PORTSMOUTH
HEALTH AND REHAB

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Melissa Green, Administrator
Portsmouth Health and Rehab
900 London Blvd
Portsmouth, VA 23704
Provider Number 495149
Phone Number: 757.393.6864

Ms. Hudnall, 8/1/17

Please find our 2567 with our Plan of Correction (POC) attached. If you have any questions feel free to call me at Portsmouth Health and Rehab, 757.393.6864.

Sincerely,

Melissa L. Green, Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 7/11/17 through 7/13/17. Two complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 104 at the time of the survey. The survey sample consisted of 30 residents, 24 current Resident reviews (Resident #1 through #24) and 6 closed record reviews (Resident #25 through #30).

F 156 SS=E 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication.
(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting

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F 156
1. There is no opportunity to correct the letters that have already been sent to residents #25, #26 and #27.
2. Residents that require Medicare cut letters are at risk for this practice.
3. The MDS coordinators and the business office manager have been re-educated by the Administrator on ensuring the cut letters have a telephone number and a QIO number on the letters prior to being sent to a resident or the POA. An audit will be completed weekly x 12 weeks, to review any cut letters to ensure they contain all the required information.
4. Results of the audit will be discussed in the monthly QAPI meeting and re-education provided as needed 8/13/17

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

RN, MSHA, admin 7/31/17

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

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personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42

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U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

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(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and

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regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(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 paragraphs (g)(17)(i)(A) and (B) of this section.

(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

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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 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 clinical record review and staff interview the facility staff failed to provide the contact information to the independent reviewer authorized by Medicare upon issuance of a Notice of Medicare Non-Coverage for 3 residents

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in the survey sample of 30, Residents #25, 26 and 27.

The facility staff failed to provide in writing the name of the Quality Improvement Organization (QIO) and toll-free contact number to appeal and or ask questions when issued a Notice of Medicare Non-Coverage for Residents #25, 26 and 27.

The findings included:

1. Resident #25 was admitted to the facility under Medicare part A, for skilled services on 2/6/17. The resident's diagnosis included chronic respiratory failure. A Notice of Medicare Non-Coverage (NOMNC) informing the resident that the effective date coverage of current services would end on 3/9/17 was issued and signed by the resident on 3/7/17. The Form CMS (Center for Medicare/Medicaid Services) 10123-NOMNC (approved 12/31//2011) did not include the QIO name or toll-free number to call for an appeal or questions.

2. Resident #26 was admitted to the facility under Medicare part A, for skilled services on 2/14/17. The resident's diagnosis included non-specific intraventicular block (a heart condition) and subsequent cardiac pace maker insertion. A Notice of Medicare Non-Coverage informing the resident that the effective date coverage of current services would end on 3/14/17 was issued and signed by the resident on 3/13/17. The Form CMS 10123-NOMNC (approved 12/31//2011) did not include the QIO name or toll-free number to call for an appeal or questions.

3. Resident #27 was admitted to the facility under

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Medicare part A, for skilled services on 5/17/17. The resident's diagnosis included supraventicular tachycardia (a heart condition). A Notice of Medicare Non-Coverage informing the resident that the effective date coverage of current services would end on 6/5/17 was issued and signed by the resident on 6/2/17. The Form CMS 10123-NOMNC (approved 12/31//2011) did not include the QIO name or toll-free number to call for an appeal or questions.

The Form CMS 10123-NOMNC section titled "How to Ask For an Immediate Appeal" read, as follows:
* You must make your request to your Quality Improvement Organization (also known as QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
* Your request for an immediate appeal should be made as soon as possible, not no later than noon of the day before the effective date indicated above.
* The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
* Call your QIO at: {Insert QIO name and toll-free number of QIO} to appeal, or if you have questions.

On 7/12/17 at 1:30 pm, the MDS (Minimum Data Set) Coordinator #1 was interviewed. She stated that she had been responsible for issuing the NOMNC notices since January 2017. She stated she filled the forms out, explains the appeal process and obtains the resident's signatures.

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F 156	Continued From page 8 She also stated she writes the phone number to contact the QIO on the form. The resident is then giving a copy of the form. The above findings of the failure to include required contact information was shared. The MDS Coordinator was not able to explain why this was not added on the form and stated, "It just didn't get done". The above information was shared with the Administrator in her office on 7/13/17 prior to exit. No additional information was provided.	F 156		
F 159 SS=E	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid:	F 159	F159 1. No opportunity to correct previous incidents with residents involving personal funds availability 2. Residents with personal funds have the potential to be affected. 3. Resident funds will be available 7 days a week from 9:00 a.m. To 5:00 p.m. Signage will be posted on the business office door and in the receptionist area to make residents aware of the availability. Random resident interviews will be completed weekly x 12 weeks to ensure practice is in place 4. Results of the audit will be discussed in the monthly QAPI meetings and any issues identified will be addressed immediately 8/13/17	

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The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

(f)(10)(iii) Accounting and records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(C)The individual financial record must be available to the resident through quarterly statements and upon request.

(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-
(A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one

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person, the resident may lose eligibility for Medicaid or SSI.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident group interview, staff interview, and facility document review, the facility staff failed to ensure residents had access to their personal funds 7 days a week.

The findings included:

On 7/11/17 at 3:30 pm, a group interview was conducted with 13 residents in attendance. During the group interview, the residents were asked if they had access to their personal funds. Residents with personal fund accounts stated that they have access to their funds. One resident stated that they were available 5 days a week, Monday through Friday, but closed on weekends. Another resident stated that they were able to access their personal funds between 10:00 am - 11:00 am and at 1:00 pm - 2:00 pm, Monday through Friday. He stated that if they need the money on weekends, they have to wait until Monday.

During observation of the main lobby area with the Administrator on 7/12/17 at 9:00 am, there was no information posted for resident "banking hours". No signage was observed in other areas of the facility that were accessible to the residents.

On 7/12/17 at 9:15 am, the Business Office Manager was interviewed and was asked about posted information for "banking hours". She stated that there were no posting of "banking hours" because "We make them available anytime". She was asked regarding resident

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access to personal funds on weekends and she stated that on weekends, the business office and the main lobby were closed for security reasons. She was asked, if the business office is closed on weekends, how the residents would access their personal funds. She stated, "Currently, they would ask someone to call in, in an emergency situation, if they need the money. I'm the only person who has access to the cash box. The manager on duty on weekends would call the Business Manager...This had never happened in the past. The manager on duty has no key to the petty cash." She stated that the facility had no process/policy in place for accessing the residents' personal funds.

On 7/12/17 at 1:15 pm, observed a sign for "banking hours" posted in the main hallway bulletin board and another posted on the door to the receptionist office. The notice read, "Resident Banking Hours. Monday-Friday, 10 AM - 11 AM, 1 PM - 2 PM".

On 7/13/17 at 9:00 am, an interview was conducted with the Administrator and she stated that at other facilities owned by the company, they had kept "banking hours" on Saturdays until 12 noon. She stated that they will provide the same service at this facility. It was discussed that the resident personal funds should be accessible to the residents on an ongoing basis.

On 7/12/17 at 10:20 am, the Business Office Manager provided a copy of the policy and procedure titled, "Resident Trust Fund Policies". The policy had no information that addressed access to resident personal funds.

The Administrator and the DON were made

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F 159	Continued From page 12 aware of these findings on 7/13/17 at approximately 3:45 pm. No further information was provided.	F 159		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to display a posting to identify the location of the past three (3) year's survey	F 167	F167 1. The issue was corrected immediately on 7/12/17 during the survey. 2. Residents and visitors have the potential to be affected by this practice 3. Signage has been placed in 4 areas of the facility to ensure everyone is aware of where the survey results are located. An audit will be added to the morning round list to ensure that these signs remain in place. 4. Morning round sheets will be reviewed in the monthly QAPI meetings to ensure this item is consistently checked during morning rounds. Any discrepancies will be corrected immediately. 8/13/17	

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F 167	Continued From page 13 results. The findings included: During the General Observation of the facility on 07/11/17 through 07/13/17 the facility staff failed to post a sign for the location of the past three (3) years of survey results. An interview was conducted with the Administrator on 07/12/17 at approximately 10:35 a.m., who stated, "There were three (3) postings in the front lobby giving the location of the survey results, I have no idea what happen to them." The surveyor requested a policy for the posting of survey results, the Administrator replied, "I don't have a policy for the posting of survey results because it's a CMS requirement anything that is a CMS requirement, there's no policy." The above information was shared with the Administrator and Director of Nursing (DON) during a pre-exit meeting on 07/13/17 at 3:45 p.m. No additional information was provided.	F 167		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility staff failed to promote care to maintain or enhance the dignity for 1 out of 30	F 241		

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residents (Resident #14) in the survey sample.

The facility staff failed to provide Resident #14 with a clothing protector during lunch.

The findings included:

Resident #14 was admitted to the facility on 07/05/17. Diagnosis for Resident #14 included but not limited to *GERD (gastroesophageal reflux disease) and *Morbid Obesity.

Resident #14 is a new admission and does not currently have a completed MDS assessment. Resident #14's Admission Data Collection Form revealed the following information under Cognitive/Communication/Mood & Behavior: no problems with short or long term memory loss.

On 07/12/17 at approximately 12:25 p.m., during observation in the main dining room during lunch, Resident #14 was observed with a sheet covering her upper chest while eating her lunch.

An interview was conducted with Resident #14 who stated, "I would rather have a protector over my clothes; I knew we were having spaghetti and I didn't want to mess my clothes up, sometimes they have protectors to protect your clothes when eating."

On 07/12/17 at approximately 12:45 p.m., an interview was conducted with CNA #4 (Certified Nurse Aide). The surveyor asked, I noticed that Resident #14 was using a sheet as a clothing protector throughout her meal, CNA stated, "There are usually two (2) CNAs in dining room during lunch time; I don't know what happened today but I couldn't leave the residents to go get

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1. Resident # 14 was given a clothing protector immediately on 7/12/17.
2. Residents who dine in the facility have a potential to be affected by this practice
3. Clothing protectors have been placed in clear containers in each of the 3 dining areas. Staff have been re-educated by the director of nursing/ designee on the use of clothing protectors and dignity. A random audit will be completed 4 x week x 12 weeks of various mealtimes and areas to ensure that residents are given clothing protectors.
4. Audits will be reviewed in the monthly QAPI meeting and any discrepancies will be corrected immediately and re-education given as needed.

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clothing protector because someone could choke or the residents could get into an altercation with one another."

An interview was conducted with the DON (Director of Nursing) on 07/12/17 at approximately 3:15 p.m., who stated, "There should be two (2) CNA's in the dining room at all times during lunch time and a resident using a sheet as a clothing protector is unacceptable; this is a dignity issue."

The facility administration was informed of the finding during a briefing on 07/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

*GERD is a back flow of contents of the stomach into the esophagus (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

*Morbid Obesity is an excess of body fat that threatens necessary body functions such as aspiration (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

F 276 SS=D 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS — F 276

(c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interviews, the facility staff failed to ensure

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quarterly Minimum Data Set (MDS) assessments were completed no less than once every 3 months for 1 of 30 residents (Resident #20) in the survey sample.

The findings include:

Resident #20 was admitted on 12/12/16 with a diagnoses of stroke and diabetes mellitus.

The most recent Minimum Data Set (MDS) assessment that was submitted to the National Data Base, Centers for Medicare and Medicaid was dated 1/23/17, a Significant Change in Status Assessment. This was the last assessment completed for the Resident per review of the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act) Assessment Report.

During an interview with the MDS Coordinator on 7/11/17 at 4:30 p.m., it was brought to her attention the resident was listed on the 3.0 Missing OBRA assessment Report that identified the last assessment submitted to the National Data Base was dated 1/23/17. She stated she was not aware of this status and would have to investigate with a return explanation.

