor asked the resident if his dressing had been done. The resident again exposed his thigh, which had no dressing in place. At this time, the surveyor approached Admin B (the Director of Nursing), and asked her to observe the resident. This surveyor asked Resident # 65 what the status was of his dressing, and the resident told and showed Admin B that he had no dressing on his thigh. At 4:35PM, this surveyor and Admin B were able to inspect the resident's skin. Resident # 65 had no dressings at all, and had skin impairment on his left thigh, right posterior thigh, and central right buttock. His back was reddened and appeared irritated. Admin B was asked to describe the resident's skin condition, and replied "He has impaired skin integrity on his thighs." When asked about the buttock wound, Admin B replied "It is a Stage II." After the observation, Admin B and the surveyor went to the nurse's station. At 4:50PM, Admin B showed the surveyor the resident's TAR, and pointed out that the resident did not have dressings done that day per the TAR. Treatments to the buttock, right thigh, and left thigh were circled by nursing staff, and the reverse of the form stated "Resident not available for tx dsg change MD aware RP	F 684		

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F 684	Continued From page 62 notified." Per the instructions on the TAR, circling initials indicate that medications or treatments are refused. Admin B was asked to provide any other documentation to show resident refusal or follow-up for wound treatment on 7/17/2018. A review of the medical record on 7/19/2018 showed no nurse's note for 7/17/2018 for either MD notification or RP notification. The only nurse's note for 7/17/2018 was for a chart check for new orders by night shift. Resident #65's care plan stated the resident has "Potential for further impaired skin integrity r/t incontinence, decreased mobility, non compliance with hygiene, edema, condom catheter use." The goal for this problem was "will continue to have interventions in place to prevent further impaired skin integrity through next review" with an implementation date of 9/21/2017, revised 6/11/2018, and with a target date of 8/18/2018. The care plan listed interventions "Administer treatments as ordered and monitor for effectiveness", and "If resident refuses treatment/interventions, wait and try again." No further information was provided prior to the end of survey.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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	F 686		9/5/18

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F 686	Continued From page 63 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility staff failed to assess appropriately, treat and/or monitor pressure ulcers for four Residents (Residents #611, #361, #100, #37) in a survey sample of 51 residents. 1. Resident #611 sustained a sacral wound that was discovered at a stage 3, was not treated or monitored, which progressed to a stage 4, requiring hospitalization. The resident also acquired a stage 3 pressure ulcer to the right posterior upper thigh which progressed to a stage 4 and became infected. This resulted in harm. 2. For Resident #361, the facility staff failed to prevent the worsening of a pressure ulcer to the left heel and failed to treat the pressure ulcers on the right and left heel resulting in harm. 3. For Resident # 100, the facility staff failed to document the administration of treatments to wounds in April 2018. 4. For Resident #37, the facility staff failed to identify three abdominal wounds prior to the stage where necrotic tissue was developed resulting in harm.	F 686	1. Ad Hoc QAPI Committee Meeting conducted on 8/13/18. Root Cause Analysis (RCA) completed. Resident #361 and 611 no longer reside in facility. Residents□ #100 and 37 have been re-assessed by Director of Nursing. Residents□ #100 and 37 have been visited and re-assessed by physician. Residents□ #100 and 37 currently receive pressure ulcer treatment/monitoring per physician orders/standards of practice. 2. Director of Nursing/Designee has conducted a Quality Review of current facility residents with identified pressure ulcers for assessment /evaluation, treatment/monitoring per physician□s order/standards of practice. Regional Director of Clinical Services/Designee to validate results of Quality Review. Follow up based on findings. 3. Regional Director of Clinical Services provided	

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F 686	Continued From page 64 The findings included: Resident #611 was admitted to the facility on 3/24/17 and discharged to the hospital on 2/12/18. Diagnoses included, but not limited to, Down's Syndrome, seizure disorder, unspecified sacral fracture before admission and hypothyroidism. Resident #611's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 1/16/18 coded Resident #611 with severe cognitive impairment. The MDS was completed as a quarterly assessment. The resident required extensive to total care with all ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was incontinent of bowel and bladder. There was one wound documented on the MDS which was coded as a stage 3 with the measurements of 4.5 cm (centimeters) by 3.3 cm with a depth of 0.3 cm. The wound bed had slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous). During this look back period, according to the clinical record, the resident actually had two stage three pressure ulcers. The NPUAP (national pressure ulcer advisory panel) describes a stage 3 ulcer as a "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III	F 686	re-education for facility Clinical Management Team regarding assessment/evaluation, monitoring, provision of treatment for resident□s with pressure ulcers per physician□s order/ standards of practice. Director of Nursing/Designee provided re-education for Licensed Nurses regarding assessment/evaluation, monitoring, provision of treatment for resident□s with pressure ulcers per physician□s order/standards of practice. 4. Director of Nursing/Designee to complete Quality Improvement Monitoring of residents with pressure ulcers for assessment/evaluation, treatment, and monitoring per standard of practice utilizing the Morning Clinical Meeting Process 5x/week x 12 weeks, 3x/week x 6 weeks, weekly x 4 weeks, then monthly and as needed. Director of Nursing/Designee to complete Quality Improvement Observation Rounds for residents with pressure ulcers for assessment/evaluation, treatment, and monitoring per standard of practice weekly x 12 weeks,	

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F 686	Continued From page 65 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." NPUAP describes a stage 4 ulcer as a "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Review of the closed clinical record revealed on 8-27-17 an SBAR-Situation/Background/Evaluation/ Appearance/Review revealed "a red, irritated area to buttock, likely related to soiled pamper." Barrier cream was applied. Review of the clinical record revealed on 11/22/17: ""Assess resident right upper thigh for bleeding. Minimal bleeding noted. Appears to be excoriation and has been a recurring incident. RP/MD (responsible party/physician) notified. On 12/6/17, the treatment was changed to Bacitracin and a dry dressing. On 12/8/17, the treatment was changed to cleaning the wound with normal saline, skin prep, Alginate, cover with Optifoam. The wound was documented as a "stage 2-3." The area measured 4 cm by 4 cm with a 0.3 depth. There were no further notes or wound tracking of this wound until 2-1-18. The treatment remained the same until 1-17-18.	F 686	every other week x 6 weeks, then monthly and as needed. Medical Director to complete Quality Improvement Review treatment/ monitoring of resident□s with pressure ulcers twice monthly x 3 months, then monthly x 1 and as needed. Regional Director of Clinical Services/Designee to validate Quality Improvement Monitoring results weekly x 6 weeks, then monthly x 3 months and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring Schedule modified based on findings.	

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F 686	Continued From page 66 On 1/10/18 a low air loss mattress was in place. On 1/17/18, the nurses notes documented, "Right lower posterior thigh... area tender to touch, resident cringes when touched..measures 3.5 cm by 2 cm with a depth 1.4 cm... wound has an odor.. drainage covers 80 % of dressing." The treatment was changed to Maxsorb, Alginate (for drainage) and Santyl (to debride dead tissue). On 1/18/18, the resident received an order for Ultracet (pain medication) every four hours for "pain of wound." On 1/22/18, there was a new physician's order for Bactrim DS (an antibiotic) diagnosis wound infection" of the right posterior thigh. On 2/1/18, the nurse's notes documented "went out to the wound clinic for consult right thigh. VS (vital signs) 97.4, 82, 12 (respirations), blood pressure 92/50. Oxygen (O2) saturation 87 % (normal above 92 %). Staff called the wound clinic to recheck oxygen sats 87%. MD notified , new order for oxygen 2 liters per minute via nasal cannula for O2 less than 95%." The wound treatment was changed to cleanse right thigh with 1/4 strength Dakins, rinse with NS (normal saline) apply Medihoney, Kaltostat 4 by 4 and ABD (absorbent dressing)." The pain medication orders were changed to Oxycodone 5 mg (milligrams) every six hours for pain. On 2/7/18 at 4:30 AM, "Resident O2 sat 88%, placed on O2 sat up to 95%." The resident did go out for an appointment with the wound clinic. On 2/10/18, the nurses notes read: "Wound care	F 686		

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F 686	Continued From page 67 provided. Facial grimacing noted during wound care." On 2/12/18, after the resident returned from the wound clinic, according to the nurse's notes, "Family came to the nurses and wanted resident to be sent to the ER (emergency room) for an evaluation because he is more lethargic to them. NP (nurse practitioner) present and assessed resident and stated that we could treat him here. But they still wanted to go." The resident was transferred to the hospital and did not return to the facility. Review of the clinical record for the resident's right buttock, also documented as sacral and right ischial wound revealed the following: There was no wound tracking, weekly measurements, treatment documentation, wound care orders upon review of the clinical record. There was documentation of at least one time that the resident received treatment that was ordered for the right posterior thigh. The physician was not notified of decline in the wound for a change in treatment. On 12/13/17, the nurse's notes documented a "dressing change to right buttocks." On 12/18/17, the nurse's notes read, "Treatment to right buttock (pressure). Area is stage 3... some yellow slough... NS, Alginate, Optifoam." Incidentally, this was the treatment for the right posterior upper thigh. 12/21/17, the nurse's notes read: ""Wound is malodorous, and appears to have bloody drainage. Resident shouted in pain upon dressing application... resident is still grimacing	F 686		

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F 686	Continued From page 68	F 686		

and vocalized his pain." There was no documentation the physician was notified of the pain. Pain medication was ordered on 1-18-18.

On 12/27/17, the nurse's notes read: "Resident threw up after lunch." There is no documentation that the MD was notified.

On 12/28/17, The NP recorded: "On assessment, patient had a dressing to his right hip, when uncovered, there was about 3.5 by 3.5 inch wound with bloody, purulent drainage noted.... Nurse called to bedside to assess the site." A culture and sensitivity was ordered, but was canceled on 1-2-18. Antibiotic therapy with Keflex was imitated.

