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	495240	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/25/17 through 4/28/17. Four complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 177 certified bed facility was 111 at the time of the survey. The survey sample consisted of 24 current Resident reviews (Residents # 1 through # 20, #28 through #30 and #32) and eight closed record reviews (Residents # 21 through #27 and #31).	F 000	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.	
F 153 SS=D	483.10(g)(2)(3) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS (g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon	F 153	F153 1. Resident #31 medical records were copied and provided to the family. 2. The Administrator re-educated the Medical Records Coordinator on the medical records request process. 3. The Medical Records Coordinator will communicate requests for medical records in stand-up with the date records were provided for approved requests. The Administrator/Director of Nursing will audit medical records requests weekly times four weeks and then monthly times two months. 4. The Administrator/Medical Records Coordinator/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	6-5-17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tanya Rocquemore NHA | TITLE: Administrator | (X6) DATE: 5/26/17

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request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:

(A) Labor for copying the records requested by the individual, whether in paper or electronic form;

(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and

(C)Postage, when the individual has requested the copy be mailed.

(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and in the course of a compliant investigation, it was determined that the facility staff failed to provide copies of the clinical record to the family in a timely manner for one of 32 residents in the survey sample, Resident #31.

The facility staff failed to release the medical records in a timely manner.

The findings include:

Resident # 31 was readmitted to the facility on 10/16/14 with diagnoses that included but were not limited to: hypothyroidism (1), macular degeneration (2), edema (3) and depression.

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The most recent MDS (minimum data set) an annual assessment, with an ARD (assessment reference date) of 01/7/16 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 being cognitively intact. The resident was coded as requiring extensive assistance of one to one staff member for activities of daily living.

Review of the clinical record revealed the resident had expired on 03/28/16.

A request was made by the responsible party for a copy of the medical record on 09/20/16. This request was sent ASM (administrative staff member) # 1, the administrator. The request by the responsible party documented in part, "Re: (Resident #31). Date of Service: 2008 TO 2016. Dear (ASM # 1), I am requesting that you send me complete electronic format copy of medical records, including imaging studies and billing records, for the above listed patient for her entire residence at (Name of Facility)."

The facility's "Chain of Custody" documented, "I, (OSM [other staff member # 20, director of medical records]), of (Name of Facility) do hereby relinquish custody of the following original Records: Medical Chart, 5 (five) volume(s) of resident (Name of Resident # 31) of (Name of Facility) to (Name of ASM # 7, paralegal) on this 27th day of September, 2016." The "Chain of Custody" further documented, "I, (Name of ASM # 7, paralegal) on this 27th day of September, 2016 hereby acknowledge by my signature, receipt of the original records listed above." The "Chain of Custody" revealed the signature of Name of ASM # 7.

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On 04/25/17 at 2:50 p.m. an interview was conducted with OSM # 20, the director of medical records, regarding the process of the responsible party obtaining copies of a resident's clinical records. OSM # 20 sated, "They complete a medical records request form or send a letter for a request for a copy of a resident's medical records, email the request to the chief clinical officer at the corporate office then they email me back when I can go ahead and get the chart and make copies of what was requested and send it." When asked how long it takes for a request of copies of medical records to be completed OSM # 20 stated, "It's done with 48 hours of receiving the request."

On 04/26/17 at 4:50 p.m. an interview was conducted with OSM # 20, the director of medical records, regarding the request by the responsible party (the son) for a copy of Resident # 31's medical records. OSM # 20 stated, "I emailed the letter from the son to the corporate office the day I got it from the administrator (ASM # 1). I waited for corporate to approve the release of the record. I don't remember how long it took. I also got a phone call from corporate stating that (ASM # 7), the paralegal, would come and pick up the records." A request was made to speak with ASM # 7.

On 04/27/17 at 10:25 a.m. during an interview with OSM # 20 she stated that phone calls had been placed that morning to the corporate office to contact ASM # 7 at 7: 20 a.m., 8:00 a.m. and 8:30 a.m.

During the days of the survey attempts to contact ASM # 7 for an interview to ask when the responsible party for Resident # 31 received the

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copy of the clinical record were unsuccessful.

The "Intake Information" on the Virginia Department of Health complaint form dated 10/26/2016 was reviewed. Under "Intake Detail" in documented, "10-25-2016 the complainant called the hotline and indicated that the records were received."

On 04/27/17 at 3:10 p.m. an interview was conducted with ASM # 1, the administrator, and OSM # 20. This surveyor was then informed they had not received a return phone call from the corporate office to speak with ASM # 7. ASM # 1 and OSM # 20 were asked why there was a delay in Resident # 31's son receiving the requested copies of Resident # 31's clinical record. ASM # 1 stated, "Once we notify the (corporate) office they take it from there and give us directions as what to do next."