On 7/13/17 at 4:00 p.m., The MDS Coordinator returned to say a quarterly assessment was missed and she would open one that would have an Assessment Reference date of 7/19/17.

The facility's MDS Coordinator stated they used the Resident Assessment Instrument Manual as the guide to completion and submission of MDS assessments. The RAI Manual indicated the following: "The Quarterly assessment is used to tract the resident's status between

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1. A quarterly assessment was completed for resident # 20 with an ARD date of 7/19/17.
2. Residents that have quarterly assessments due are at risk for this practice. An audit was completed on 7/28/17 to ensure that quarterly and annual assessments were completed.
3. MDS staff re-educated by the VP of Clinical Reimbursement. Education included the process for auditing and completing the quarterly assessments. A missing assessment report will be pulled monthly to ensure no resident has a missing assessment.
4. The results of the missing assessment report will be reviewed in the monthly QAPI meeting.

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F 276	Continued From page 17 comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. At a minimum, three quarterly assessments and one comprehensive assessment are required in each 12 month period, not less frequently than once every three months."	F 276		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278	F278 1. Corrections to residents #16, #10 and # 11 were made on 7/27/17 2. An audit was completed on the most current assessments for residents currently residing in the facility to ensure the assessment accurately reflected the status of the resident. This audit was completed 8/8/17. 3. The MDS staff were re-educated by the VP of Clinical Reimbursement. Education included how to accurately fill out the MDS. An audit will be completed by MDS staff 3 x weekly x 12 weeks to verify that the MDS assessments accurately reflect the current status of the resident. 4. Results of the audit will be discussed at the monthly QAPI meeting	8/13/17

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subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure resident assessments were accurate and/or complete for 3 of 30 sampled residents (Residents #16, Resident #10, and Resident #11).

1. The facility staff failed to accurately code Section O0100J (Dialysis (1)) under Special Treatments, Procedures, and Programs for Resident #16.

2. The facility staff failed to accurately code section C under Cognitive Pattern (Brief Interview for Mental Status - BIMS) and section J under Health Condition (Pain) for Resident #10.

3. The facility staff failed to accurately code section B under (Hearing, Speech and Vision) for Resident #11.

The findings included:

1. Resident #16 was admitted to the facility on 3/17/17 and was readmitted on 6/16/17. Diagnoses for Resident #26 included but not limited to, high blood pressure and end stage renal disease (2).

The most recent MDS (Minimum Data Set) with an assessment reference date of 6/23/17, coded Resident #16 with a score 12 out of possible 15

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on the Brief Interview for Mental Status (BIMS), indicating Resident #16 was moderately impaired in the skills needed for daily decision making.

On 7/13/17 at 9:50 am, Resident #16 was interviewed and she stated that she received dialysis treatment on Mondays, Wednesdays and Fridays at a dialysis center. Her dialysis access site was located on her left upper arm.

On 7/13/17 at approximately 10:15 am, Resident #16's MDS (Minimum Data Set) dated 6/23/17 was reviewed. In Section O0100. Special Treatments, Procedures, and Programs, with an instruction to "Check all of the following treatments, procedures, and programs that were performed during the last 14 days"; the response was documented as "No" instead of "Yes" for dialysis treatment.

On 7/13/17 at 12:35 pm, an interview with MDS Coordinator #1 was conducted regarding the inaccurate entry in the MDS. She stated, "It should be "Yes". It was probably an oversight; I knew she was on dialysis. I was probably rushing to get it done."

On 7/13/17 at approximately 1:00 pm, the MDS Coordinator #1 presented a copy of a section in the Resident Assessment Manual titled, "Chapter 1: Resident Assessment Instrument (RAI)", dated 10/21/06. In section "1.5 MDS 3.0", it stated, "Goals: The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool...Providers, consumers, and other technical experts in nursing home are requested that MDS 3.0 revisions focus on improving the tool's utility,

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clarity, and accuracy." The facility did not have a policy on MDS.

The Administrator and the DON were made aware of these findings on 7/13/17 at approximately 3:45 pm; no further information was provided.

Definition:

(1) Dialysis - either of two medical procedures to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances by utilizing rates at which substances diffuse through a semipermeable membrane. (Source: http://c.merriam-webster.com/medlineplus/dialysis)

(2) End-stage kidney disease is the last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD). (Source: https://medlineplus.gov/ency/article/000500.htm)

2. Resident #10 was originally admitted to the facility on 03/22/16. Diagnoses for Resident #10 included but not limited to *Bipolar Disorder and *Rheumatoid Arthritis (RA).

Review of Resident #10's comprehensive Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 03/27/17 under section C (Cognitive Patterns) asked the question, "Should Brief Interview for Mental Status be Conducted" the MDS was coded yes; continued review of the MDS under section C was marked

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with dashes indicating that section C was incomplete. In addition section J under (Health Conditions) asked the question, "Should Pain Assessment be Conducted" the MDS was coded yes; continued review of the MDS under section J was also marked with dashes indicating section J was incomplete.

An interview was conducted with MDS coordinator #1 on 07/13/17 at approximately 12:50 p.m., who stated, "Section C for Cognition and section J under Pain should have been completed; I guess I just got distracted and forgot to complete those sections of the MDS."

*Bipolar Disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again (https://medlineplus.gov/ency/article/007365.htm).

*Rheumatoid Arthritis (RA). Rheumatoid arthritis (RA) is a form of arthritis that causes pain, swelling, stiffness and loss of function in your joints. It can affect any joint but is common in the wrist and fingers (https://medlineplus.gov/ency/article/007365.htm).

3. Resident #11 was admitted to the facility on 08/15/13. Diagnoses for Resident #11 included but not limited to *Epilepsy and *Depression.

Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/17 coded Resident #11 with a BIMS score of 14 out of a possible 15 indicating no cognitive impairment. In addition, the MDS coded Resident #11 requiring limited assistance of one with bed

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mobility, toilet use and personal hygiene and supervision of one with transfers, dressing and eating. Resident #11 is occasionally incontinent of bowel and bladder.

Review of Resident #11's comprehensive MDS with an ARD of 04/21/17 was coded for moderate difficulty - speaker has to increase volume and speak distinctly but was coded 0 for wearing hearing aids or other hearing appliance used.

Resident #11's comprehensive care plan indicated a problem with the potential for impaired communication related to (r/t) impaired hearing. The goals the facility staff set for the resident was to be able to communicate basic needs. Some of the interventions included but not limited to: Assist with hearing aids as needed and allow a calm unhurried environment to encourage communication.

On 07/12/17 at approximately 9:55 a.m. and 3:05 p.m., Resident #11 was observed wearing hearing aids bilaterally.

On 07/13/17 at approximately 11:40 a.m., Resident #11 was observed wearing bilateral hearing aids.

On 07/13/17 at approximately 10:40 a.m., an interview was conducted with LPN #12 who stated, Resident #11 wears his hearing aids daily, she then stated, "The nurses put his hearing aid in his ears in the morning and removes them at bedtime; his hearing aids are stored locked inside the medication cart."

An interview was conducted with MDS Coordinator #2 on 07/13/17 at approximately

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12:40 p.m., who stated, "It was an oversite on my part, I should have marked yes for hearing aids under section B for the use of hearing aids.

The facility administration was informed of the finding during a briefing on 07/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI)

1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status.

Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.

*Epilepsy is a group of neurologic disorders characterized by recurrent episodes of convulsive seizures, sensory disturbances, abnormal behaviors, loss consciousness, or all of these (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

*Depressive disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).

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F 279 483.20(d);483.21(b)(1) DEVELOP

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483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

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

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

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

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR

1. Care plans have been reviewed and corrected for residents #1, #4 and #6 to reflect the current status of the resident and also to reflect any CAA's that triggered from the MDS.
2. An audit was completed of residents in the facility to ensure their care plan accurately reflects their status and includes any triggered CAA areas from the MDS.
3. MDS and nursing staff were re-educated on care plans by DON/designee. Education included areas triggered by CAA and updating of care plans to reflect current status of resident. A random audit will be completed on 3 resident's 2x week x 12 weeks to ensure that care plans are being updated and accurately reflect the current status of the resident.
4. Results of the audit will be reviewed and discussed monthly in the QAPI meeting.

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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 staff interview, clinical record review and facility document review, the facility staff failed to develop a Comprehensive Resident-Centered Plan of Care based on the Care Area Assessments triggered by the MDS (Minimum Data Set) for 3 of 30 sampled residents (Residents #1, Resident #4 and Resident #6).

1. The facility staff failed to develop a Comprehensive Resident-Centered Care Plan for 6 out
of 9 Care Area Assessments triggered by the MDS for Resident #4.

2. The facility staff failed to revise the

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Comprehensive Care Plan to show evidence for Care
Plan Interventions for all CAAs (Care Area Assessments) triggered by the MDS (Minimum Data Set) for Resident #1.

3. The facility staff failed to revise the Comprehensive Care Plan to show evidence for Care
Plan Interventions for all CAAs (Care Area Assessments) triggered by the MDS (Minimum Data Set) for Resident #6.

The findings included:

1. Resident #4 was originally admitted to the facility on 2/1/17 and was readmitted to the facility on 2/21/17. Diagnoses for Resident #4 included but not limited to, high blood pressure and seizure disorder.

The most recent quarterly Minimum Data Set with an assessment reference date of 5/9/17, coded Resident #4 with a score of 9 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #4 was moderately impaired in the skills needed for daily decision making.

On 7/12/17 at approximately 11:00 am, the Resident #4's clinical records were reviewed. The admission Minimum Data Set with an assessment reference date of 2/9/17, coded Resident #4 with a score of 10 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #4 was moderately impaired in the skills needed for daily decision making. Resident #4 was assessed as needing extensive assistance with one person physical assist in dressing, toilet use, and hygiene; total

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dependence in eating and bathing with one person assist; always incontinent of bowel and bladder; usually understood with difficulty in communicating words or finishing thoughts; an impaired vision, able to see large print but not regular print in newspaper/book; and at risk of developing pressure ulcers.

The Care Area Assessment (CAA) Summary dated 2/14/17 indicated that 9 Care Area Assessments were triggered by the MDS (reference date of 2/19/17) and the decision was to proceed with developing care plans for all CAAs. In reviewing the Resident #4's Comprehensive Resident-Centered Plan of Care, it was documented that only 3 CAAs were addressed in the care plan: Falls, Feeding Tube, and Dehydration/Fluid Maintenance. The 6 CAAs that were not addressed in the plan of care were the following: Cognitive Loss/Dementia, Visual Function, Communications, ADL (Activities of Daily Living) Functional/Rehabilitation Potential, Urinary Incontinence, and Pressure Ulcer.

On 7/12/17 at 12:30 pm, MDS Coordinator #1 was interviewed regarding the missing care plans for Resident #4. She stated, "It probably was missed". She was asked who was responsible for completing the resident-centered plan of care and she stated, "It was me". She was asked regarding the facility process to ensure care plans are completed for the residents. She stated, "Usually, we look through them to make sure everybody's part is put in. We haven't done it as it's supposed to be done". She stated that if care plans were appropriately done, there would be no issues but "things have fallen through the cracks" and the "system is broken". She stated that action plans were in place in formalizing the process to make

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sure comprehensive care plans were done correctly.

On 7/13/17 at 9:15 am, an interview was conducted with the Administrator regarding the missing care plans. She stated that the facility had a process to complete the resident assessments and the comprehensive care plan on admission. She stated that care plans were validated in the morning meeting and were revised daily as needed. She provided a copy of the form titled, "Morning Meeting Agenda" and it included areas to document the residents' "24 Hour Report" Issues, New Skin Issues, Weight Loss, Falls, New Restraints, and New Psychotropic Medications. The tool is utilized to identify the residents' care areas needed to develop the care plan.