On 12/29/17: The nurse's notes read: "Treatment provided. Some discomfort... Area is improving, healing nicely. Measurements- inner dimensions 2.9 by 2.7." There is no indication which wound was being assessed and there is no depth recorded.

12/31/17: Nurses notes recorded: "Resident's wound to right buttock showing signs of improvement." There were no measurements.

On 1/3/18, the nurses notes read: "Wound has developed yellowish-gray slough on wound bed with an odor, however wound is reducing in size and depth." No measurements were taken and it is unclear which wound was being assessed.

On 1/5/18, the nurse's notes read: "Treatment performed... Area is improving slowly, the area of the wound is hard to heal, in middle of buttock cheek, very close to anus."

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F 686	Continued From page 69 On 1/8/18, "Area on right posterior buttocks measures 2.4 by 1.9 by 0.2." On 1/10/18, a low air loss mattress was ordered. On 1/12/18, the nurses note read: "Treatment completed on sacral/right posterior buttocks. Measures 4.5 by 3.3 by 0.3." There is no documentation the physician was notified of the worsening of the wound. On 1/15/18, the nursing notes read: "Treatment completed, area is sore, there is stool in the wound, needs an irrigation with saline, to help clear wound." There is no documentation the physician was notified of the observation and no new physician orders. On 1/17/18, in the nurse's notes: "New order to culture right lower buttocks, do aerobe (sic) and anerobic and do surgical consult on right lower buttock pressure." On 1/22/18, the nurse's notes revealed: "New order for Bactrim DS (antibiotic)." On 1/25/18, the notes read: "Sacral wound dressing changed, moderate drainage noted. Area malodorous." No measurements documented. On 2/7/18 at 4:30 AM, "Resident O2 sat 88%, placed on O2 sat up to 95%." The resident did go out for an appointment with the wound clinic. The treatment orders per the wound care physician read: "Right ischial (hip) wound stage 3-4, measurements 4.3 cm by 3.0 cm with a depth of 3.8 cm. PT (physical therapy) wound care with pulsed lavage 1000 cc (cubic centimeters) 0.9 %	F 686		

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F 686	Continued From page 70 NS 4.8 PSI (pounds square inch) 100 mm (millimeters) mercury to right ischial wound. Dressing medihoney, packed with Kaltostat, 4 by 4 and Mepilex border." There is no documentation that the wound treatment or PT referral was done as ordered. On 2/12/18, after the resident returned from the wound clinic (no wound documentation available), according to the nurse's notes, "Family came to the nurses and wanted resident to be sent to the ER (emergency room) for an evaluation because he is more lethargic to them. NP (nurse practitioner) present and assessed resident and stated that we could treat him here. But they still wanted to go." The resident was transferred to the hospital and did not return to the facility. Review of the care plan dated 2/21/18 revealed there was no documentation of the right buttock/sacrum/hip wounds. It also included to "notify the physician for change in condition." Review of the skin evaluations done by nursing from 10/3/17 to 1/6/18 revealed no markings on the body diagram or notations of the right buttock/sacral/ip wound. The facility policy (clinical guideline) was reviewed. The policy read: * Licensed nurse to complete skin evaluations weekly and document in the clinical record. * CNA (certified nursing assistant) to complete skin observations and report changes to Licensed nurse. * Licensed nurse to document presence of skin impairment/ new skin impairment when observed and weekly until resolved. * Licensed nurse to report changes in skin	F 686		

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F 686	Continued From page 71 integrity to the physician/ practitioner and resident/responsible party and document in the medical record * Develop individualized goals and interventions and document on care plan and the CNA Kardex * Monitor resident's response to treatment and modify treatment as indicated * Refer to therapy as indicated * Evaluate the effectiveness of interventions and progress towards goals during the care management meeting and as needed. On 7/19/18 at 4:10 PM, the DON (director of nursing) stated, "The nurses should call the MD and get an order for wound treatments." She also stated there were no wound care minutes or weekly tracking. The DON and Administrator were notified of harm level deficiency. On 7/19/18 at 5:20 PM, the facility Regional Clinical Director stated, "We don't do wound vacs." 2. For Resident #361, the facility staff failed to prevent the worsening of a pressure ulcer to the left heel and failed to treat the pressure ulcers on the right and left heel resulting in harm. Resident #361 was admitted to the facility on 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral Arterial Disease. Review of the Resident # 361's closed clinical	F 686		

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F 686	Continued From page 72	F 686		

record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder.

Review of the FRI (Facility Reported Incident) submitted to the state agency on 2/15/2018 reported an allegation of neglect that occurred on 9/18/17. The FRI stated a nurse LPN (Licensed Practical Nurse) H failed to provide wound care to Resident # 361 resulting in resident being sent to the Emergency Room for further evaluation. It was noted that maggots were in his wound located on his right heel. The hospital sent the resident back to the facility on 9/19/17 and requested that the resident have a wound consult. Resident #361 did return with orders for antibiotic treatment. The resident was sent back to hospital on 9/20/17 and did not return. LPN H was suspended and during the investigation, LPN H verbally admitted that she did not provide wound care as ordered by the physician during her assigned shift.

Review of the closed clinical record was conducted on 7/18/2018 and 7/19/2018.

Review of the Physicians Orders revealed orders written on 8/31/2017 for:
Cleanse right heel with Normal Saline apply Santyl and dry dressing every day and PRN (as

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F 686	Continued From page 73 needed). Cleanse left heel with Normal Saline apply Santyl and dry dressing every day and PRN (as needed). Review of the TAR (Treatment Administration Record) for September 2017 revealed documentation of treatments to the right heel and left heel being signed off as having been administered every day in September 2017 from 9/1/2017-9/18/2017. There were no missing signatures or circled signatures indicating treatments had not been administered. Review of the Facility Investigation and Statement revealed that when questioned by the Director of Clinical Services about whether treatments had been completed over the weekend of 9/16/2017-9/17/2017, the nurse, LPN (Licensed Practical Nurse) H, admitted that she did not do treatments on Resident # 361 on 9/16/2017 and 9/17/2017. When the Director of Clinical Services asked why the treatments had not been completed, LPN H stated Resident # 361 told her he was not in the mood on that Saturday, 9/16/17 and Sunday someone came and got him by the time I went back in there he was already gone." (sic) LPN H stated "no, I probably did not " when asked if she told another nurse that the wound care needed to be completed. LPN H admitted that it was "possible" she "signed off" the treatments on the TAR because "I do sign my stuff and then go to the patient". Review of the September TAR in the Investigation packet had yellow highlights on those two dates: September 16, 2017 and September 17, 2017.	F 686		

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F 686	Continued From page 74 Review of the hospital Emergency Room notes dated 9/18/17 at 5:23 PM revealed documentation of "Chronic ulcerations to bilateral heels. Left heel has maggot visible in wound. Left heel ulceration appears to reach the bone." Review of the SBAR (Situation, Background, Appearance, Review and Notify) Communication Form dated 9/18/2018 revealed documentation of the Situation being a "change in condition of a wound." Background-under # 8 Skin evaluation was written-"wound-odor/drainage", # 9-Pain Evaluation-Does resident have pain- "yes", Is the pain "new" was checked, location was described as "heel" The non-verbal signs of pain were listed as Yes-moaning, guarding foot" Appearance-"noted with infestation to his heel" Review and Notify-Primary Care Clinician Notified-nurse practitioner was notified 9/18/17-(no time was listed) Other-"Send to ER (Emergency Room)" Nurses Notes-"Resident assessed noted with infestation to his right heel. NP (nurse practitioner) in observed N.O. (new order) to send to ER for eval. (evaluation)" Review of Physicians Orders revealed order on 8/15/17 for: Skin prep to right heel every shift and as needed. Skin prep to bottom of left foot every shift	F 686		

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F 686	Continued From page 75 8/21/17- 3 PM- Cleanse right heel with normal saline pat dry, apply Santyl and cover with 4 X 4 Kling and tape 8/22/17 10 AM- "Order Clarified" Cleanse right heel with Normal Saline or wound cleanser Apply Santyl and dry dressing every day and as need 8/25/2017-Cleanse left heel with Normal Saline or wound cleanser Apply Santyl 4 X 4's Kling every day and as needed (4 X 4) 8/28/17- Resident from Physical Therapy Review of August 2017 TAR Treatment Administration Record revealed documentation on 8/28/2017 of treatments not being administered to the right and left heel for the reason " off unit" The order was for daily treatments and as needed. The treatments were listed on the TAR as scheduled for 7-3 shift. There was no documentation of the next shift (3-11) administering the treatment on 8/28/2017. The next documentation of providing treatments to the right and left heels was 8/29/2017. Review of the new admission assessment on 7/28/2017 revealed documentation of no problems with Resident # 361's heels upon admission. The documentation stated "skin intact, several old surgical scars." There were three documented foot problems listed on the Admission assessment: a scab on the left great toe, an old surgical scar on the bottom of the left foot, and a dark hard calloused area on the side of the right foot. Review of the Daily Skilled Nurse's notes revealed documentation:	F 686		

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F 686	Continued From page 76 8/10/17-9:30 AM-... in to assess right heel small amt (amount) blood observed on sock and heel. skin tough, intact small pinpoint opening no drainage. new order skin prep every shift." 8/15/2017-9 AM- ... in to do treatment resident has boggy heel observed right heel 4 X 4 order for skin prep continues, no odor or drainage . resident has callous area to bottom of left foot skin prep added. MD (medical doctor) and RP (Responsible Party) aware will continue to monitor for changes. Resident has Prevalon Boots in place and continues in therapy caseload. 8/21/2017-"Late Entry: at 3 PM was called to residents room by therapy. Resident observed having some leakage on sock. Sock was removed. Observed open area to right heel Stage 2, area was cleaned with normal saline, pat dry and Santyl was applied and covered. Resident own RP made aware. MD was called and made aware obtained new orders for treatment. {note was written after a note written 8/21/2017 at 10:25 PM by the 3-11 shift} 8/22/2017-8:10 AM Resident discussed 8/18/17 for wounds right heel 4 x 4 x 0 black blistery eschar wound edges firm no drainage no odor. Heel center boggy. Resident utilizes wheelchair for mobility on rehab caseload. All IDT (Interdisciplinary) members present. continue skin prep to heel and left bottom for small callous intact no drainage. Treatment indicated skin prep no pain expressed. Will continue to monitor for changes. MD and RP aware. 8/25/2017 12 PM Resident discussed at Wound meeting for areas to right heel 4 X 4 eschar	F 686		