On 7/12/17 at 2:00 pm, the facility provided a copy of the facility procedure titled, "Care Plan Preparation" from the Lippincott's Nursing Procedure textbook, 6th edition. It stated, in part, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings...A nursing care plan should be written for each patient, preferably within 24 hours of admission."

The Administrator and the DON were made aware of these findings on 7/13/17 at approximately 3:45 pm; no further information was provided.

2. For Resident #1, the facility staff failed to to revise the comprehensive Care Plan to show evidence for Care Plan Interventions for all CAA's

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(Care Assessment Areas) triggered by the MDS (Minimum Data Set).

Resident #1 was admitted to the facility on 3/21/17. Diagnoses for Resident #1 included but are not limited to Non-Alzheimer's Dementia*, Malnutrition and Stage IV Right Heel Pressure Ulcer*. Resident #1's Quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 6/26/17 coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 1 of 15 indicating severe cognition impairment. The MDS documented Resident #1 had vision impairment and did not wear glasses. The MDS documented Resident #1 had unclear speech.

In addition the MDS scored Resident #1 as requiring total dependence with 2 staff persons for Transfers. Resident #1 was coded as requiring total dependence with one staff person assistance for Dressing, Hygiene, and Bathing.

Review of Resident #1's Admission MDS included CAA Triggers of vision and communication. Resident #1's Current 7/7/17 Care Plan did not include focus areas of vision and communication.

The Director of Nurses was interviewed on 7/12/17 at approximately 1:15 p.m. The DON stated, "It is the Charge Nurse's responsibility first to bring issues for Care Plan updating and then MDS staff will update the Care Plan." The DON was asked if she saw included on Resident #1's current Care Plan focus areas of Communication and Vision. The DON replied, "No."

On 7/12/17 at approximately 1:35 p.m. the MDS Registered Nurse #2 was interviewed and asked

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why the Care Plan did not include the CAA triggers of communication and vision. The MDS Registered Nurse #2 stated, "It was an oversight. It should be on the Care Plan."

The Facility Staff provided a copied section from the October 2016 RAI (Resident Assessment Instrument) manual. Section 2.7 documented the following: "After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT (Interdisciplinary Team) must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs (described in detail in Chapter 4 of this manual).

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

3. For Resident #6, the facility staff failed to to revise the comprehensive Care Plan to show evidence for Care Plan Interventions for all CAA's (Care Assessment Areas) triggered by the MDS (Minimum Data Set).

Resident #6 was admitted to the facility on 8/19/15 with a readmission on 9/14/16. Diagnoses for Resident #6 included but are not limited to Stage IV Sacral Pressure Ulcer* and Non-Alzheimer's Dementia*. Resident #6's Annual Minimum Data Set (MDS-an assessment

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protocol) with an Assessment Reference Date of 8/24/16 coded Resident #6 with a BIMS (Brief Interview for Mental Status) of 8 of 15 indicating a moderate cognition impairment.

In addition the MDS scored Resident #6 as requiring Extensive Assistance with two staff person assistance for Transfers, Bed Mobility, and Dressing. Resident #6 was coded as always incontinent of Urine and frequently incontinent of Bowel functions.

Resident #6's Annual MDS CAA (Care Assessment Areas) triggered for Cognition and Communication. Review of Resident #6's Current Care Plan did not show focus areas of Cognition and Communication.

The Director of Nurses was interviewed on 7/12/17 at approximately 1:15 p.m. The DON stated, "It is the Charge Nurse's responsibility first to bring issues for Care Plan updating and then MDS staff will update the Care Plan." The DON was asked if she saw included on Resident #6's current Care Plan focus areas of Cognition and Communication. The DON replied, "No."

On 7/12/17 at approximately 1:35 p.m. the MDS Registered Nurse #2 was interviewed and asked why the Care Plan did not include the CAA triggers of communication and vision. The MDS Registered Nurse #2 stated, "It was an oversight. It should be on the Care Plan."

The Facility Staff provided a copied section from the October 2016 RAI (Resident Assessment Instrument) manual. Section 2.7 documented the following: "After completing the MDS and CAA portions of the comprehensive assessment, the

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next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT (Interdisciplinary Team) must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs (described in detail in Chapter 4 of this manual).

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

DEFINITIONS:

Non Alzheimer's Dementia: Medline Plus documented: forms of dementia other than Alzheimer's disease such as dementia caused by vascular issues

Stage IV Pressure Ulcer: The National Pressure Ulcer Advisory Panel - NPUAP documented: Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible.

F 287 SS=E 483.20(f)(1)-(4) ENCODING/TRANSMITTING RESIDENT ASSESSMENT F 287

(f) Automated Data Processing Requirement

(1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each

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resident in the facility:

(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting Data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

1. The state RAI coordinator was contacted during the survey and instruction was given on how to correct the discharge assessments and errors in transmittals. These items were corrected by 8/5/17
2. Residents that have assessments transmitted or are discharged are at risk for this practice.
3. The MDS coordinators were re-educated by the VP of clinical reimbursement. The education included transmittals, scheduling and discharge assessments.
   The audit report will be pulled monthly as part of the monthly QAPI meeting process. Any discrepancies will be corrected immediately.
4. Audit results will be reviewed in monthly QAPI meeting.

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(4) Data Format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed to assure prompt encoding and transmittal to Centers for Medicaid and Medicare (CMS) for 4 of 30 residents (Resident #21, #22, #23 and #30).

1. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 2/17/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #21 who was a current resident.

2. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 1/2/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #22 who was a current resident.

3. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 1/18/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #23 who was a current resident.

4. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 2/21/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #30 who had been discharged from the facility.

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The findings include:

1. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 2/17/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #21 who was a current resident.

The Resident's last MDS submitted and transmitted to CMS was a Quarterly and currently listed on the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act Assessment) Report dated 2/17/17.

Resident #21 was admitted to the nursing facility on 1/23/14 with diagnoses that included Dementia.

During an interview with the MDS Coordinator on 7/11/17 at 4:30 p.m., it was brought to her attention the resident was listed on the 3.0 Missing OBRA Assessment Report that identified the last assessment submitted to the National Data Base was dated 2/17/17. She stated she was not aware of this status and would have to investigate with a return explanation.

On 7/13/17 at 4:00 p.m., The MDS Coordinator returned to say the last MDS completed for Resident #21 was a quarterly assessment dated 5/17/17, but was in a batch that did not get transmitted to CMS data base.

The MDS Coordinator stated she used the RAI (Resident Assessment Instrument) Manual as the guide to completing and transmitting MDS assessments. The RAI Manual indicated that all Medicare and/or Medicaid-certified nursing homes must transmit required MDS data to

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CMS's Data Base Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System.

2. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 1/2/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #22 who was a current resident.

The resident's last MDS that was submitted and transmitted to CMS was an Annual, and was currently listed on the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act Assessment) dated 1/2/17.

Resident #22 was admitted to the nursing facility on 4/26/05 with diagnoses that included Diabetes.

During an interview with the MDS Coordinator on 7/11/17 at 4:30 p.m., it was brought to her attention the resident was listed on the 3.0 Missing OBRA Assessment Report that identified the last assessment submitted to the National Data Base was dated 1/2/17. She stated she was not aware of this status and would have to investigate with a return explanation.

On 7/13/17 at 4:00 p.m., The MDS Coordinator returned to say the last MDS completed for Resident #22 was a quarterly assessment dated 5/16/17, but was in a batch that did not get transmitted to CMS data base.

3. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 1/18/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #23 who was a current resident.

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The resident's last MDS submitted and transmitted to CMS was an Annual, and was currently listed on the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act Assessment) dated 1/18/17.

Resident #23 was admitted to the nursing facility on 1/11/17 with diagnoses that included Heart Failure.

During an interview with the MDS Coordinator on 7/11/17 at 4:30 p.m., it was brought to her attention the resident was listed on the 3.0 Missing OBRA Assessment Report that identified the last assessment submitted to the National Data Base was dated 1/18/17. She stated she was not aware of this status and would have to investigate with a return explanation.

On 7/13/17 at 4:00 p.m., The MDS Coordinator returned to say the last MDS completed for Resident #23 was a quarterly assessment dated 5/18/17, but was in a batch that did not get transmitted to CMS data base.

4. The facility staff failed to electronically transmit any Minimum Data Set (MDS) assessments after 2/23/17 to the National Data Base, the Centers for Medicare and Medicaid (CMS) for Resident #30 who had been discharged from the facility.

According to the clinical record, Resident #30 was admitted on 2/16/17 with heart disease and generalized weakness. She was discharged from the nursing facility on 2/27/17.

The resident's last transmitted Minimum Data Set (MDS) assessment was an Admission with an

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F 287	Continued From page 38 assessment reference date of 2/23/17. This was the last MDS that was submitted and transmitted to CMS and was currently on the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act Assessment) Report. During an interview with the MDS Coordinator on 7/11/17 at 4:30 p.m., it was brought to her attention the resident was listed on the 3.0 Missing OBRA Assessment Report that identified the last assessment submitted to the National Data Base was dated 2/23/17. She stated she was not aware of this status and would have to investigate with a return explanation. On 7/13/17 at 4:00 p.m., The MDS Coordinator returned to say that the resident had been discharged from the facility since 2/27/17 and they failed to complete a discharge MDS and transmit it to CMS. The MDS Coordinator stated they used the Resident Assessment Instrument (RAI) as their MDS Assessment policy. The RAI Manual indicated Discharge Assessments with a return that is not expected must be completed when the resident is discharged from the facility within 30 days.	F 287		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	F 309		

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F 309	Continued From page 39	F 309	F309	8/13/17

practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident interview, medical record review, facility documentation review, and staff interview the facility staff failed to ensure MD (Medical Doctor's) orders were followed for vascular wound care for 1 Resident (Resident #12) of 30 Residents in the survey sample.

The findings included:

1. MD orders were verified for resident # 12 to ensure accuracy
2. An audit was completed by 8/5/17 to ensure residents that were in facility had accurate Physician orders being followed
3. Licensed Nurses were re-educated by DON/designee. The education included how to transcribe orders, notation of orders and following MD orders. New orders will be reviewed in morning meeting with the clinical team to ensure orders are accurate. An audit will be completed 2x week x 12 weeks to ensure orders are accurate
4. Results of audits will be reviewed in the monthly QAPI meeting

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Resident #12 was admitted to the facility on 1/16/17. Diagnoses for Resident #12 included but are not limited to Peripheral Vascular Disease and open ulcers to Left leg. Resident #12's Quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 5/26/17 coded Resident #12 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no cognition impairment.

In addition the MDS scored Resident #12 as requiring extensive assistance with two staff person assistance for transfers, bed mobility and toileting. Resident #12 was coded as being frequently incontinent of bowel functions.

Resident #12's current Care Plan documented the following 5/22/17 focus area:
Altered skin integrity non pressure related to Vascular deficiency:
Left lateral ankle
left outer ankle
left heel
left shin #1
left shin #2
left shin #3
right 2nd toe resolved 5/22/17
Interventions documented included the following:
Treatments as ordered
Weekly Wound assessment
Conduct weekly skin inspection
Skin assessment to be completed per Living Center Policy

Resident #12's TAR (Treatment Administration Record) for July 2017 documented the following Physician ordered wound care:
7/6/17 MD order: Left anterior ankle: Cleanse

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with normal saline, apply alginate dressing to wound bed, cover with dry dressing daily.
7/6/17 MD order: Left heel: Cleanse with normal saline, apply silvadene to wound bed, cover with dry dressing daily.
7/6/17 MD order: Left outer ankle: Cleanse with normal saline, apply santyl nickel thick to wound bed, cover with dry dressing, daily.
7/6/17 MD order: Left shin area #1, top area: cleanse with normal saline, apply santyl nickel thick to the wound bed, cover with dry dressing, daily.
Skin prep apply to right second toe topically every day for protection.
Left transmetatarsal amputation site: leave open to air and monitor area at this time.
Triad Hydrophillic Wound Dressing Paste apply to scrotum topically every shift for healing.

LPN (Licensed Practical Nurse) #2 was observed doing wound care for Resident #12 on 7/12/17 at approximately 12:00 noon. LPN #2 removed Resident #12's dressing and needed to clarify wound care orders as she noted three areas of open ulcer on shin area and she observed that Resident #12 had his entire lower leg covered with dressings.
The LPN called Resident 12's Vascular Surgeon and obtained phone orders as follows:
Clean all leg wounds with normal saline, apply santyl ointment, cover with dry dressing, wrap in kling gauze.
Resident #12 refused to have his scrotum assessed as he stated that area was healed.

Review of Resident #12's Treatment Administration Record (TAR) for July 2017 showed 16 omissions for completed wound care orders. Review of Resident #12's June 2017 TAR

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showed 69 omissions for completed wound care.

Review of Resident #12's weekly skin assessments did not reveal any assessments after 6/20/17. The Director of Nurses stated that the facility wound care nurse position was discontinued July 20, 2017, and that it would have been the Resident's Nurse's responsibility to complete wound care as ordered by the Doctor. The last wound assessment on 6/20/17 only noted one wound on the shin. It did not address the two large ulcers noted at the left ankle and left heel.

A Braden Scale assessment of 1/17/17 scored Resident #12 as having "High Risk" for predicting Pressure Sore Risk".

The Director of Nursing was asked to show evidence that the 85 wound care omisions were completed. The DON stated on 7/12/17 at approximately 1:15 p.m.: "I couldn't find any explanation as to why treatments were not done." The DON added, Nursing staff is to follow the orders the doctor writes for patients. The DON stated following MD orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders for wound care.

Resident #12 stated on 7/12/17 at approximately 1:45 p.m.: "Staff often don't do wound care. It has gotten a little better recently."

Review of the Facility Policy titled, "Skin Assessment Weekly" with an effective date of 1/2017 documented the following: "A Licensed

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Nurse will complete a total body assessment on each resident weekly and document the assessment on the "Weekly Skin Integrity Checks" form."

The Facility Guidance from Lippincott's Nursing procedures sixth edition documented the following: "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors.

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

F 314 SS=E 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES — F 314

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives

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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 observations, resident interview, medical record review, facility documentation review, and staff interview the facility staff failed to ensure wound care was done to promote healing and to prevent infection of pressure ulcers for 2 Residents (Resident #1 and #6) of 30 Residents in the survey sample.

The findings included:

1. Resident #1 was admitted to the facility on 3/21/17 with a readmission on 4/26/17 after hospitalization for a wound infection and urinary tract infection. Diagnoses for Resident #1 included but are not limited to Non-Alzheimer's Dementia, Malnutrition and Stage IV* Right Heel Pressure Ulcer. Resident #1's Quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 6/26/17 coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 1 out of 15 indicating severe cognition impairment.

In addition the MDS scored Resident #1 as requiring total dependence with 2 staff persons for Transfers. Resident #1 was coded as requiring total dependence with one staff person assistance for Dressing, Hygiene, and Bathing.

Resident #1's physician orders documented the following:
7/5/17 MD order: Cleanse Right heel wound with normal saline. Apply nickel thick santyl and

1. Licensed nurse #22 that performed the wound care on resident #1 was re-educated on the professional standards of wound care dressing changes. They were given a competency return demonstration test on 8/3/17.
Resident #1 is receiving wound care per physicians order. Resident #1 and #6 weekly skin assessments are being completed per policy.
2. Residents that require wound care are at risk for this deficient practice.
3. Licensed nurses will be re-educated on the professional standard of wound care by AMT on 8/3/17 and 8/9/17.
Return demonstration competencies were completed for each licensed nurse by Unit Managers and will continue to be on-going as needed.
Wound dressing observation will be completed randomly 3 x wk x 12 weeks to ensure licensed nurses are following professional standards of wound care.
Re-education and training provided as needed.
4. Results of wound observations will be reviewed in the monthly QAPI meeting

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alginate to wound bed daily. Cover with dry gauze and kerlix daily and as needed.

Resident #1's Treatment Administration Record (TAR) for June 2017 included two wound care documentation omissions and the TAR for July 2017 included 1 wound care documentation omission.

Licensed Practical Nurse (LPN) #22 was observed performing wound care on 7/12/17 at approximately 3:20 p.m. The LPN did not utilize infection control measures of hand hygiene after removing soiled gloves and she did not sanitize the soiled table prior to placing a clean field.

Resident #1's 4/26/17 Care Plan documented a focus area of:
At risk for further skin breakdown due to: Assistance required in bed mobility and repositioning and incontinence of bowel and bladder. 4/26/17 Stage III* to right outer heel
Interventions included:
Conduct weekly skin inspection
Float heels
Treatments as ordered

Resident #1's clinical record documented a 3/21/17 initial Risk for Pressure Ulcers to be 12 indicating High Risk for Pressure Ulcers.

Resident #1's clinical record weekly assessments from her initial admission documented the heel ulcer was initially identified at a Stage II and worsened to a Stage III* on 4/24/17 when the resident required hospitalization. Upon readmission 4/26/17, weekly assessments were documented from admission through 6/18/17.

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Review of the Facility Policy titled, "Skin Assessment Weekly" with an effective date of 1/2017 documented the following: "A Licensed Nurse will complete a total body assessment on each resident weekly and document the assessment on the "Weekly Skin Integrity Checks" form.

The Facility Guidance from Lippincott's Nursing procedures sixth edition documented the following: "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

The Director of Nursing was asked to show evidence that the wound care documentation omissions was completed. The DON stated on 7/12/17 at approximately 1:15 p.m.: "I couldn't find any explanation as to why treatments were not done." The DON added, Nursing staff is to follow the orders the doctor writes for patients. The DON stated following MD orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders for wound care.

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

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2. Resident #6 was admitted to the facility on 8/19/15 with a readmission on 9/14/16. Diagnoses for Resident #6 included but are not limited to Stage IV Sacral Pressure Ulcer* and Non-Alzheimer's Dementia*. Resident #6's Annual Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 8/24/16 coded Resident #6 with a BIMS (Brief Interview for Mental Status) of 8 out of 15 indicating a moderate cognition impairment.

In addition the MDS scored Resident #6 as requiring Extensive Assistance with two staff person assistance for Transfers, Bed Mobility, and Dressing. Resident #6 was coded as always incontinent of Urine and frequently incontinent of Bowel functions.

Resident #6's Care Plan documented a focus area of:
Stage IV* Pressure ulcer due to Assistance required in bed mobility, wound assessment Score 18 or less than, bowel incontinence. Use of Foley catheter for wound healing
9/14/16 readmitted
9/21/16 chemical cauterization performed by wound specialist
2/6/17 treatment change
4/17/17 new treatment
4/24/17 new treatment
5/3/17 new treatment
Interventions included:
Conduct weekly skin inspection
Foley cath (catheter) as needed
Treatments as ordered
Weekly wound assessment

7/19/17 Braden Scale scored Resident #6 as

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High Risk for developing Pressure Ulcers.

Current 7/5/17 Physician order for wound care included: Clean wound with normal saline, apply collagen to wound bed, apply skin prep to skin surrounding the wound apply clean dressing and secure.

7/5/17 Wound Care Physician measurements of sacral wound are Length by width by depth: 1 by 0.4 by 0.3 centimeters; surface area .40 centimeters, moderate sero sanguinous exudate with 100% granulation tissue.

Review of the June 2017 Treatment Administration Record included 3 sacral wound care omissions; 8 catheter care omissions, and 16 Triad Paste application omissions to buttock area excoriations.

The weekly skin assessment form stopped showing documentation after the 6/28/17 measurements. This same form documented deteriorated wound on 3/20/17, 4/3/17, 4/10/17, 4/17/17, and 4/24/17.

Review of the Facility Policy titled, "Skin Assessment Weekly" with an effective date of 1/2017 documented the following: "A Licensed Nurse will complete a total body assessment on each resident weekly and document the assessment on the "Weekly Skin Integrity Checks" form".

The Facility Guidance from Lippincott's Nursing procedures sixth edition documented the following: "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among

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health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors.

The Director of Nursing was asked to show evidence that the multiple wound care documentation omissions were completed. The DON stated on 7/12/17 at approximately 1:15 p.m.: "I couldn't find any explanation as to why treatments were not done." The DON added, Nursing staff is to follow the orders the doctor writes for patients. The DON stated following MD orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders for wound care.

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

DEFINITIONS:

Stage II Pressure Ulcer: The National Pressure Ulcer Advisory Panel: documented: Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are

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not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

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

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

F 315 SS=D — 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER — F 315

(e) Incontinence.

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(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review the facility staff failed to provide the appropriate care

F315

1. LPN nurse #12 was an agency nurse and will not return to the facility until agency provides proof of training and competencies for Foley care. C.N.A #1 was re-educated on Foley catheter care and return demonstration competency on 8/4/17.
2. Residents with Foley catheters are at risk for this practice.
3. Nursing staff were re-educated on proper Foley care by DON/designee. Return demonstration were completed for current nursing staff by the Unit Managers and will continue to be on-going as needed. A random observation of Foley care will be completed 2 x week x 12 weeks to ensure that appropriate Foley care is provided.
4. The results of the audit will be discussed and reviewed in the monthly QAPI meeting.

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and services to prevent complications for the use of a Foley catheter for 1 of 30 residents in the survey sample, Resident #7.

The facility staff failed to ensure the Foley catheter tubing was anchored and secured properly and failed to implement appropriate infection control practices during the change of the Foley catheter leg bag for Resident #7.

The findings included:

Resident #7 was admitted to the facility on 8/1/14. The resident's current diagnoses included, but not limited to Alzheimer's and a stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon, or muscle is not exposed).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 4/17/17 coded the resident as scoring a 00 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident was coded as having one stage 3 pressure ulcer.

A review of the comprehensive person-centered care plan dated 6/15/17 identified the resident had alteration in elimination of bowel and bladder due to a indwelling urinary catheter inserted to promote wound healing. One goal listed was the resident would not have any complications from the use of the indwelling catheter such as pain, infection, obstruction. Three of the interventions listed to achieve/ maintain the goal included; anchor catheter, avoid excessive tugging on the catheter during transfer and delivery of care and change catheter bag every 2 weeks and as

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needed, indwelling catheter care every shift and as needed.

The physician Order Summary Report order date range 5/1/17 through 7/31/17 included an order dated 6/15/17. The order was for a Foley catheter (1), 16 French, 10 cc (cubic centimeter) balloon to aid in healing of stage 3 ulcer of the right buttock.

On 7/12/17 at 10:47 am, an observation of Foley catheter care with an agency nurse (Licensed Practical Nurse #12) accompanied by CNA #1 (Certified Nurse Aide) was conducted. The resident was transferred from the wheelchair to the bed by CNA#1. The resident's pants were removed to evidence a Foley catheter leg bag. The leg bag was observed secured tightly around the resident's right leg. The leg bag was missing one of two straps, the one strap was tied with a knot. Upon untying the knot the resident's skin under the strap was noted to be dark red with an indentation encircling the leg. The area was blanchable. The Foley catheter anchor was bunched up around the catheter tubing and not adhered to the resident's skin. The nurse performed catheter care by using soap and water from a basin placed on the bedside table. The nurse washed her hands and then put on gloves, she then cleaned around the urethral meatus (2, 3) and the Foley tubing several times, dipping her gloves hands into the water basin. She then removed a new leg bag from the plastic package, disconnected the leg bag from the Foley catheter tubing and reconnected the clean leg bag using the same gloves. The nurse then removed the bunched up anchor from the tubing. The nurse then stated she would obtain an anchor. She then removed the gloves, washed her hands and

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left the room.