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F 686	Continued From page 77 present no drainage no odor intact and left heel 4 x 4 eschar Santyl treatment indicated no complaints of pain Prevalon boots in place. MD and RP aware. will continue to monitor. 8/25/2017 12:05 PM Resident also presents with callous to bottom left foot intact no drainage, skin prep only no pain. MD and RP aware 8/27/2017 2:45 PM-....dressing to heels intact. 8/31/2017 (no time written) Orders clarified to change cleanse right and left heel wounds with Normal Saline only and dry dressing MD and RP aware. 9/7/17 7 PM- transferred from Unit 1.....Prevalon Boots to bilateral intact will monitor. 9/12/2017 (no time written) Resting upon rounds combative at times, refuses care at times. Chart check 9/12/17 1505 (3:05 PM) LOA (Leave of Absence) with friend in manual wheelchair no skin issues noted at this time-can be uncooperative 9/13/2017 2:15 PM ... Resident stated 'He didn't want to get up doesn't feel well,' Writer asked what wrong (sic) Resident stated 'Lady leave me alone. I just don't feel well. Resident has new order to obtain Complete Blood count, comprehensive Metabolic Profile and urinalysis and culture and sensitivity 9/14/18 9/18/17 1 PM Called to resident room by nurse manager. Resident left heel note with eschar, thick dark drainage. no odor. NP (nurse practitioner made aware. N.O. (new order) to	F 686		

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F 686	Continued From page 78 send to ER for evaluation. Review of the care plan revealed documentation of the Focus: At risk for impaired skin integrity with interventions which included: "Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing weekly... Float heels Monitor changes in skin status appearance, color, wound healing signs and symptoms of infection, wound size and/or stage" The facility policy titled "Clinical Guidelines-Skin and Wound" dated 4/1/2017 was reviewed. The Process read "Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. Process: On Admission/re-admission the resident's skin will be evaluated for baseline skin condition and documented in the medical record. Braden Risk Evaluation to be completed on admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition. Licensed Nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record. CNA (Certified Nursing Assistant) to complete skin observations and report changes to Licensed Nurse	F 686		

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F 686	Continued From page 79 Licensed Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record Develop individualized goals and interventions and document on the care plan and in the CNA Kardex Refer to therapy as indicated Monitor residents' response to treatments and modify treatment as indicated. Evaluate the effectiveness of interventions and progress towards goals during the care management meeting and as needed QAPI: Patterns and trends of newly developed and/or worsening skin conditions will be reviewed by the QAPI team In summary, Resident # 361 was admitted to the facility with no wounds on the left or right heel. Resident # 361 was described on Admission as weight bearing. Treatments were not administered as ordered by the physician. Resident # 361 was sent to the ER with maggots in his heel wounds and according to the ER documentation, the Left heel was open to the bone. During the end of day debriefing on 7/19/2018, the facility Administrator, Director of Nursing and Corporate Consultant were informed of the findings. No further information was provided.	F 686		

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F 686	Continued From page 80	F 686		

3. For Resident # 100, the facility staff failed to document the administration of treatments to wounds in April 2018.

Resident # 100 was a 69 year old female admitted to the facility on 12/15/2017 with the diagnoses of, but not limited to, Hypertension, CAD (Coronary Artery Disease), Glaucoma/Blindness, and Diabetes.

The most recent Minimum Data Set (MDS) was a Significant Change assessment with an Assessment Reference Date (ARD) of 5/29/18. The MDS coded Resident # 100 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive to total assistance with activities of daily living including extensive help in bathing; always incontinent of bowel and bladder.

Review of the clinical record was conducted on 7/18/2018.

Review of the April 2018 Treatment Administration Record revealed missing documentation of administration of treatments as listed below:

Cleanse both feet and heels with warm water and soap, pat dry, and apply skin prep twice daily for scaly skin- not documented 4/12/2018 3-11 shift 4/29/2018 7-3 shift

Optifoam to sacral area change every 3 days -not documented 4/27/18-(resulting in 6 days between treatments to the sacral area.)

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F 686	Continued From page 81 Wound observation was done on 7/18/2018 at 10:22 with the wound care doctor and wound care nurse. Valid physicians orders were evident. During the end of day debriefing, the Administrator, Director of Nursing and Corporate Nurse were informed of the findings. All stated treatments should be administered as ordered by the physician. No further information was provided. COMPLAINT DEFICIENCY 4. For Resident #37, the facility staff failed to identify three abdominal wounds prior to the stage where necrotic tissue was developed resulting in harm. A review of the clinical record revealed that Resident #37 had an abdominal wound. A nursing note dated 5/9/18, 9:35 a.m. read, "Nursing Aid reported areas on abdomen to writer observed 3 circular necrotic(dead tissue) areas surrounded by redness directly under adult diaper line, nursing aid was providing AM (morning) care when areas were found." "Resident shows no s/s (signs/symptoms) of pain MD (doctor) made aware/ wound doctor made aware. N.O. (new order) clean with NS (normal saline), apply Santyl cover with ABD pad + secure with tape per wound doctor request in which MD (doctor) Jennings agreed to tx (treatment) order." On 5/9/18 at 11:15 a.m., the wound doctor wrote out and signed the above treatment order on a	F 686		

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F 686	Continued From page 82	F 686		

telephone order sheet.

A "Skin Evaluation" flow sheet used to document weekly skin checks was identified in the clinical record. The flow sheet began with the date 5/11/18. On 5/11/18, the "current skin condition" was described as "3 narc areas" with three X marks drawn on the abdomen of the body diagram.

The CNA (Certified Nursing Assistant) -ADL (Activities of Daily Living) Tracking Form for May 2018 was reviewed. The Bathing section was reviewed. Resident #37 was coded to have received a "partial" bath from 5/4/18-5/7/18. On 5/8/18, a "4/2" (total dependence/ one person assist) was documented for the 3-11 but the type of bath provided was not documented.

The Treatment Administration Record for May 2018 was provided. The treatment to the abdomen was completed as ordered from 5/9/18-5/28/18.

A note written by the wound care doctor on 5/23/18 documented that the abdominal wound "Resolved on 5/23/18". "Wound Progress" read "Epithelialized and Resolved." No other wound care doctor notes were located in the clinical record or provided by the facility.

The care plan dated 9/6/17 was reviewed. The focus read, "(Resident) has the potential for impaired skin integrity r/t (related to) incontinence, fragile skin". The interventions date 9/6/17 read, administer treatments as ordered, encourage adequate nutrition, identify causative factors and eliminate where possible, incontinence are post episode, keep skin dry,

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F 686	Continued From page 83 weekly skin checks. The facility staff were asked to provide any skin and wound management protocols used at the facility. The "Wound Classification Guide" was provided. The Stage III wound description read, "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss." The Stage IV wound description read, "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present." The Unstageable wound description read, "Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/ or eschar (tan, brown or black) in the wound bed." The following information was accessed on 7/25/18 at 10:20 a.m. at the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/ "Necrotic tissue, slough, and eschar The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in colour), or eschar (dry, black, hard necrotic tissue). Such tissue impedes healing." According to the above descriptions, the necrotic tissue in Resident #37's wound was either slough or eschar, indicating her wounds would be staged at a III, IV or unstageable when first identified. On 7/18/18 at the end of day meeting, the Administrator, Director of Nursing (DON) and Corporate Nurse were notified of the concerns regarding the abdominal wounds. They were	F 686		

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F 686	Continued From page 84 asked to provide all documentation related to the abdominal wound. The facility provided information on 7/19/18. No information regarding the stage, the description of the wound bed or measurements of the wound upon first identification were provided. On 7/19/18 at 8:30 a.m. an interview was conducted with the DON. The DON began working at the facility on 5/10/18. The DON stated that when she started at the facility she identified that the management of pressure ulcers needed immediate attention. From October 2017 until May 2018, the facility did not have a wound care nurse. The floor nurses assessed the resident's skin and completed wound treatments. During the interview, the DON stated that there was no wound measurements or staging completed for the abdominal wound. In summary, the three abdominal wounds were under the waist band of the adult brief. This is a highly visible area as this skin would be exposed with each brief change. While the facility did not stage the three abdominal wounds, when they were first identified they were necrotic. This would indicate that these wounds were first identified at a stage III, IV or unstageable.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including	F 687		9/5/18