After the Foley catheter care observation the nurse was interviewed at 2:36 pm. The observation of using the same gloves for both cleaning the meatus and Foley catheter and then changing out the old leg beg with the new leg bag was discussed. She stated she should have removed the gloves, and washed her hands before changing the leg bag to prevent potential cross contamination.

The above observation was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

The facility utilized Lippincott's Nursing Procedures Sixth Edition for standards of care. A copy of the section titled "Indwelling urinary catheter care and removal" pages 374-375 was provided for review and read, in part: Clean the outside of the catheter and the tissue around the meatus using soap and water...Remove and discard your gloves and perform hand hygiene. Reapply the leg band, and reattach the catheter to the leg band.

Potter and Perry Fundamentals of Nursing 7th Edition chapter 45 Urinary Elimination skill 45-2 page 1160 read, in part: 31. Anchor catheter: Secure catheter tubing to inner thigh with strip of nonallergenic tape (or multipurpose tube holders with a Velcro strap). Allow for slack so movement of this does not create tension on catheter. Rationale-Anchoring catheter to inner thigh reduces pressure on urethra, thus reducing possibility of tissue injury.

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1. Foley catheter-A urinary tract catheter with a balloon attachment at one end. After the catheter is inserted, the balloon is inflated. Thus the catheter is prevented from leaving the bladder until the balloon is emptied. (Source-Taber's Cyclopedic Medical Dictionary Edition 20).

2. Urethra- The tube for the discharge of urine extending from the bladder to the outside. (Source-Taber's Cyclopedic Medical Dictionary Edition 20).
3. Urethra Meatus-External opening of the urethra. (Source-Taber's Cyclopedic Medical Dictionary Edition 20).

F 323 SS=D 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES — F 323

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with

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the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility documentation review, staff interviews and clinical record review the facility staff failed to implement interventions to reduce a potential accident hazard for 1 Resident (Resident #1) of 30 residents in the survey sample.

The findings included:

Resident #1 was admitted to the facility on 3/21/17. Diagnoses for Resident #1 included but are not limited to Non-Alzheimer's Dementia, Malnutrition and Stage IV Right Heel Pressure Ulcer. Resident #1's Minimum Data Set Quarterly assessment (MDS-an assessment protocol) with an Assessment Reference Date of 6/26/17 coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 1 of 15 indicating severe cognition impairment.

In addition the MDS scored Resident #1 as requiring total dependence with 2 staff persons for Transfers. Resident #1 was coded as requiring total dependence with one staff person assistance for Dressing, Hygiene, and Bathing.

During an observation of wound care for Resident #1 on 7/12/17 at approximately 3:20 p.m., LPN #22 removed the soiled dressing using pointed tip scissors from her pocket that she did not sanitize. After completion of the wound care, the LPN was asked what type tipped scissors she should have

1. LPN #22 that utilized the scissors was re-educated on 8/3/17 on proper wound care including type of scissors to utilize.
2. An audit was completed to ensure that nursing staff were not utilizing the wrong type of scissors for resident care, and that every nurse had appropriate scissors needed for patient care needs.
3. Nursing staff were re-educated by the DON/designee on safe practice standards for residents. An audit will be completed 2x week x 12 weeks by unit managers to ensure resident care is conducted in a safe manner.
4. Results of the audit will be discussed daily in the morning meeting and in the monthly QAPI meeting

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used and she stated: "bandage scissors so I won't risk cutting the patient's skin."

The Director of Nurses was asked on 7/12/17 at approximately 2:00 p.m. if nurses should be using pointed tip scissors. The DON stated: "No, pointed tip scissors can possibly cut the Resident and the correct type of scissors should be sanitized prior and after use.

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

F 332 SS=D 483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE — F 332

(f) Medication Errors. The facility must ensure that its-

(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record reviews and staff interview the facility failed to ensure that its medication error rates were not 5% or greater. A medication administration observation pass was conducted to include 27 opportunities, with 2 medication errors resulting in a 7.40% error rate, involving 2 residents, Residents #18 and #19.

1. The nurse failed to shake the drug Megace (an appetite stimulant) that was in a liquid suspension form for Resident #18 prior to administration.

2. The nurse failed to administer a 20 mEq

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(milieu) potassium tablet before dinner as ordered for Resident #19.

The findings included:

1. Resident #18 was admitted to the facility on 3/9/17 with diagnosis to include, but not limited to vascular dementia.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 6/16/17 coded the resident as scoring a 00 out of a possible 15 on the brief interview for mental status indicating the resident cognition was severely impaired.

A physician telephone order dated 5/23/17 read: Megace oral suspension 40 milligrams (mg)/ml (milliliter) BID (twice a day) r/t (related to) decrease appetite. Under this order was a clarified order change reading, "Megace oral suspension 400 mg BID r/t decrease appetite".

A medication pass administration observation for Resident #18 was conducted with Licensed Practical Nurse #1 on 7/11/17 at 4:09 pm. The nurse obtained the Megace suspension from inside the medication cart. The label was incorrect and read Megace take 1 ml (40 mg) by mouth twice a day. The pharmacy label was not changed when the order was clarified. A pharmacy auxiliary label read, "Shake well before each use". The nurse poured 10 ml of Megace (400 mg) inside a medication cup without shaking the suspension first. The nurse administered the medication. After the medication pass the nurse was questioned about the failure to read the instructions for shaking the suspension prior to pouring the Megace. She stated she normally

F332

1. LPN #1 that did not shake the suspension was re-educated on liquid suspensions and correct process for unavailable medications. Residents #18 and #19 receive medications per physicians order.
2. Residents that reside in facility are at risk for this practice
3. Licensed nurses were re-educated on the 8 rights of medication administration by DON/designee. A random audit on medication administration will be completed by Pharmacist/designee 3x week x 12 weeks. Nurses who are noted to have errors will be re-educated immediately.
4. Results of the audit will be discussed and reviewed in the monthly QAPI meeting.

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reads all the labels but did not this time. She stated the rationale for shaking the suspension was to ensure "you get a good mixture". She also acknowledged the pharmacy label dose was inaccurate and stated she would call the pharmacy.

The above observation and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

Suspension drugs-pharmacy departments often provide important drug use information on each dose or on the medication administration record to remind nurses about special administration techniques that should be employed in the preparation of a dose. Failure to vigorously shake a multi-dose suspension can result in a wrong-dose medication administration error. It is important to ensure that the active ingredient(s) in a suspension is (are) properly dispersed throughout the vehicle before administration. (Source Agency for Healthcare Research and Quality (AHRQ) U.S. Department of Health & Human Services).

2. The nurse failed to administer a 20 mEq (milieu) potassium tablet before dinner as ordered for Resident #19.

Resident #19 was admitted to the facility on 5/25/16 with diagnoses to include, but not limited to hypo-osmolality(1) and hyponatremia (low sodium).

The current MDS (Minimum Data Set) a a quarterly with an assessment reference date of

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4/11/17 coded the resident as scoring a 9 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had moderately impaired daily decision making skills.

The physician order dated 5/19/17 instructed the staff to administer Potassium Chloride Crystals 20 mEq by mouth with meals related to hype-osmolality and hyponatremia. The medication was scheduled to be administered at 8 am, 12 pm and 6 pm every day.

A medication pass administration observation for Resident #19 was conducted with Licensed Practical Nurse #1 on 7/11/17 at approximately 5:00 pm. The Potassium Chloride was not available in the medication cart for administration. The nurse stated dinner arrives on the unit between 5:30 pm-6:00 pm. She stated she would call the pharmacy for a refill. The nurse stated the medication would be sent on the night run after 11:00 pm.

A review of the Medication Administration Record on 7/12/17 evidenced the resident was not administered the 6:00 pm dose of Potassium Chloride on 7/11/17.

The above observation and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

1. Hypo-osmolality-a decrease in the osmolality of the body fluids; body fluid volume increases and solute volumes usually decrease. Symptoms are those of hyponatremia such as cerebral edema with disorientation, focal neurological deficits, and seizures. (Source-National Health Institute-NIH).

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F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

483.45(f) Medication Errors.

The facility must ensure that its-

(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure 1 of 30 sampled residents (Resident #24) was free of significant medication error.

The facility staff failed to administer Resident #24's medications according to the times ordered by the physician.

The findings included:

Resident #24 was admitted to the facility on 4/8/15 and was readmitted on 2/2/16. Diagnoses for Resident #24 included but not limited to, high blood pressure and diabetes mellitus (1).

The most recent Minimum Data Set with an assessment reference date of 5/31/17, assessed Resident #24 with a score of 14 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #24's cognitive abilities for daily decision making are intact.

On 7/13/17, Resident #24's clinical record review was conducted. The Physician Order Review Report documented the following orders:

a. Humalog Solution 100 unit/ml (milliliter). Inject

F333

1. Resident #24 receives medications per physicians order. LPN #3 was re-educated on medication administration and evaluated for additional training for medication administration.
2. An audit was completed to ensure that residents that currently reside in the facility have their medications available.
3. Licensed nursing staff were re-educated by the DON/designee regarding obtaining orders and ensuring medications are available. An audit will be completed 2x week x 12 weeks on random residents to ensure medications are administered timely.
4. Results of the audit will be reviewed and discussed at the monthly QAPI meeting.

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8 units subcutaneously (4) with meals related to Type 2 Diabetes Mellitus. Order date - 5/24/17.

b. Metformin HCl Tablet 500 mg. (milligrams) Give 500 mg by mouth two times a day related to Type 2 Diabetes Mellitus. Order date - 5/24/17

c. Humalog Sliding Scale 0-200 0 unit; 201 - 250 2 units; 251 - 300 4 units; 301-350 6 units; 351-400 8 units; 401-450 10 units before meals and at bedtime related to Type 2 Diabetes Mellitus. Order date - 4/29/16

A review of Resident #24's Medication Administration Record on 7/13/17, indicated delayed administration of medications for diabetes such as, Humalog Solution (2) and Metformin HCl Tablets (3).

Resident #24's Medication Administration Audit Report documented the following:

On 7/13/17, Humalog Solution 100 unit/ml 8 units subcutaneously with meals, was scheduled to be administered at 8:00 am. The report indicated that it was administered on 7/13/17 at 13:17 (1:17 pm), 5 hours and 17 minutes after it was supposed to be administered.

On 7/13/17, Metformin HCL 500 mg by mouth was scheduled to be administered at 9:00 am. The report indicated that it was administered at 13:09 (1:09 pm), 4 hours and 9 minutes after it was supposed to be administered.

On 7/13/17, Humalog Sliding Scale was scheduled to be administered at 11:30 am with meals. The report indicated that it was administered at 13:18 (1:18 pm), 1 hour and 48

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minutes after it was supposed to be administered. The blood sugar level was 123.

The Comprehensive Resident Centered Plan of Care for Resident #24 stated, "Focus: Alteration in Blood Glucose (blood sugar) due to: Insulin Dependent Diabetes Mellitus; Goal: Patient will experience minimal signs and symptoms associated with hyperglycemia (high blood sugar)/hypoglycemia (low blood sugar) through next review. Date initiated - 5/21/15; Interventions: Administer medications as ordered."

On 7/13/17, the facility policy titled "Preventing Medication Errors ABC's Quick Reference" (not dated) stated, in part, "Key Points in Medication Pass: ...Medications must be passed within one hour of scheduled time".