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F 687	Continued From page 85 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide foot care for one resident (Resident # 17) in a survey sample of 51 residents. For Resident # 17, the facility staff failed to obtain Podiatry services to cut her toenails. Her toenails appeared to be over a quarter of an inch to a half inch long, jagged and discolored. Findings included: Resident # 17 was an 83 year old female admitted to the facility on 12/1/2007 and readmitted on 5/22/2009 with the diagnoses of, but not limited to, Chronic Obstructive Pulmonary Disease The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 4/16/18. The MDS coded Resident # 17 with a severe cognitive impairment; the resident required extensive to total assistance with activities of daily living including extensive help in bathing; always incontinent of bowel and bladder. Review of the clinical record was conducted on 7/18/2018. On 7/18/2018 during wound observation with the	F 687	1. Resident #17 received podiatry services. 2. Quality review of current residents by Director of Nursing and Assistant Director of Nursing/designee to identify podiatry services needs. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to ensure residents feet/toenails are assessed and podiatry services are obtained as needed. CNA staff re-educated to report needed toe nail care. 4. DON/UM/designee to conduct quality monitoring of residents feet/toenails, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 687	Continued From page 86 Wound Care Physician and the Wound Care nurse, Resident # 17 was observed to have long, broken, jagged edged, thick, yellowish, discolored toenails on both feet. The toenails appeared to be over a quarter of an inch to a half inch long. The wound care nurse agreed that the toenails were long and stated she did not know when Resident # 17 was last seen by a Podiatrist. Resident # 17 had Bunny Boots on both feet. Resident # 17 had several wounds including wounds on the right ankle, foot and toes. The Wound care doctor stated the wounds were arterial and agreed that the toenails were long. Review of Physicians orders revealed no orders for Podiatry care. There was an order written on 6/13/18 for Lateral Right Foot "Cleanse with Normal Saline, Apply Santyl and cover with dry dressing every day and as needed. An order written on 6/6/2018 read: Right Medial Foot Wound-Discontinue current treatment , start Santyl every day and as needed. Review of the TAR (Treatment Administration Record) revealed facility staff administered treatments as ordered in June and July 2018. Review of the Nurses Notes revealed no mention of long toenails noted during administration of treatments even though facility staff provided treatments to foot wounds daily. There was no documentation about observation of toenails and need for Podiatry care. On 7/18/218, an interview was conducted with the	F 687		

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F 687	Continued From page 87 Unit Manager who stated the usual process was for the staff to place the residents' names on the list for the Podiatrist to examine during the next visit to the facility. The Unit Manager reviewed the Podiatry list for June 2018 and found no documentation of Resident # 17's name being added to the list of residents to be seen. The Unit Manager stated she would follow upon notify the doctor for an order and add Resident # 17 to the list. During the end of day debriefing on 7/18/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings. The Director of Nursing stated Resident # 17 would be added to list of residents to be seen by the Podiatrist. No further information was provided.	F 687		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to 1a) ensure 1 resident (Resident #37) of 51 residents in the survey sample was free from a choking hazards resulting in immediate jeopardy and 1b) failed to supervise	F 689	1. Ad Hoc QAPI Committee Meeting conducted on 8/13/18. Root Cause Analysis (RCA) completed. Resident # 64 no longer resides in facility. Resident #37 has been	9/5/18

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F 689	Continued From page 88 Resident #37 resulting in falls with injury resulting in harm. 2) the facility staff failed to mitigate a fall hazard for 1 resident (Resident #64) in a 51 resident sample. 1a. Resident #37, who had diagnoses of dementia, dysphagia, and pica, and who had a mechanical soft diet with pureed meats, severe cognitive impairment, and total dependence on staff for eating, was observed sitting alone in her room for at least 30 minutes wearing a beaded silicone necklace. She was observed to stuff the necklace into her mouth. She was also observed to bite down on the beads with her teeth and forcefully pull the necklace with her hands. This resulted in Immediate Jeopardy 1b. Resident #37 fell on 12/10/17 requiring an emergency room visit and six sutures to the head. She fell again without injury on 3/16/18 as a result of being left unattended in a standing position by staff. She fell a third time on 6/7/18 requiring an emergency room visit and three sutures to the head. This is harm. 2) Resident #64 had multiple falls. After a therapy screen, the facility did not implement using colored tape on the call bell as a visual reminder to use his call bell for assistance. The findings included: 1a. Resident #37, who had diagnoses of dementia, dysphagia, and pica, and who had a mechanical soft diet with pureed meats, severe cognitive impairment, and total dependence on staff for eating, was observed sitting alone in her room for at least 30	F 689	reassessed by physician regarding repetitive behavior of placing nonfood objects in mouth /swallowing/potential for choking. Psych Services consult for reassessment of behavior (placing nonfood objects in mouth) has been completed. Speech Therapy completed swallow evaluation. Resident supervision needs evaluated /adjusted as applicable. Care Plan Meeting has been held with Interdisciplinary Team, resident (if able to attend) and family/ (responsible party) to review resident□s current condition and recommended plan of care. Director of Nursing has re-assessed resident #37 for fall risk. Therapy screen completed for resident #37. Interdisciplinary Team review completed for resident #37. Recommendations reviewed with physician/residents/family (responsible party); implemented as applicable. 2. Director of Rehabilitation/Designee to complete a Quality Review of residents with identified swallowing impairments for appropriate supervision/interventions/strategies. Director of Nursing/Designee to conduct a Quality	

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F 689	Continued From page 89 minutes wearing a beaded silicone necklace. She was observed to stuff the necklace into her mouth. She was also observed to bite down on the beads with her teeth and forcefully pull the necklace with her hands. This resulted in Immediate Jeopardy Resident #37, a 64 year old, was admitted to the facility on 9/4/17. Her diagnoses included dementia, dysphagia, and pica. The resident had her own teeth. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/28/18. Resident #37 was coded with severely impaired cognitive skills. She required extensive assistance with activities of daily living and was coded as a 4/2 (total dependence, one person assistance) for eating. On 7/17/18 at 11:35 a.m., Resident #37 was observed in her room seated in a wheelchair. There were no staff present in the room. Resident #37 was wearing a beaded necklace around her neck. The necklace included two types of beads: round approximately the size of a nickel and flat approximately an inch long. The resident was observed to chew on the necklace and also stuff the necklace into her mouth. She was observed from 11:35 a.m. until 11:55 a.m. by this surveyor. She was observed by Surveyor 2 from 11:25 a.m. until 11:35 a.m. No staff entered the room during the 30 minute observation. At this time, a family member of Resident #37's roommate was in the room. The family member stated she was a nurse and she was extremely concerned that Resident #37 was going to choke on the necklace because she stuffed in her	F 689	Review of residents with repetitive behavior of placing nonfood items in mouth for appropriate compensatory device/interventions (if applicable) and supervision needs. Director of Nursing/ Designee conducted a Quality Review of residents with falls for the last 90 days for implementation of recommended fall interventions. Regional Director of Clinical Services/Designee to validate results of Quality Review. Follow up based on findings. 3. Regional Director of Clinical Services provided re-education for facility Interdisciplinary Team regarding prevention of Accidents/Hazards including but not limited to potential for choking /fall management/ prevention. Executive Director /Designee completed re-education with facility staff regarding prevention of Accidents/Hazards including but not limited to potential for choking /fall management/prevention. Regional Director of Clinical Services provided re-education for Executive Director/Director of Nursing	

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F 689	Continued From page 90 mouth. The family member stated she had alerted the staff of the concern. On 7/17/18 at 11:55 a.m., Licensed Practical Nurse B (LPN B), Unit Manager, was asked to observe Resident #37 with this surveyor. Upon entrance to the room, Resident #37 had the necklace beads in her mouth. LPN B was asked if it was ok that Resident #37 was wearing the necklace and putting it in her mouth. LPN B stated that the resident had a diagnosis of pica. She called the necklace a "teething ring" and stated that Resident #37 was care planned to have the teething ring. It was reviewed with LPN B that Resident #37 had been stuffing the necklace in her mouth for the last 30 minutes. LPN B was asked if the facility was concerned that Resident #37 would choke on the necklace LPN B stated that the resident was supervised when wearing the necklace. It was reviewed with LPN B that Resident #37 had not been supervised while wearing the necklace for the last 30 minutes. LPN B was asked to describe the type of supervision that was supposed to be provided. LPN B stated that the staff usually sat Resident #37 at the nursing station. On 7/17/18 at 12:20 p.m., Resident #37 was observed at the nursing station holding the necklace, no staff were in sight. On 7/18/18 at 9:00 a.m., Resident #37 was in the dining room alternating between chewing on the necklace as she held it in her hand and inserting the necklace in her mouth. The Speech Therapist (ST) was on the unit and she was asked to look at the necklace. She stated that she had never seen the necklace before, as it was not a device that had been recommended or	F 689	regarding provision of adequate supervision. 4. Director of Nursing/Designee to complete Quality Improvement Monitoring of post fall implementation /maintenance of interventions/appropriate supervision utilizing the Morning Clinical Meeting Process and conducting random resident/staff observations5x/week x 12 weeks, weekly x 6 weeks, monthly x 2 months and as needed. Director of Rehabilitation/Designee to conduct Quality Improvement Monitoring of residents with identified swallowing impairment for implementation/ maintenance of interventions/strategies 5x/week x 6 weeks, weekly x 6 weeks, then monthly x 2 months and as needed. Regional Director of Clinical Services to validate Quality Improvement Monitoring findings weekly x 6 weeks, then monthly x 2 months and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 689	Continued From page 91 provided by the therapy department. She stated that therapy would recommend a product called a "chewy tube". The ST stated she had worked with Resident #37 previously. The ST stated that Resident #37 needed constant supervision and was a 1:1 for feeding. The ST was asked to provide the product information for the chewy tube. On 7/18/18 at 9:25 a.m., the ST provided a product book depicting the "chewy tube". The product had a "D" shape to it. When asked if she considered the necklace to be a choking hazard, the ST hesitated to answer and then stated she has not assessed the resident so she could not say. This conversation was held at the nursing station desk. While not directly part of the discussion, LPN B was seated at the nursing station desk during the conversation with the ST. On 7/18/18 at 1:00 p.m.- 1:12 p.m., Resident #37 was observed in the dining room. She was seated at the table waiting for lunch. There were seven residents in the dining room. Staff varied from one or two staff. They were removing trays from the meal cart and setting up the trays for the residents in the room. At this time, Resident #37 held the necklace in her hand. The ends were not clasped and the necklace was a long strand of beads approximately 30 inches long. The resident alternated between inserting the beads in her mouth from the middle of the strand, the end of the strand (4 beads) and chewing on her hands. Resident #37 was also observed to bite down on the beads with her teeth and pull forcefully with her hands. The staff did not redirect Resident #37's actions at any time.	F 689		

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The care plan dated 12/5/17 read, "Behaviors related to, Attempts to bite, cognitive loss, ineffective impulse control, insufficient safety awareness" with the intervention dated 6/20/18 "have an object acceptable for mouth".