On 7/13/17 at approximately 3:45 pm, the Administrator and Director of Nursing (DON) were made aware of the findings and were asked what had caused the delay in the administration of Humalog and Metformin HCl on Resident #24. They stated that LPN (Licensed Practical Nurse) #3 was a new nurse who started in June 2017. The Administrator stated that the new nurses went through 4 weeks of orientation; the first week was classroom orientation, the second week was with their mentor, the third week was performing a few assigned tasks and the fourth week was performing more assigned duties. The DON stated that LPN #3 was in orientation for a month and had recently "took a medication cart". The DON was asked what could be the possible outcome if the administration of the medications, like Humalog and Metformin, were delayed. She stated that a resident could have a complication

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of hyperglycemia (high blood sugar) depending on the resident's blood sugar level at the time.

The DON provided a copy of LPN #3's Core Competency Review Checklist with a completion date of 7/13/17. For Medication Administration Competency, LPN #3 was coded "2" as "Experienced" (0 - No experience; 1 - Minimal Experience; 2 - Experienced; 3 - Does not Apply). No further information was provided.

Definition:

(1) Diabetes Mellitus - is a disease in which your blood glucose, or blood sugar, levels are too high. (Source: NIH U.S. National Library of Medicine : Medline Plus)

(2) Humalog Solution - Humalog (insulin lispro) is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. (Source: https://www.drugs.com/humalog.html)

(3) Metformin HCl Tablets - Metformin is used alone or with other medications, including insulin, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). (Source https://medlineplus.gov/druginfo/meds/a696005.html#why)

(4) Subcutaneously - being, living, used, or made under the skin

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F 333	Continued From page 65 (Source: http://c.merriam-webster.com/medlineplus/subcutaneous%20ly)	F 333		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	F425 1. Resident #19 receives Potassium Chloride per physicians order. LPN #1 has been re-educated on correct process for availability of medications 2. Residents that reside in the facility are at risk for this deficient practice. 3. Licensed nurses were re-educated on the 8 rights of medication administration by the DON/designee. A random audit on medication administration will be completed by Pharmacist/designee 3x week x 12 weeks. Nurses who are noted to have errors will be re-educated immediately. 4. Results of the audit will be reviewed and discussed at the monthly QAPI meeting.	

(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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed to ensure medications were acquired to meet the needs of 1 of 30 residents in the survey sample, Resident #19.

The facility staff failed to ensure Potassium Chloride 20 mEq (milliequivalent) was available for administration as ordered for Resident #19.

The findings included:

Resident #19 was admitted to the facility on 5/25/16 with diagnoses to include, but not limited to hypo-osmolality(1) and hyponatremia (low sodium).

The current MDS (Minimum Data Set) a a

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quarterly with an assessment reference date of 4/11/17 coded the resident as scoring a 9 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had moderately impaired daily decision making skills.

The physician order dated 5/19/17 instructed the staff to administer Potassium Chloride Crystals 20 mEq by mouth with meals related to hypo-osmolality and hyponatremia. The medication was scheduled to be administered at 8 am, 12 pm and 6 pm every day.

A medication pass administration observation for Resident #19 was conducted with Licensed Practical Nurse #1 on 7/11/17 at approximately 5:00 pm. The Potassium Chloride was not available in the medication cart for administration. The nurse stated dinner arrives on the unit between 5:30 pm-6:00 pm. She stated she would call the pharmacy for a refill. The nurse stated the medication would be sent on the night run after 11:00 pm.

A review of the Medication Administration Record on 7/12/17 evidenced the resident was not administered the 6:00 pm dose of Potassium Chloride on 7/11/17.

The above observation and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

1. Hypo-osmolality-a decrease in the osmolality of the body fluids; body fluid volume increases and solute volumes usually decrease. Symptoms are those of hyponatremia such as cerebral edema with disorientation, focal neurological deficits, and

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seizures. (Source-National Health Institute-NIH).

F 431 SS=D 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

F 425

F 431

F431

1. The medication that was observed to be on the medication cart was removed and stored properly at the time of the survey. LPN #4 was re-educated on proper storage of medications and LPN #1 was re-educated on administration of an oral suspension medication.
2. The licensed nursing staff were re-educated by the DON/designee regarding the appropriate storage of medications. An audit was conducted on 8/5/17 to ensure that medications were stored appropriately on each nursing unit.
3. A random audit will be conducted 3x week x 12 weeks to check nursing units for appropriate storage of medications.
4. Results of the audit will be reviewed in the monthly QAPI meeting.

8/13/17

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(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on general observations of the nursing facility, the facility failed to ensure medications (Purified Protein Derivative) PPD-Aplisol was stored in a secured location and to ensure a medication label of a resident's drug was accurate for 1 out of 30 residents (Resident #18) in the survey sample.

1. The facility staff failed to ensure medication medications (Purified Protein Derivative) PPD-Aplisol was stored in a secured location, on 1 out of 2 units, Unit 2.

2. The facility staff failed to ensure that the medication label in response to an order change was accurate for Resident #18's Megace suspension.

The findings included:

1. On 7/13/17 at approximately 9:30 a.m., during

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general observations with the maintenance director, an open multi-dose vial of PPD (for tuberculosis testing) solution was observed sitting on top of the treatment cart on Unit 1 unattended.

An interview was conducted with Licensed Practical Nurse (LPN) #3 on 07/13/17 at approximately 9:35 a.m., who stated "I'm just getting to work but the vial of PPD solution should have been locked up in the medication refrigerator; not sitting on top of the treatment."

The Maintenance Director paged LPN #4 who stated, I may have let the PPD solution on top of the treatment cart; I'm new and I just got side tracked. The surveyor asked, "Where should the open vial of PPD solution have been stored, she replied, "Either on the treatment cart or in the medication refrigerator; it was a mistake leaving the PPD sitting on top of the treatment cart unattended."

An interview was conducted with the Director of Nursing (DON) on 07/13/17 at approximately 1:53 p.m., who stated, "The open vial of PPD solution should have been locked in the medication cart or in the medication refrigerator but not sitting on top the treatment cart unattended."

A policy for storage of medications was requested from the DON on 07/13/17 at approximately 2:05 p.m. On the same day the DON handed the surveyor a policy, titled "ADU Policies and Procedures" but it did not contain any information regarding the storage of medications.

The above information was shared with the Administrator and DON during a pre-exit meeting on 07/13/17 at 3:45 p.m. No additional

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information was provided.

2. The facility staff failed to ensure that the medication label in response to an order change was accurate for Resident #18's Megace (an appetite stimulant) suspension.

Resident #18 was admitted to the facility on 3/9/17 with diagnosis to include, but not limited to vascular dementia.

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 6/16/17 coded the resident as scoring a 00 out of a possible 15 on the brief interview for mental status indicating the resident cognition was severely impaired.

A physician telephone order dated 5/23/17 read: Megace oral suspension 40 milligrams (mg)/ml (milliliter) BID (twice a day) r/t (related to) decrease appetite. Under this order was a clarified order change reading, "Megace oral suspension 400 mg BID r/t decrease appetite".

A medication pass administration observation for Resident #18 was conducted with Licensed Practical Nurse #1 on 7/11/17 at 4:09 pm. The nurse obtained the Megace suspension from inside the medication cart. The label was incorrect and read Megace take 1 ml (40 mg) by mouth twice a day. The pharmacy label was not changed when the order was clarified. A pharmacy auxiliary label read, "Shake well before each use". The nurse poured 10 ml of Megace (400 mg) inside a medication cup without shaking the suspension first. The nurse administered the medication. After the medication pass the nurse was questioned about the failure to read the

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instructions for shaking the suspension prior to pouring the Megace. She stated she normally reads all the labels but did not this time. She stated the rationale for shaking the suspension was to ensure "you get a good mixture". She also acknowledged the pharmacy label dose was inaccurate and stated she would call the pharmacy.

The electronic Medication Administration Record included the corrected dose of 400 mg twice a day. The pharmacy label for the dose amount to be given in milliliter equivalents on the multi-dose bottle of Megace was incorrect.

The above observation and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

The facility policy titled "Medication Ordering and Receiving From Pharmacy Medication Labels" Section 3.10 revises 05/12 read, in part:
Policy-Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels.
Procedures-B. Each prescription medication label includes:
4. Strength of medication a. Injectable's and Liquids-strength per ml, and the amount to be given in milliliter (ml) equivalents on the label.

F 441 SS=E — 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

(a) Infection prevention and control program.

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of 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

F441

1. No opportunity to correct missing infection control log for October-December 2016. LPN #2 and #22 were re-educated on Infection control practices. LPN #9, #10 and #11 were re-educated on infection control practices and wound dressing label codes. Linen on the shower room floor was removed during survey, Medication carts and pill crushers were cleaned immediately.
2. An audit was completed on 7/31/17 to ensure that the infection control monitoring process is current and up to date. An audit was completed on 7/31/17 to ensure that wound dressing treatments were intact and unopened per package coding.

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circumstances.

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

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

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

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

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure ongoing healthcare-associated infection (HAI) surveillance and failed to maintain appropriate infection prevention and control practices to prevent infections for 2 of 30 sampled residents, (Residents #1, #12), failed to implement appropriate hand hygiene practices, failed to ensure medical equipment and supplies were maintained in a clean and sanitary manner and failed to place soiled items in the appropriate storage space.

1. The facility staff failed to ensure surveillance

3. Facility staff were re-educated by the DON/designee to include infection control practices that include resident care, standard precautions and wound care.
An audit will be completed 3x week x 12 weeks to ensure infection control practices are being followed. This will include general care practices, medication carts and pill crushers and wound care. observations. Discrepancies will be corrected immediately.
4. Audits will be reviewed in the monthly QAPI meetings.

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for healthcare-associated infections were completed for October 2016, November 2016 and December 2016.

2. The facility staff failed to ensure infection control measures were followed to prevent the potential transmission of infection for Resident #1.

3. The facility staff failed to ensure infection control measures were followed to prevent the potential transmission of infection for Resident #12.

4. The facility staff failed to implement appropriate hand hygiene technique during a medication pass observation conducted on 7/11/17.

5. The facility staff failed to ensure resident medical equipment and medical supplies were maintained and utilized in a manner to prevent the potential for cross-contamination.

6. The facility staff failed to put soiled linens and a bag of soiled towels in the designated area (soiled utility room) on 1 out of 2 units (Unit 2).

The findings included:

1. The facility staff failed to ensure surveillance for healthcare-associated infections were completed for October 2016, November 2016 and December 2016.

On 7/13/17 at approximately 1:00 pm, a review of the HAI surveillance records from July 2016 through July 2017 was conducted. The 2016 records included infection surveillance reports from 7/1/16 through 9/30/16 only. Surveillance

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reports were missing for the months of October 2016, November 2016 and December 2016.

On 7/13/17 at 3:00 pm, an interview with the Director of Nursing (DON) was conducted and she was informed of the missing infection surveillance reports. She stated that the facility did not have these records; they had searched but were unable to locate them.

On 7/13/17 at 3:10 pm, the Administrator was interviewed and she stated that the facility had no access to the old facility records through December 2016 due to change of facility ownership. The Administrator described the current process for infection surveillance at the facility and provided copies of policies and procedures that addressed the following:

The facility policy and procedure titled, "Infection Control Surveillance" with an effective date of 02/2017, stated, "Policy: The Infection Control Committee is responsible for overseeing the Infection Control Surveillance monitoring and evaluation process. Indicators are chosen. Indicator data are collected, analyzed, and reported to the Infection Control Committee and the Performance Improvement Committee".

The policy and procedure titled, "Infection Control Surveillance Reporting", effective 02/2017, stated, "Specific Recommendations for Infection Control and Surveillance activities are identified by the ICC (Infection Control Committee). The ICC reports its activities to the Quality Assurance Performance Improvement Committee".

The policy and procedure titled, "Infection Control Reports" stated, "The facility will monitor and

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investigate the cause and spread of infection. Continuous surveillance will be provided by staff. Any infection will be reported using the Infection Report Form.