The care plan read, "(Resident #37) has the potential for injury r/t (related to) pica, dementia, poor communication/ comprehension, poor safety awareness, impaired mobility." An intervention dated 9/7/17 read, "Monitor resident for chewing and inappropriate items in mouth."

The care plan read, "The resident has the potential for imbalanced nutrition r/t (related to) dementia, hx (history) etoh (alcohol) use, dx (diagnosis) dysphagia, hx (history) burns. Hx (history) significant weight change." Interventions dated 9/26/17 read, "Redirect resident to discourage consumption of non food items" and "Remove potentially hazardous items & debris from environment."

On 7/18/18 at 1:42 p.m., IJ was called.

On 7/18/18 at 1:51 p.m., a meeting was held with the Administrator, Director of Nursing (DON) and Corporate Nurse. At this time, the facility was notified that Resident #37 was observed unsupervised in her room for 30 minutes alternating between chewing on the beaded necklace and stuffing it in her mouth. They were notified that Immediate Jeopardy had been called regarding Resident #37. At this time, the DON stated that the necklace was a teething necklace for a baby.

At 2:05 p.m., the DON provided Resident #37's

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F 689	Continued From page 93 necklace to the survey team. The beads of the necklace were strung on a string. Knots were tied between every bead. Two beads were observed missing from the necklace. The facility presented a plan of correction on 7/18/18 at 3:11 p.m., and IJ was abated. The facility plan of correction is as follows: July 18, 2018 1. Resident identified with necklace beads. Necklace beads have been removed and given to surveyor. Speech therapy evaluation has been requested by Physician. 2. No other residents have been identified as using the necklace beads. Residents with oral PICA diagnosis will received speech therapy evaluation as indicated by Physician. 3. Residents with oral PICA diagnosis will receive adaptive device(s) as indicated by speech therapist. Current in-house licensed nurses will receive education regarding oral PICA and adaptive devices by 1 pm on 7/19/18. Education will be provided by Regional Nurse Consultant. 4. Identified residents will be monitored daily using PI tool to ensure appropriate oral devices have been assessed by speech therapy. 5. Any new recommendations will be discussed in monthly QAPI meeting. On 7/18/18 at 5:30 p.m., the DON, Corporate Nurse and Administrator provided the packaging for the teething necklace. The necklace was a "Nuby Teething Necklace". Product information included in the packaging read, "Teething Trends Silicone Jewelry is fashion forward for mom and provides comfort to baby's gums. A variety of colors captivate your baby while the soft silicone provides stimulation to gums and emerging	F 689		

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F 689	Continued From page 94 teeth." The product was found on the Nuby website in the "Teethers" section. The website https://www.nuby.com/usa/en/teethers was accessed on 7/24/18 at 9:35 a.m. The Teethers" section read "Teething is one of the most difficult stages of early development. Our teethers are designed to make it easier on both of you with soft silicone that soothes those sore gums and calms fussy babies." The DON stated that she purchased the necklace on the recommendation of the psychology nurse practitioner. The DON stated that a mother wears the necklace around her neck and the baby chews on the necklace while the mother holds the baby. It was reviewed with the DON that the mother is with the baby, supervising the baby at the time of use. The DON stated that Resident #37 was supervised while wearing the necklace and she does not wear it at night. It was reviewed that Resident #37 was unsupervised, as she was in her room alone for at least 30 minutes wearing the necklace. The DON stated that Resident #37 was not supposed to be left alone with the necklace. The DON stated "she was supposed to be supervised." It was reviewed with the DON, Corporate Nurse and Administrator that Resident #37's admitting nursing note documented that the resident was admitted with a teething ring. It was reviewed that a teething ring and a beaded teething necklace are different devices. A teething ring can not be swallowed. On 7/19/18 at 9:05 a.m. an interview was held with the DON. When asked how the facility	F 689		

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F 689	Continued From page 95 decided to provide the teething necklace, the DON stated that it was decided during a phone conversation with the psychology nurse practitioner. The DON stated they were trying to find something appropriate Resident #37 could put in her mouth to address her constant chewing behavior. They decided on the teething necklace which was purchased at the store by the DON. The following information about the eating disorder Pica was accessed at the National Eating Disorders website on 7/24/18 at 12:39 p.m. at https://www.nationaleatingdisorders.org/learn/by-eating-disorder/other/pica "EVALUATION & DIAGNOSIS · There are no laboratory tests for pica. Instead, the diagnosis is made from a clinical history of the patient. · Diagnosing pica should be accompanied by tests for anemia, potential intestinal blockages, and toxic side effects of substances consumed (i.e., lead in paint, bacteria or parasites from dirt). WARNING SIGNS & SYMPTOMS OF PICA · The persistent eating, over a period of at least one month, of substances that are not food and do not provide nutritional value. · The ingestion of the substance(s) is not a part of culturally supported or socially normative practice (e.g., some cultures promote eating clay as part of a medicinal practice). · Typical substances ingested tend to vary with age and availability. They may include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal, ash, clay, starch, or ice. · The eating of these substances must be	F 689		

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developmentally inappropriate. In children under two years of age, mouthing objects-or putting small objects in their mouth-is a normal part of development, allowing the child to explore their senses. Mouthing may sometimes result in ingestion. In order to exclude developmentally normal mouthing, children under two years of age should not be diagnosed with pica.
· Generally, those with pica are not averse to ingesting food.

RISK FACTORS
· Pica often occurs with other mental health disorders associated with impaired functioning (e.g., intellectual disability, autism spectrum disorder, schizophrenia).
· Iron-deficiency anemia and malnutrition are two of the most common causes of pica, followed by pregnancy. In these individuals, pica is a sign that the body is trying to correct a significant nutrient deficiency. Treating this deficiency with medication or vitamins often resolves the problems.
· A medical professional should assess if the behavior is sufficiently severe to warrant independent clinical attention (e.g., some people may eat nonfood items during pregnancy, but their doctor may determine that their actions do not indicate the need for separate clinical care)."

Nurse Practitioner notes were reviewed. Notes were documented as follows:

9/6/17 The plan section read, "3. Pica- h/o (history of) GI (gastrointestinal) bleed" and "5. Dysphagia (difficulty swallowing)- SP (speech therapy)

9/12/17 "Patient with history of dementia which

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F 689	Continued From page 97 has been worsening. The hypomagnesium (low magnesium) is not an acute finding but has been worsening she is in her bed resting today." 9/26/17 "Patient is seen today regarding her multiple vitamin/ mineral deficiencies. She has a noted magnesium level of 1.3, which is critically low. Yesterday afternoon, she began biting herself and 'gnawing at her fingers' per psychiatry and nursing staff. I asked her to be sent to the ER (emergency room) for IV (intravenous) replenishment, hydration and full assessment. Per staff, she returned later last night with a diagnosis of 'dementia' per discharge paperwork. Staff called the ER and were told (per Wing 4 charge nurse) that 'her magnesium levels were normal and that lab was almost 4 days old'. The ER did not return any lab results or other notes with her. We will request these as well as repeat her labs stat (Magnesium and CBC [complete blood count] since these were her most critically low readings). I have already written for a hematology consult to assess her reasons for malabsorption." The plan section read, "PICA: Psychiatry feels this is related to her deficiency of multiple vitamins/ minerals not an underlying psychiatric issue. Dementia does cause further complication of this. Will address the underlying deficiencies and follow from there." 10/5/17 "Her dementia appears stable and her PICA has slightly improved. She does tend to continue to bite on anything she has in her mouth." The plan section read, "PICA: Has improved slightly. Will continue supplements and continue to monitor." 10/13/17 "Of note, patient has also gained weight and her PICA has improved." The plan section	F 689		

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F 689	Continued From page 98	F 689		

read, "PICA: Improved with diet and weight gain. Continue to monitor."

12/8/17 "She has been noted by staff to have started 'eating things again' including on nurse reporting that she was 'biting at her own arm'." The plan read "2. DEMENTIA: She exhibits continued cognitive decline. Continue monitoring and medications as ordered. 3. PICA: Continue monitoring and labs are obtained. Likely related to deficiency. Will assess labs and adjust treatment as indicated."

12/23/17 Past Medical History included "dysphagia" and "dementia, multifactorial". The plan read "Dementia: Resident continues to decline unresponsive to therapy." and "Dysphagia: Aspiration precautions. Weekly weights. Close observation with food ingestion. Sit up right in chair."

1/22/18- no mention of PICA

5/22/18 "She is wheelchair and bed bounds at this time and is total assist." "She may follow some commands at the time, but for the most part, she is symptoms of severe dementia." No mention of PICA. Labs ordered.

6/20/18 Diet: pureed Plan: PICA: labs ordered

Speech Therapy notes were reviewed. Notes were documented as follows:

Speech Therapy note from hospital stay prior to admittance to the facility on 9/4/17. The hospital Speech Therapy note read "strict aspiration & reflux precautions".

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F 689	Continued From page 99 4/24/18 The Speech Therapy Initial Eval note read, "Patient Referral and History"section: "Pt (patient) with fast rate of intake and needs supervision, verbal cues to slow rate." The "Clinical Impressions" section read, "Due to ongoing decline in cognitive abilities, patient is currently a dependent feed and demonstrates good potential for diet advance with caregiver assist to follow safe swallowing precautions." 7/18/18 "Short-term goals" read, "Patient will demonstrate safe oral manipulation of a non nutritive resistive chewing device (i.e. Chewy Tube, Y-Chews, Etc) for up to 15 minutes without s/s (signs/symptoms) aspiration, gagging or distress." "Long-Term Goals" read, "Patient will demonstrate a reduced risk of ingesting inedible objects and inflicting self harm via safe use of a non-nutritive chewing device between meals." The "Clinical Impressions/ Recommendations" section read, "Caregivers are independent and compliant with previous recommendations to follow aspiration precautions." "Patient does present with behaviors associated with Pica most evident between meals including biting/chewing/ingesting inedible objects and biting/chewing on self. To reduce frequency of these behaviors, patient would benefit from speech therapy to conduct a trial using non nutritive resistive chewing devices such as a Chewy-tube or Y-Chews device to determine the safest and most effective intervention to reduce frequency of behavior and to decrease risk of aspiration, accidental ingestion of a non food item and self harm." The description of "Aspiration precautions" was accessed on 7/24/18 at 11:34 p.m. at the website	F 689		

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F 689	Continued From page 100 https://www.drugs.com/cg/aspiration-precautions.html. Aspiration precautions: "Aspiration means that foods or fluids get into your airway. This can lead to trouble breathing or lung infections such as pneumonia. Aspiration precautions are practices that help prevent these problems." The recommendation for "aspiration precautions" and/or "swallowing precautions" was documented in Resident #37's clinical record in all three speech therapy notes and the 12/23/17 nurse practitioner note. The facility was asked on multiple occasions to provide the aspiration policy or protocol used at the facility. On 7/23/18 at 1:40 p.m., the DON stated that the facility did not have an aspiration protocol. Nursing notes were reviewed. Notes were documented as follows: 9/4/17 "Patient arrived with a childs teething ring + pacifiers as she bites anything + places it in her mouth." 9/15/17 "Resident continues to enter other residents' rooms, grabbing everything (trash, diapers, papers etc to eat) 12/7/17 "Resident keeps biting her arms and hands The wound on her left forearm bigger and bigger. Resident took dressing off. Writer apply a new dressing and wrap with Kerlix on her left arm to prevent Resident biting her wound again. Continue to monitor." 12/7/17 "Resident continues to bite on her hands, arms and noted to be chewing on side rail to	F 689		

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F 689	Continued From page 101 wheelchair (arm of chair). Pillow case wrapped around arm of chair. redirecting resident frequently. Notified NP (Nurse Practitioner)" 12/8/17 "Resident alert. confusion. Still keeps bit things including her hand and arm." 6/20/18 "Res. obs. chewing on table. Res given an object acceptable for chewing 6/21/18 "Continues to chew on object provided by nursing." In summary, Resident #37 was known to have severe dementia, have a swallowing difficulty and known to repeatedly place non food items in her mouth. She was observed alone in her room for at least 30 minutes alternating between stuffing a beaded necklace into her mouth and gripping the beads with her teeth and forcefully pulling the necklace with her hands. She was observed in the dining room stuffing the beads into her mouth. She was not redirected by staff. Speech Therapy had never seen the necklace. Speech Therapy did not recommend, evaluate or provide the beaded necklace. When the necklace was given to the survey team, two beads were observed to be missing. The DON stated Resident #37 should not have been left alone with the necklace. 1b) Resident #37 fell on 12/10/17 requiring an emergency room visit and sutures to the head. She fell again without injury on 3/16/18 as a result of being left unattended in a standing position by staff. She fell a third time on 6/7/18 requiring an emergency room visit and sutures to the head.	F 689		

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F 689	Continued From page 102 Resident #37's three falls are listed below: 1. 12/10/17 fall The "Fall Root Cause Investigation Report" read, "-Breakfast up to floor @ 10 AM- resident in day room -Approx 11 AM CNA (certified nursing assistant) informed writer resident on floor in day room - Resident on knees in floor with head on floor trying to bite cord to box fan beside her blood noted on side of fan probably hit her head on side of fan. w/c (wheelchair) over backside of resident locked. - Blood (fresh) from laceration to forehead + L temple appears to need stitches- area cleansed + bandage applied- resident put in w/c and ambulance called- No RP (responsible party)- NP (nurse practitioner) (name) called + informed- resident out to ER (emergency room) @ 11:15 AM". 12/10/17 "Discharge Instructions" from the ER visit read, "Sutured Wound Care" "Your cut has been cleaned and closed with stitches." The instructions also read, "Wound Care- Facial Laceration" "You have been treated for a laceration on your face. A laceration is a cut through the skin. This will usually require stitches if it is deep." A "Weekly Skin Integrity Review" form was included in the clinical record. On 12/15/17, documentation in the "Current skin condition" section read, "6 sutures to forehead". 2. 3/16/18 fall The "Fall Root Cause Investigation Report" documented that the resident was "toileting" prior to the fall or at the time of the fall. Attached was	F 689		

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F 689	Continued From page 103 a witness statement which read, "I, (name), was assigned to (resident name): I was in the process of changing her: she had been playing in feces: I stood her up and she held on to the night table: I went to the sink to wet a towel to clean her up: before I got back t her she lost her Balance and Feel (sic): (she slightly hit her left side of head on her wheel chair." The most recent Minimum Data Set assessment completed prior to the fall had an assessment reference date of 12/28/17. She was coded as a 4/3 (total assistance/ 2 persons) for "Transfers" between surfaces and standing position. On 3/16/18, a "Fall Risk Evaluation" was completed. Resident #37 scored a 10, indicating "high risk" for potential falls. 3. 6/7/18 fall 6/7/18, 3:10 p.m. nursing note read, "Resident was found on the floor in her bedroom. Before the event occur the resident was lying bed. The resident have a deep laceration to the L forehead. The laceration was cleaned a dressing was applied. Resident was sent out to (hospital) for eval." 6/7/18, 8:00 p.m. nursing note read, "Call ER (emergency room to get information on how many sutures, wasn't in the chart @ the hospital on how many. Upon assessment it look to be 3 sutures on the left side of forehead." The hospital emergency provider report "stated complaint" read, "Head Pain". Diagnostic tests included CT (computerized tomography) scan of the head and spine. Both had negative findings. The hospital discharge summary read, "suture	F 689		

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F 689	Continued From page 104 care". Resident #37's care plan initially dated 9/7/17 was reviewed. There was no focus area specific to fall prevention. The focus "(Resident name) has the potential for injury r/t (related to) pica, dementia, poor communication/ comprehension, poor safety awareness, impaired mobility" included safety interventions. Interventions included 9/15/17 revised 5/4/18: be sure call light is within reach 9/15/17 revised 5/4/18: ensure appropriate footwear 9/15/17 revised 5/4/18: Follow facility fall protocol 9/7/17: keep needed items, water, etc, in reach The care plan interventions were not reviewed and revised after each fall. On 7/19/18 at the end of day meeting, Resident #37's falls with injury and lack of supervision were reviewed with the Administrator and Director of Nursing. They were also notified that it did not appear that the care plan interventions were updated. All information regarding the falls was accepted and reviewed. No information was provided about the care plan. COMPLAINT DEFICIENCY 2) Resident #64 had multiple falls. After a therapy screen, the facility did not implement using colored tape on the call bell as a visual reminder to use his call bell for assistance. Resident #64 was admitted to the facility on 2/23/18. Diagnoses included, but not limited to,	F 689		

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F 689	Continued From page 105 High blood pressure, heart failure, Dementia and history of falling. Resident #64's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 5-15-18 coded Resident #64 with severe cognitive impairment. The MDS was completed as a quarterly assessment. The resident required extensive assistance with ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident could feed himself. The resident was incontinent of bowel and bladder. The resident was coded as having two falls since the last assessment with no injury. On 2/26/18, the SBAR (situation, background, appearance, resident evaluation) recorded, "Found resident sat (sic) on floor many times with no injury." On 5/25/18, the SBAR report documented a fall. No specifics documented. On 6/29/18, the resident was found "sitting on bedside mat." No injuries were noted. A rehabilitation referral was reviewed with a date of 7-2-18 . It included to "add bright color to call bell." On 7/18/18 at 9:14 AM, Resident #64 was observed in his room, in a wheelchair. The call bell was on the bed. There was no tape or color added to the call bell. When asked if he had fallen before, he stated he had fallen before and hit his head. There was a fall mat on the floor beside the bed and the bed was against a wall.	F 689		

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F 689	Continued From page 106 On 7/19/18 11:00 AM: Surveyor requested the rehabilitation referral copy yesterday, have not received. On room check, the resident now has colored tape on his call bell. The rehabilitation form was provided. Review of the care plan dated 5-23-18 revealed the resident had a potential for injury related falls, unsteady gait, psychotropic medication and tremors. On 7/18/18, an intervention was added to the care plan to add "color to call bell." On 7/19/18 at 4:10 PM, the facility Administrator and Director of Nursing were notified of above findings.	F 689		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.	F 712		9/5/18

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F 712	Continued From page 107 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure for 1 resident (Resident #37) of 51 residents in the survey sample that a physician visit was completed at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. Resident #37, a current resident, was assessed by the physician upon admittance to the facility on 9/6/17. She had not been assessed by a physician in the last 10 months. In addition, Resident #37 did not have a physician visit from 1/22/18- 5/22/18, a time period of four months. The findings included: Resident #37, a 64 year old, was admitted to the facility on 9/4/17. Her diagnoses included dementia, dysphagia, and pica. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/28/18. Resident #37 was coded with severely impaired cognitive skills. She required extensive assistance with activities of daily living and was coded as a 4/2 (total dependence, one person assistance) for eating. Physician and Nurse Practitioner notes were reviewed. Progress notes were completed on the following dates: 9/6/17 Physician note 9/12/17 Nurse Practitioner note	F 712	1. Resident #37 was seen by Physician on 7/30/2018. 2. Quality review of current residents by Regional Director of Clinical Services to ensure physician visits completed per regulation/standard. Follow up based on findings. 3. Physicians re-educated by the Administrator/ designee regarding requirements for visits, frequency and timeliness. 4. DON/UM/Medical Records or designee to conduct quality monitoring to ensure residents are seen by Physician per regulation. 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 712	Continued From page 108 9/26/17 Nurse Practitioner note 10/5/17 Nurse Practitioner note 10/13/17 Nurse Practitioner note 12/8/17 Nurse Practitioner note 12/23/17 Nurse Practitioner note 1/22/18 Nurse Practitioner note 5/22/18 Nurse Practitioner note 6/20/18 Nurse Practitioner note The issue was reviewed with the Administrator and Director of Nursing at the end of day meeting on 7/19/18. On 7/23/18 at the end of day meeting, the Director of Nursing agreed that Resident #37 had not been seen by a physician.	F 712		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		9/5/18