The policy and procedure titled "Infection Control Resident Worksheet" with an effective date of 02/17 and explained the process of infection surveillance activities in the facility. The policy stated, "The Infection Control Resident Worksheet will be used as a surveillance data collection tool for recording information related to infections. The Infection Control Nurse will utilize the data collection tool to gather information for monitoring, evaluation and analysis as directed by the Infection Control Committee."

Copies of the forms titled, "Infection Report Form", "Epidemiology Worksheet", and "Infection Control Surveillance Report - Monthly Report of Infections" were provided by the Administrator. She stated that the "Infection Report Form" was completed by the staff nurse, forwarded to the Nurse Manager (NM) and the NM turned in the completed form to the Infection Control Nurse. The Infection Control Nurse reviewed and investigated the infection control reports and attached them to the "Infection Control Surveillance Report - Monthly Report of Infections" form.

The above findings were discussed again with the Administrator and the DON on 7/13/17 at approximately 3:45 pm; no further information was provided.

2. Resident #1 was admitted to the facility on 3/21/17. Diagnoses for Resident #1 included but

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are not limited to Non-Alzheimer's Dementia, Malnutrition and Stage IV Right Heel Pressure Ulcer. Resident #1's Quarterly Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 6/26/17 coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 1 out of 15 indicating severe cognition impairment.

In addition the MDS scored Resident #1 as requiring total dependence with 2 staff persons for Transfers. Resident #1 was coded as requiring total dependence with one staff person assistance for Dressing, Hygiene, and Bathing.

Wound Care was observed on 7/12/17 at approximately 3:20 p.m. The LPN initially took scissors from her pocket and used them to remove a soiled dressing. The nurse did not sanitize the scissors prior to use nor did she sanitize them after use. The scissors were not dull tip bandage scissors but pointed tip scissors. The LPN placed a clean barrier on a soiled and wet table and proceeded to perform wound care. The nurse had previously washed her hands, placed her supplies on the clean barrier and removed the soiled dressing. The nurse then removed her gloves and did not wash her hands prior to cleaning and applying a clean dressing per the Physician orders. The Nurse did not sanitize the Resident's bedside table after performing wound care.

The facility policy and procedure titled, "Hand Washing Techniques" with an effective date document:
All personnel will wash hands before beginning the treatment/care of a resident and upon completion of such tasks, to prevent the spread

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of nosocomial infections. Wash hands after removal of gloves or other personal protective barrier equipment.

The facility Policy and Procedure titled, "Standard Precautions" with an effective date of 2/2017 documented the following:
Wash hands after gloves are removed between resident contacts, and when otherwise indicated to avoid transfer of micro-organisms to other residents or environments.
Wash hands between tasks and procedures on the resident when contaminated with body fluids to prevent cross contamination of different body sites.

The facility Policy titled, "Standard Precautions Resource Sheet" (undated) documented the following:
Standard Precautions apply to all blood, all body fluids, secretions, excretions except sweat whether or not they are visibly bloody, non-intact and mucous membranes of all residents. ...
Environmental Control: follow procedures for routine care, cleaning and disinfecting of resident furniture and the environment.

The DON was asked on 7/12/17 at approximately 4:00 p.m., if the soiled over-bed table should have been sanitized prior to the placement of a clean barrier. The DON stated, "Yes."

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

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3. Resident #12 was admitted to the facility on 1/16/17. Diagnoses for Resident #12 included but are not limited to Peripheral Vascular Disease and open ulcers to Left leg. Resident #12's Quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 5/26/17 coded Resident #12 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no cognition impairment.

In addition the MDS scored Resident #12 as requiring extensive assistance with two staff person assistance for transfers, bed mobility and toileting. Resident #12 was coded as being frequently incontinent of bowel functions.

Resident #12's current Care Plan documented the following 5/22/17 focus area:
Altered skin integrity non pressure related to Vascular deficiency:
Left lateral ankle
left outer ankle
left heel
left shin #1
left shin #2
left shin #3
right 2nd toe resolved 5/22/17
Interventions documented included the following:
Treatments as ordered
Weekly Wound assessment
Conduct weekly skin inspection
Skin assessment to be completed per Living Center Policy

Resident #12's TAR (Treatment Administration Record) for July 2017 documented the following Physician ordered wound care.
7/6/17 MD order: Left anterior ankle: Cleanse with normal saline, apply alginate dressing to

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wound bed, cover with dry dressing daily.
7/6/17 MD order: Left heel: Cleanse with normal saline, apply silvadene to wound bed, cover with dry dressing daily.
7/6/17 MD order: Left outer ankle: Cleanse with normal saline, apply santyl nickel thick to wound bed, cover with dry dressing, daily.
7/6/17 MD order: Left shin area #1, top area: cleanse with normal saline, apply santyl nickel thick to the wound bed, cover with dry dressing, daily.
Skin prep apply to right second toe topically every day for protection.
Left transmetatarsal amputation site: leave open to air and monitor area at this time.
Triad Hydrophillic Wound Dressing Paste apply to scrotum topically every shift for healing.

LPN (Licensed Practical Nurse) #2 was observed doing wound care for Resident #12 on 7/12/17 at approximately 12:00 noon. LPN #2 removed Resident #12's dressing and needed to clarify wound care orders as she noted three areas of open ulcer on shin area and she observed that Resident #12 had his entire lower leg covered with dressing.
The LPN called Resident 12's Vascular Surgeon and obtained phone orders as followed:
Clean all leg wounds with normal saline, apply santyl ointment, cover with dry dressing, wrap in kling gauze.
Resident #12 refused to have his scrotum assessed as he stated that area was healed.
After clarification of Physician orders for the Resident, the LPN placed a clean barrier onto a soiled over bed table without sanitizing the table first. The LPN proceeded with wound care as ordered and when completed, she did not sanitize the over bed table after removing all of the

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supplies.

Review of Resident #12's Treatment Administration Record (TAR) for July 2017 showed 16 documentation omissions for completed wound care orders. Review of Resident #12's June 2017 TAR showed 69 omissions to indicate completed wound care.

Review of Resident #12's weekly skin assessments did not reveal any assessments after 6/20/17. The Director of Nurses stated that the facility wound care nurse position was discontinued July 20, 2017, and that it would have been the Resident's Nurse's responsibility to complete wound care as ordered by the Doctor. The last wound assessment of 6/20/17 only noted one wound on the shin. It did not address the large two ulcers noted at the left ankle and left heel.

A Braden Scale assessment of 1/17/17 scored Resident #12 as having "High Risk" for predicting Pressure Sore Risk".

The Director of Nursing was asked to show evidence that the 85 wound care documentation omissions were completed. The DON stated on 7/12/17 at approximately 1:15 p.m.: "I couldn't find any explanation as to why treatments were not done." The DON added, Nursing staff is to follow the orders the doctor writes for patients. The DON stated following MD orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders for wound care.

Resident #12 stated on 7/12/17 at approximately 1:45 p.m.: "Staff often don't do wound care. It

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has gotten a little better recently."

The facility Policy and Procedure titled, "Standard Precautions" with an effective date of 2/2017 documented the following:
Wash hands after gloves are removed between resident contacts, and when otherwise indicated to avoid transfer of micro-organisms to other residents or environments.
Wash hands between tasks and procedures on the resident when contaminated with body fluids to prevent cross contamination of different body sites.

The facility Policy titled, "Standard Precautions Resource Sheet" (undated) documented the following:
Standard Precautions apply to all blood, all body fluids, secretions, excretions except sweat whether or not they are visibly bloody, non-intact and mucous membranes of all residents. ...
Environmental Control: follow procedures for routine care, cleaning and disinfecting of resident furniture and the environment.

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

4. The facility staff failed to implement appropriate hand hygiene technique during a medication pass observation conducted on 7/11/17.

A medication pass administration observation was conducted with Licensed Practical Nurse #1 on 7/11/17 on unit 2 from 4:00 pm to approximately 5:00 pm. During this time the

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nurse was observed before prepping and after administration of drugs to have washed her hands on six (6) separate occasions. For four (4) of those hand washing occasions the nurse washed her hands for a count of less than fifteen seconds; i.e., five (5) seconds, eleven (11) seconds, ten (10) seconds and ten (10)seconds. For five (5) of the six (6) hand washing occasions the nurse turned off the water faucet handles with her bare hands and then grabbed paper towels to dry her hands.

After the medication pass observation the above was shared with the nurse. She was asked how long should you rub your hands with soap during hand washing, she stated, "15 seconds".

The above observations and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

Per the Administrator the facility's nursing standards are obtained from Lippincott's Nursing Procedures Sixth Edition. Under Hand Hygiene page 327, read in part: Proper hand-washing technique. To minimize the spread of infection, follow these basic hand-washing instructions.
1. With your hands angled downward under the faucet, adjust the water temperature until it's comfortably warm.
2. Work up a generous lather by scrubbing vigorously for 15 seconds...
3. Rinse your hands completely to wash away suds and microorganisms. Pat dry with a paper towel. To prevent recontamination your hands on the faucet handles, cover each one with a dry paper towel when turning off the water.

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The above observation and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

5. The facility staff failed to ensure resident medical equipment and medical supplies were maintained and utilized in a manner to prevent the potential for cross-contamination.

An inspection of the facility's medication carts and treatment carts was conducted on 7/13/17 from 10:50 a.m. through 11:25 a.m.

On both units the medication administration carts (a total of 4) were found to have multiple various loose medication pills inside the drawers containing the multi-dose blister packs and were in need of cleaning. Each of the four carts two drawers containing bulk liquid medications were observed with sticky substances on the bottom of the drawers from spillage. The pill crushers on the unit 1 odd cart and unit 2 back hall cart had a built up of debris on the back that were in need of cleaning.

The treatment carts on both unit 1 and unit 2 contained multiple opened and partially used dressings that were designated on the package as single use items. These opened and partially used dressings included Promgram 4.34 inch matrix wound dressing, 4 packages of DermaGinate/Ag (silver) 4 x 5 packages, one package of Mesalt 2 x 100 cm (centimeter) sodium chloride dressing, 3 packages of Curad 4 x 4 xeroform petrolutum dressings, and one package of Maxorb extra 4 x 8. The tops of both treatment carts were in need of cleaning. The

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drawers inside the carts needed to be cleaned also.

Each of these single use dressings packages contained the universal symbol for one time usage. Three nurses were shown the symbol separately and asked if they knew what this symbol meant. Licensed practical nurse (LPN #9) stated, "I'd have to check the box". The nurse checked the box and then stated, "I don't know". She was asked who is responsible for ensuring the medication and treatment carts are cleaned she stated, "Every nurse should clean the cart".

LPN #10 response to the universal one time use symbol was, "Not sure, is it use only once?" She stated, "We (nursing) are supposed to clean it (med/treatment cart) every shift".

LPN #11's response to the universal on time use symbol was, "I'm not sure".

The above observations and findings was shared with the Administrator and the Director of Nursing during a pre-exit meeting conducted on 7/13/17 at 3:45 pm.

6. During General Observation on 07/13/17 at 9:40 a.m., located in the shower room on Unit 2 was a dirty towel and wash cloth. The maintenance director immediately called housekeeping to remove the soiled items off the floor; housekeeping arrived and removed soiled items off the shower room floor, placed them in a clear plastic bag and stated, "I'm putting these items in the soiled utility room."

On 07/13/17 at 9:52 a.m., located on the floor in

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the residents' lounge on Unit 2 was a bag of soiled towels. The Maintenance Director called nursing who removed the bag of soiled towels from the floor and stated, "This should have been put in the soiled utility room, not on the floor."

The facilities policy: "Exposure Control Plan: Linen Handling" (Effective 02/2107)

Procedure: Facilities without Laundry Chutes
1) All soiled linen must be bagged or placed directly into mobile soiled linen barrels/carts at the location where it is generated.