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F 755	Continued From page 109 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to dispose of two expired medications. Expired Famotidine was found in the wing one medication room and expired Lantus was found in the wing one medication cart. The findings included: On 07/17/2018 at approximately 3:00 pm, an inspection was conducted of the wing one medication room and the wing one medication cart. In the medication room, a box of Famotidine 10 milligram tablets was found to have an expiration date of 5/2018. On the medication cart, a bottle of Lantus was found with an open date of 05/18/2018 and a discard date on 06/17/2018. During the inspection, LPN H was interviewed. LPN H stated that the expired medications should have been discarded.	F 755	1. Expired Famotidine from wing one medication room discarded 7/17/2018. Expired Lantus from wing one medication cart discarded and reordered 7/17/2018. 2. Quality review of medication carts and medication rooms completed including medication refrigerator by Divisional Director of Nursing and Divisional Clinical Quality Specialist to ensure no other medications are expired. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to	

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F 755	Continued From page 110 The facility's policies and procedures were reviewed. The policies and procedures for Disposal/Destruction of Expired or Discontinued Medication read, "Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction." The facility was informed of the findings during a meeting on 07/19/18 at 04:16 PM	F 755	ensure expired medications are discarded. 4. DON/UM/designee to conduct quality monitoring medication carts and medication rooms including medication refrigerator to ensure no medications are expired, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to notify the physician of laboratory results for one resident (Resident # 361) in a survey	F 773	1. Resident #361 was discharged from the facility on 9/20/2017. 2. Quality review of current resident□s	9/5/18

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F 773	Continued From page 111 sample of 51 Residents. For Resident #361, the facility staff failed to notify physician of a urine culture and sensitivity report in August 2017. Findings included: Resident #361 was admitted to the facility on 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral Arterial Disease. Review of the Resident # 361's closed clinical record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder. Review of Resident #361's laboratory reports revealed a report for a urine culture and sensitivity collected on 8/11/2017 with results reported on 8/13/2017 of the bacteria Serratia Marsescens along with the sensitivity report. There was a note written on the report which stated: MD (Medical Doctor) never notified!! (initialed by	F 773	who have received lab services within the last 30 days conducted by Assistant Director of Nursing and Unit Managers to ensure Physicians were notified of lab results. Physician notification of labs reviewed in Morning Clinical Meeting. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to ensure Physician is notified of lab results with documentation. 4. DON/UM/designee to conduct quality monitoring to ensure Physician is notified of lab results with documentation in the medical record, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 773	Continued From page 112 physician) 8/19 Bactrim ordered." Review of Resident #361's Interdisciplinary notes revealed no documentation of the physician being notified of the urine culture and sensitivity results prior to the doctor's note written on the lab report on 8/19/17. During the end of day debriefing, the facility Administrator, Director of Nursing, and Corporate Consultant were informed of the findings. The Director of Nursing and Corporate Consultant stated the facility staff should notify the physician of all lab values as soon as the report becomes available. No further information was provided.	F 773		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and	F 791		9/5/18

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F 791	Continued From page 113 (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, clinical record review, facility documentation review, the facility staff failed for 1 resident (Resident #109) in the survey sample of 51 residents to provide routine dental services. For Resident #109, the facility staff failed to obtain a referral to dental services to ensure his dentures fit properly for approximately one year. The findings include: Resident #109 was a 71 year old male admitted to the facility on 01/30/2015 with diagnoses of	F 791	1. Resident #109 received dental services on 7/23/2018. 2. Quality review of current residents conducted by Director of Nursing, Assistant Director of Nursing and Unit Managers to determine need/validate provision of dental services. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to	

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F 791	Continued From page 114 spinal stenosis, essential hypertension, other abnormalities of gait and mobility, other osteoporosis without current pathological fracture, low back pain, gastro-esophageal reflux disease, anemia unspecified, schizophrenia unspecified, major depressive disorder single episode, anxiety disorder unspecified, chronic viral hepatitis C, and dysphagia, oropharyngeal phase. The quarterly Minimum Data Set (MDS) dated 06/12/2018 for Resident #109 indicated a Brief Interview for Mental Status summary score of 15. For self-performance for eating, Resident #109 requires supervision for oversight, encouragement, and cueing. In addition, Activities of Daily Living Support is coded for set-up help only. On 07/17/2018 at 2:10pm during an interview with Resident #109 he stated, "My dentures hurt, and I can't wear them. I need them to eat my food. The therapist is working on getting these adjusted." Resident #109 stored dentures in a container at his bedside. On 07/18/2018 at 12:52pm, a record review of Resident #109's MDS annual assessment dated 03/13/2018 indicates resident has no broken or loosely fitting dentures. An Oral Status Evaluation form dated 05/02/2018 stated that the resident "does not wear his dentures, (resident) stated they don't fit and they hurt when he wears them." A speech therapy note dated 07/03/2018 states, "Patient is edentulous [lacking teeth]. He reports owning dentures that "hurts" when he wears them." The Care Plan revised on 06/14/2018 indicated Resident #109 requires staff participation with personal hygiene and oral care.	F 791	ensure residents mouth/teeth are evaluated/assessed and dental services provided as indicated. CNAs re-educated to report dental concerns. 4. DON/UM/designee to conduct quality monitoring of dental services provided as indicated 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 791	Continued From page 115 On 07/19/2018 at 08:25am, an interview was conducted with certified nursing assistant (CNA) #1 who cares for Resident #109. CNA #1 stated Resident #109 wore his dentures "once or twice" last year when he first received them but hasn't worn them since because they are "too tight". On 07/19/18 at 12:55pm, an interview was conducted with the unit manager, licensed practical nurse (LPN) #1, and she verified the signature on the oral evaluation form was hers. When asked what was done after learning the dentures did not fit well, LPN #1 stated, "He never said he wanted new dentures." On 07/19/2018 at 1:10pm, LPN #1 and this surveyor entered the room of Resident #109. The resident stated the dentures make him gag and the bottom dentures hurt his gums. He said he wants to wear his dentures but he is unable to because they don't fit and cause pain. LPN #1 opened the denture cup at resident's bedside. The dentures were submerged in water and appeared new, clean, and intact. According to the facility's policies and procedures regarding dental services, the facility will obtain an order for dental consult when indicated. On 07/19/2018, the Director of Nursing was asked to provide documentation of referral for dental services, documentation of dentist and physician notified of painful dentures, and comprehensive assessment documentation of dental condition and impact on residents function. No further documentation was offered.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		9/5/18

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F 842	Continued From page 116 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		

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F 842	Continued From page 117 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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 observation, staff interview, and facility documentation review, the facility staff failed to 1) document the administration of Tylenol to Resident #1 during a medication administration observation and 2) failed to document a blood sugar reading or medication administration in the clinical record for Resident #49 and 3) failed to maintain an accurate clinical record for Resident # 361. The request for consultation form reported he was insulin dependent and his insulin had been discontinued a month prior to the	F 842	1. Resident #1 received Tylenol per Physician order on 7/18/2018, with late entry documentation in the Medication Administration Record on 8/13/18. Resident #49 received medications per Physician order; late entry documentation for 7/16/2018 was completed	

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F 842	Continued From page 118 consultation request. The findings included: 1) For Resident #1 the facility staff failed to document the administration of Tylenol On 07/18/2018 at approximately 9:23 am, a medication administration observation was conducted with LPN G. Among other medications, LPN G prepared two 500-milligram tablets of Tylenol for Resident #1. LPN G administered the medications including the Tylenol to Resident #1. During the reconciliation process on 07/18/2018, Resident #1's July Medication Administration Record (MAR) was reviewed. The MAR showed that Resident #1 Tylenol was not signed off as given. The facility was informed of the findings during a meeting on 07/19/18 at 04:16 PM 2) For Resident #49, the facility staff failed to document a blood sugar reading or medication administration in the clinical record. Resident #49 was a 74 year old who was admitted to the facility on 1/30/18. Resident #49's diagnosis included Diabetes Mellitus Type 2, Acute Kidney Failure, and Hypertension. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 5/11/18, coded Resident #49 as having A Brief	F 842	on 7/17/2018. Resident #361 was discharged from facility on 9/20/2017. 2. Quality review of current resident□s Medication Administration Record (MAR) was completed by Divisional Director of Nursing and Divisional Clinical Quality Specialist to ensure medications were administered per Physician order with documentation in the medical record. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to ensure medications are documented post administration. 4. DON/UM/designee to conduct quality monitoring of MAR for omissions, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 842	Continued From page 119 Interview of Mental Status Score of 15, indicating no cognitive impairment. She was also coded as requiring insulin injections for 7 out of 7 days during the assessment period. On 7/18/18 a review was conducted of Resident #49's clinical record. Resident #49's signed Physician Order read, "Humalog 100 Unit. Inject subcutaneously per sliding scale before meals and at bedtime; If 141-180 = Give 4 Units Subq; 181-220= Give 6 Units 221-260= Give 8 Units 261-300 = Give 10 Units 301-350 = Give 12 Units 351-400 = Give 16 Units Greater than 401 Give 16 Units and Call MD (medical doctor)." Resident #49's clinical record contained a Medication Administration Record that did not contain documentation of a Blood Sugar level, or medication administration of insulin on 7/16/18 at 7:30 A.M. In addition, the Interdisciplinary Progress Notes did not contain any entries on 7/16/18. On 7/18/18 a review was conducted of facility documentation, revealing a Medication Administration Policy dated September, 2016 that read, "It is the policy that the resident can expect safe and accurate administration of medication. Chart on MAR (Medication Administration Record)." The facility also submitted an Oral Administration of Medications Policy dated 9/22/17. It read, "Chart on Medication Administration Record immediately following when medication is given and before proceeding	F 842		

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F 842	Continued From page 120 to the next resident." On 7/18/18 at approximately 3:00 P.M. an interview was conducted with the Director of Nursing (Administration B) in the conference room. She stated, "The nurse should notify the physician and assess the resident, and document on the MAR. That shows we followed thru with the physician's order. Initials should be circled and a nurse's note put on back of the MAR. Blood sugar should be on the MAR." When asked about the importance of implementing the physician's orders, the Director of Nursing stated, "The physician gave the orders, that's the way we monitor whether or not we should give insulin. That's the physician's communication to us to determine if the quantitative value he set for the resident is correct. It it was hyperglycemic or hypoglycemic I would expect them to tell me what was done for the resident." On 7/18/18 the facility Administrator (Administration A) was informed of the findings. No further information was received. 3) For Resident # 361, the facility staff failed to maintain an accurate clinical record. The request for consultation form reported he was insulin dependent and his insulin had been discontinued a month prior to the consultation request. Resident #361 was admitted to the facility on 7/28/2017 for skilled services in nursing and therapy related to altered mental status and Cerebrovascular Accident. Diagnoses included but were not limited to Cerebrovascular Disease, Diabetes, Parkinsonism, Hypertension, Diabetic Neuropathy, Chronic Kidney Disease, Peripheral	F 842		

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F 842	Continued From page 121 Arterial Disease. Review of the Resident # 361's closed clinical record revealed the most recent MDS (Minimum Data Set) was an Admission Assessment with an ARD (Assessment Reference Date) of 8/9/2017. Resident # 361 was coded as having a BIMS (Brief Interview of Mental Status) of 13/15 indicating no cognitive impairment. The resident was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) including bathing except for eating, where he was coded as independent and requiring set up only. Resident # 361 was coded as always incontinent of bowel and bladder. Review of Provider Progress Note dated 9/13/2018 revealed note written by Nurse Practitioner which stated resident had "Diabetes: well controlled on diet, repeat A1C in October. No changes." Review of "Request for Consultation" form completed by the attending physician dated 9/19/17 under Findings-Diabetic- insulin dependent-pedal pulses non palpable- non healing ulcers-2 month duration Diagnosis-Stage II-III diabetic ulcers both feet secondary to PVD (Peripheral Vascular Disease and Neuropathy." Recommendations: Needs to be admitted to the hospital for vascular, I.D. (Infectious Disease and Orthopedic evaluation.." Resident # 361 did have Diabetes but was not insulin dependent at the time of the report. According to the clinical record, insulin had been discontinued on 8/12/2017.	F 842		

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F 842	Continued From page 122 During the end of day debriefing on 7/19/2018, the Administrator and Director of Nursing stated clinical records should be complete and accurate. No further information was provided.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		9/5/18

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F 880	Continued From page 123 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review the facility staff failed to 1) clean four glucometers during a medication administration observation according to	F 880	1. LPN F re-educated on glucometer disinfecting and hand hygiene related to medication administration by Staff Development Coordinator. LPN I re-	

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F 880	Continued From page 124 manufacturer's instructions and 2) failed to perform hand hygiene between three residents during medication administration The findings included: 1) During a medication administration observation on 07/17/2018 from approximately 4:25 pm to 4:37 pm, LPN F clean three different glucometers with an alcohol pad before use. LPN F did not clean the three glucometers after use. During a medication administration observation on 07/17/2018 at approximately 4:48 pm, LPN I was observed to clean one glucometer after use with an alcohol pad. The instructions for cleaning the glucometers were obtained from the facility. Alcohol only pads were not listed as an approved way to clean the glucometers. The facility's policies and procedures were reviewed. The policies and procedures for Blood Glucose Monitoring and Disinfecting read, "Meter to be cleansed utilizing a disinfectant wipe (according to manufacturer's guidelines for wet time) if the meter is visibly soiled, or dropped." The facility was informed of the findings during a meeting on 07/19/18 at 04:16 PM 2) During a medication administration observation on 07/17/2018 from approximately 4:25 pm to 4:37 pm, LPN F failed to perform hand hygiene between three residents during medication administration. After the observation on 07/17/2018 at approximately 4:43 pm, LPN F	F 880	educated on glucometer disinfecting on by Staff Development Coordinator. LPN F demonstrated hand hygiene competency related to mediation administration practices. LPN I demonstrated competency related to glucometer disinfection. 2. Quality review of current nurse□s glucometer competency and handwashing competency skills by Staff Development Coordinator. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee to ensure glucometers are disinfected appropriately and hand hygiene is appropriate related to medication administration. 4. DON/UM/designee to conduct quality monitoring of glucometer disinfecting, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. DON/UM/designee to conduct quality monitoring of proper hand hygiene, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 125 asked why she failed to perform hand hygiene. LPN F stated that she was "nervous." The facility's policies and procedures were reviewed. The policies and procedures for Medication administration read, "Perform Hand hygiene." The policies and procedures for Hand Hygiene read, "Hand hygiene should be performed: ... Before and after patient care" The facility was informed of the findings during a meeting on 07/19/18 at 04:16 PM	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on Observation, and facility document review, facility staff failed to maintain a safe, clean, comfortable, and homelike environment. The facility failed to treat noticeable mold and mildew odor on 1 out of 5 units, in a hall alcove across from resident rooms. The findings included: On 7/17/18 at 11:56 a.m. during initial tour of the facility, surveyors observed an alcove in the 200 hall with wallpaper hanging off the wall, revealing dark colored mold underneath. Surveyors noted a strong odor of mold/mildew in the hall by the alcove.	F 921	1. Facility repaired wallpaper identified on 200 hallway 7/18/2018, area is free from mold and mildew odor. 2. Quality review of facility conducted by Maintenance Director/designee to ensure facility is free from mold and mildew odors. Follow up based on findings. 3. Administrator re-educated by the Regional Vice President of Operations/designee to ensure facility is free from mold and mildew odor. 4. Administrator/designee to conduct quality monitoring to ensure facility is free from	9/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 07/23/2018

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F 921	Continued From page 126 Facility staff provided surveyors with documents related to a mold inspection the facility had set up following a recent incident of flooding. The first document was a Laboratory Report prepared by [LABORATORY] for [MOLD REMEDIATION COMPANY] and was dated 7/2/18. This document contained analysis of samples taken by [MOLD REMEDIATION COMPANY] onsite at the Facility. The second document was an analysis of that report, titled "Indoor Air Quality Investigation, written by [MOLD REMEDIATION COMPANY] and dated 7/6/18. The Air Quality Report states, among other findings, the following: "The visual inspection showed the walls downstairs outside the shower room were wet and crumbling." "The Ceiling and pipes/pipe insulation in the basement were wet and presenting with signs of microbial growth." "Although the levels are tremendously high, the conditions are optimal for microbial organisms to flourish." The report goes on to suggest "a list of items that should be addressed to assure that the microbial levels do not climb even higher than they currently are." Item #2 on the list is "The water damaged/wet sheetrock needs to be removed as well as any insulation inside the walls." On the morning of 7/18/18, surveyors noted that the wallpaper in the alcove was no longer hanging from the wall. The Administrator and the Director of Nursing were informed of the findings at the end of day meeting on 7/18/18. No further information was provided.	F 921	mold and mildew odor, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		9/5/18

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F 925	Continued From page 127 §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation, the facility staff failed to maintain an effective pest control program. Findings: On 7/18/2018 at 8:51AM, Surveyor A observed a roach crawling on the curtain next to the resident in room 306. A review of the provider's contract with Exterminating Unlimited INC (dated 3/3/2009) showed the contract specified that: I. Objective B. Exterminating Unlimited INC will maintain control and preventive devices and material for the following: 1. Roaches, including American, Brown-banded, German, Oriental and Smoky Browns III. Scope of Service A. Twice monthly service 2. Check all Pest Watch Report books and address any reported pest sightings 3. Apply roach control baits, and/or provide residual crack and crevice treatment in the building to manage the insect populations as needed. V. Terms and Conditions A. Exterminating Unlimited INC agrees to the following: 4. Respond to urgent service requests between regularly scheduled visits as needed A review of the Pest Watch Program sheets	F 925	1. Pest Control treatment completed in room 306 on 7/20/2018. 2. Quality review of resident rooms and facility wide by Administrators to ensure they are free from pests and rodents. Follow up based on findings. 3. Staff re-educated by the Staff Development Coordinator/designee to report pest sightings in Log Book. Maintenance staff re-educated on reviewing Pest Sighting Log with appropriate follow up. Administrator to review Pest Sighting Log in Morning Stand Up Meeting and follow up. 4. Interdisciplinary Team (IDT) to conduct quality monitoring of resident rooms utilizing the Mock Survey Process to ensure they are free from pests and rodents, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Maintenance Staff to conduct weekly Pest Sighting rounds; follow up as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring	

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F 925	Continued From page 128 showed that for the three wings identified, roaches were noted by staff on 5/22/2018, 6/11/2018, 6/19/2018, and 6/29/2018. No Pest Watch Program sheets were provided for Wing 4, and no records prior to 6/29/2018 were provided for Wing 1. No further information was provided prior to exit.	F 925	schedule modified based on findings.	