F 465 SS=E 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

(i) Other Environmental Conditions

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility staff failed to maintain a safe, clean, comfortable and sanitary environment.

The findings included:

During General Observation of the facility on 07/13/17 at 9:30 a.m., with the Maintenance

F 441

F465

1. A contractor has been secured to repair and paint the Facial boards under the activities room and for exterior of rooms #1,#3,#7,#9,#15,#17 and #19. Also to repair the wooden casing around the air conditioning unit. The outside mop area and drain were cleaned immediately during the survey on 7/13/17.
2. Environmental rounds were completed on facility physical plant on 8/2/17 and any noted repairs needed were completed or scheduled to be completed.
3. Rounds are made 5x week by department managers to identify any repairs or maintenance items that need to be completed. Any identified areas are discussed in morning meeting and follow up will be discussed.
4. Results of rounds will be discussed in monthly QAPI and any outstanding items will be addressed.

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Director, the facility staff failed to maintain a safe, clean, comfortable and sanitary environment.

During observation of the exterior surrounding of the building, in the back of the building a wooden facial board located directly under the windows was observed with chipped paint and a hole was observed in the wooden siding measuring 2 inches x 8 inches.

The outside screen to the window next to the activities room was torn. Outside the activities room and the back hall of the activities room, the wooden casing around the air-conditioning unit was observed with chipped paint and rotten boards. The Maintenance Director stated the chipped paint and rotten boards were probably the result of water damage or just from being old.

On the right side of the building facing London Boulevard, the facial boards under the following rooms was observed with chipped and rotten boards; Rooms 1, 3, 7, 9 15, 17 19 and the Administrators office.

On the side of the building was a mop area with a drain. The drain was observed with debris and a tan colored stringy substance. The Maintenance Director stated that housekeeping uses this area to empty their mop buckets. He stated he would call housekeeping to clean the drain out right away.

The Administrator and DON (Director of Nursing) were informed of the findings during a briefing on 07/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

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F 514 SS=E	Continued From page 88 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review	F 514 F 514	F514 1. There is no opportunity to correct missing documentation for Resident #1, #3 and #6. Resident #1, #3 and #6 currently have treatments signed and completed per physicians order. 2. Residents that previously resided in the facility are at risk for this practice 3. Nursing staff have been re-educated by the DON/ Designee regarding the professional standards of documentation in the medical record. The nursing staff were also re-educated on the clinical dashboard and how to check for alerts indicating missing documentation. An audit will be completed 3x week x 12 weeks to ensure that documentation is completed. The Unit Managers will also monitor documentation in Point Click Care daily by accessing "clinical dashboard". 4. Results of the audit will be reviewed in the monthly QAPI meeting. Any discrepancies will be addressed and re-education provided immediately. 8/13/17	

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and facility document review, the facility staff failed to maintain a complete and accurate medical record for 3 of 30 residents in the survey sample, Resident #3, Resident #1, Resident #6.

The findings included:

1. Resident #3 was admitted to the facility on 8/28/15 with a readmission date of 12/14/16. Diagnoses for Resident #3 included but not limited to, quadriplegia (1) and pressure ulcer (2).

The most recent Minimum Data Set with an assessment reference date of 4/12/17, coded Resident #3 with a score of 13 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating an intact cognitive abilities for daily decision making. Resident #3 was assessed as at risk for pressure ulcer with a history of pressure ulcers.

On 7/12/17, during the clinical record review, Resident #3's Treatment Administration Records (TAR) for May 2017, June 2017, and July 2017 were missing nursing documentation for treatments ordered. The nurses' initials that indicate treatments were provided were missing on the following orders:

(Brand Name) Ointment, apply to feet topically one time a day for dry skin - missed documentation on 5/21/17 at 0900; 6/13/17 at 0900; 7/6/17 at 0900.

Skin Prep Wipes Miscellaneous, apply to left buttocks topically every shift for prevention - missed documentation on 5/21/17 on day shift; 6/9/17 on evening shift; 6/13/17 on day shift; 6/16/17 on evening shift; 6/20/17 on evening shift;

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6/23/17 on evening shift; 6/26/17 on evening shift; 6/29/17 on evening and night shift; 6/30/17 on evening shift; 7/1/17 on evening shift; and 7/6/17 on day shift.

(Brand Name) Wound Dress Paste (Wound Dressings); apply to right buttock topically every shift for prevention. Apply thin layer to right buttock - missed documentation on 5/21/17 on day shift; 6/9/17 on evening shift; 6/13/17 on day shift; 6/14/17 on day shift; 6/16/17 on evening shift; 6/20/17 on evening shift; 6/23/17 on evening shift; 6/26/17 on evening shift; 6/29/17 on evening and night shift; 6/30/17 on evening shift; 7/1/17 on evening shift; and 7/6/17 on day shift.

On 7/12/17 at 2:30 pm, an interview was conducted with the Director of Nursing (DON) and was asked regarding the missing documentation on the TARs. She stated that usually, when treatment was not done, the nurse had to document the reason why it was not done and would notify the physician. The DON was asked to find out the reasons for missing documentation on the TARs for 5/17, 6/17 and 7/17.

On 7/13 /17 at 3:10 pm, the DON stated that she did not find the reasons for missed documentation on the TARs. She stated, "It is what it is, so we will move forward and do better".

On 7/13/17 at 10:00 am, Licensed Practical Nurse (LPN) #3 was interviewed and was asked what it meant when treatment orders were not documented on the TAR. She stated, "It means not able to get it done. The nurse should let the oncoming nurse complete the task." She stated that nurses are expected to make sure treatments were done and documented; nurses

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should check the documentation on the computer for each resident at the end of the shift.

On 7/12/17, a copy of the facility policy on documentation was provided as requested. The document was copied from the Lippincott's textbook titled, "Nursing Procedures", 6th edition. The "Documentation" procedure read, in part, "Documentation is the process of preparing a complete record of a patient's and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

The findings were reviewed with the Administrator and the DON on 7/13/17 at approximately 3:45 pm. No further information was provided.

Definition:

(1) Quadriplegia - partial or complete paralysis of both the arms and legs that is usually due to injury or disease of the spinal cord in the region of the neck. (Source: http://c.merriam-webster.com/medlineplus/quadriplegia)

(2) Pressure Ulcer - also known as bedsore - an ulceration of tissue deprived of adequate blood supply by prolonged pressure. (Source: http://c.merriam-webster.com/medlineplus/bedsore)

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2. Resident #1 was admitted to the facility on 3/21/17 with a readmission on 4/26/17 after hospitalization for a wound infection and urinary tract infection. Diagnoses for Resident #1 included but are not limited to Non-Alzheimer's Dementia, Malnutrition and Stage IV* Right Heel Pressure Ulcer. Resident #1's Quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 6/26/17 coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 1 out of 15 indicating severe cognition impairment.

In addition the MDS scored Resident #1 as requiring total dependence with 2 staff persons for Transfers. Resident #1 was coded as requiring total dependence with one staff person assistance for Dressing, Hygiene, and Bathing.

Resident #1's physician orders documented the following:
7/5/17 MD order: Cleanse Right heel wound with normal saline. Apply nickel thick santyl and alginate to wound bed daily. Cover with dry gauze and kerlix daily and as needed.

Resident #1's Treatment Administration Record (TAR) for June 2017 included two wound care documentation omissions and the TAR for July 2017 included 1 wound care documentation omission.

Resident #1's 4/26/17 Care Plan documented a focus area of:
At risk for further skin breakdown due to:
Assistance required in bed mobility and

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repositioning and incontinence of bowel and bladder. 4/26/17 Stage III* to right outer heel
Interventions included:
Conduct weekly skin inspection
Float heels
Treatments as ordered

Resident #1's clinical record documented a 3/21/17 initial Risk for Pressure Ulcers to be 12 indicating High Risk for Pressure Ulcers.

Resident #1's clinical record weekly assessments from her initial admission documented the heel ulcer was initially identified at a Stage II and worsened to a Stage III* on 4/24/17 when the resident required hospitalization. Upon readmission 4/26/17, weekly assessments were documented from admission through 6/18/17.

Review of the Facility Policy titled, "Skin Assessment Weekly" with an effective date of 1/2017 documented the following: "A Licensed Nurse will complete a total body assessment on each resident weekly and document the assessment on the "Weekly Skin Integrity Checks" form.

The Facility Guidance from Lippincott's Nursing procedures sixth edition documented the following: "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

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The Director of Nursing was asked to show evidence that the wound care documentation omissions was completed. The DON stated on 7/12/17 at approximately 1:15 p.m.: "I couldn't find any explanation as to why treatments were not done." The DON added, Nursing staff is to follow the orders the doctor writes for patients. The DON stated following MD orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders for wound care.

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

3. Resident #6 was admitted to the facility on 8/19/15 with a readmission on 9/14/16. Diagnoses for Resident #6 included but are not limited to Stage IV Sacral Pressure Ulcer* and Non-Alzheimer's Dementia*. Resident #6's Annual Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 8/24/16 coded Resident #6 with a BIMS (Brief Interview for Mental Status) of 8 out of 15 indicating a moderate cognition impairment.

In addition the MDS scored Resident #6 as requiring Extensive Assistance with two staff person assistance for Transfers, Bed Mobility, and Dressing. Resident #6 was coded as always incontinent of Urine and frequently incontinent of Bowel functions.

Resident #6's Care Plan documented a focus

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area of:
Stage IV* Pressure ulcer due to Assistance required in bed mobility, wound assessment Score 18 or less than, bowel incontinence. Use of Foley catheter for wound healing
9/14/16 readmitted
9/21/16 chemical cauterization performed by wound specialist
2/6/17 treatment change
4/17/17 new treatment
4/24/17 new treatment
5/3/17 new treatment
Interventions included:
Conduct weekly skin inspection
Foley cath (catheter) as needed
Treatments as ordered
Weekly wound assessment

7/19/17 Braden Scale scored Resident #6 as High Risk for developing Pressure Ulcers.

Current 7/5/17 Physician order for wound care included: Clean wound with normal saline, apply collagen to wound bed, apply skin prep to skin surrounding the wound apply clean dressing and secure.

7/5/17 Wound Care Physician measurements of sacral wound are Length by width by depth: 1 by 0.4 by 0.3 centimeters; surface area .40 centimeters, moderate sero sanguinous exudate with 100% granulation tissue.

Review of the June 2017 Treatment Administration Record included 3 sacral wound care omissions; 8 catheter care omissions, and 16 Triad Paste application omissions to buttock area excoriations.

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The weekly skin assessment form stopped showing documentation after the 6/28/17 measurements. This same form documented deteriorated wound on 3/20/17, 4/3/17, 4/10/17, 4/17/17, and 4/24/17.

Review of the Facility Policy titled, "Skin Assessment Weekly" with an effective date of 1/2017 documented the following: "A Licensed Nurse will complete a total body assessment on each resident weekly and document the assessment on the "Weekly Skin Integrity Checks" form".

The Facility Guidance from Lippincott's Nursing procedures sixth edition documented the following: "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors.

The Director of Nursing was asked to show evidence that the multiple wound care documentation omissions were completed. The DON stated on 7/12/17 at approximately 1:15 p.m.: "I couldn't find any explanation as to why treatments were not done." The DON added, Nursing staff is to follow the orders the doctor writes for patients. The DON stated following MD orders is part of the Nurse's job description. The DON also stated that a wound can develop complications as a result of not following orders

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for wound care.

The facility administration was informed of the findings during a briefing on 7/13/17 at approximately 3:45 p.m. The facility did not present any further information about the findings.

DEFINITIONS:

Stage II Pressure Ulcer: The National Pressure Ulcer Advisory Panel: documented: Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage III Pressure Ulcer: The National Pressure Ulcer Advisory Panel: documented: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage

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and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

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