Review of the facility's admission agreement revealed documentation regarding access to the resident's clinical record. The admission agreement documented, "RECORDS: Access to Records. You have the right to access your records, including clinical records. The nursing home must provide you access within 24 hours of your request (excluding weekends and holidays). You also have the right to purchase photocopies of your record of a cost that is no more than the standard rate in your community. The nursing home must provide you with the photocopies within two working days of your request."

On 04/27/17 at 3:25 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

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No further information was provided prior to exit.

COMPLAINT DEFICIENCY

References

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

(2) A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from the website: https://medlineplus.gov/maculardegeneration.html.

(3) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html.

F 165 SS=D 483.10(j)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL — F 165

(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other

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F 165	Continued From page 6 residents, and other concerns regarding their LTC facility stay. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility staff interview, facility document review, and clinical record review, it was determined that facility staff failed to act on a grievance expressed by one of 32 residents in the survey sample, Resident #13. After Resident #13 told the facility social worker that she did not want a particular nurse administering her medications, the social worker suggested to the resident that she should take medications by whomever offers them to her, and that she should tell that nurse thank you. The findings include: Resident #13 was admitted to the facility on 6/5/15 and readmitted on 3/31/17 with diagnoses including, but not limited to: Diabetes, bipolar disorder (1), congestive heart failure, and schizoaffective disorder (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 2/6/17, she was coded as having no cognitive impairment for making daily decisions. A review of the progress notes for Resident #13 revealed the following entry written 3/15/17 by OSM (other staff member) #4, the social worker: "SW (social worker) met with resident to discuss issues of concern that resident has voiced to staff over the past week. Suggested resident compromise, receive her meds (medications) from any of the nurses, and offer a thank you. Resident said she would. SW to observe and monitor."	F 165	F165 1. Resident #13 grievance initiated and resolved. 2. The Social Services Director re-educated the Social Services Assistant on the concern process. 3. The Social Service Director/ Social Service Assistant will communicate concerns in stand up to ensure concern forms are completed, investigations conducted and follow-up occurred. A random review of concern forms will be audited three times a week times four weeks and monthly times two months. 4. The Social Services Director/ Designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision. RECEIVED MAY 31 2017 VDH/OLC	6-5-17

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A review of the facility grievance/concern log revealed no evidence of any concerns expressed by Resident #13 during March 2017.

On 4/26/17 at 9:45 a.m., OSM #5, the social services director, was interviewed. She stated her role, once a concern is expressed by a resident through staff, is to log it in the concern log and proceed to resolve the concern. She stated staff members fill out a form with the details of the concern, and then they submit the form to the social workers. OSM #5 stated: "When we receive any type of concern, we meet with the necessary departments and inform them. They work to resolve the issue, and then they contact the complainant." She stated she records any follow up actions on the concern log. OSM #5 stated: "I now do [the logs] month by month. I put the resolution and the action plan in the log." When asked to locate the log entry regarding concerns expressed by Resident #13 in March 2017, OSM #5 reviewed the log and stated: "I don't see any. If it's not given to me as a grievance, it does not go on the log." OSM #5 stated OSM #4 "would have more information" on Resident #13.

On 4/26/17 at 10:05 a.m., OSM #4 was interviewed. After reviewing the above referenced note she had written on 3/15/17, she was asked to provide the details of the concerns expressed by Resident #13 in the week prior to 3/15/17. OSM #4 stated: "It was something that occurred on a Sunday. It goes back to a personal relationship [Resident #13] had established with the nursing staff. She had wanted not to have some particular nurses assigned to her. I told her I always say thank you when I get a med

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(medication), and I told her I expected her to say thank you." When asked to clarify exactly what she stated to the resident about the need for the resident to express gratitude to the staff, OSM #4 stated: "That is not being respectful. Whatever nurse offers the medication, you need to accept it and offer a thank you. I told her that's the only way we are going to get past this." When asked if it is a resident's responsibility to "get past" anything with the staff, or if, rather, it is the staff's responsibility to navigate around the resident, OSM #4 stated: "Well don't you say thank you when someone offers you something? It is just courtesy." When asked if she talked to any of the nurses named by Resident #13, OSM #4 stated she had not. She stated she did not put it on the concern log. When asked why she had not logged the concern, OSM #4 stated: "When they seek us out with a particular complaint, I will put it on that. I feel like you are violating their right to confide certain things with me if I put everything they say on the log."

On 4/26/17 at 12:50 p.m., Resident #13 was interviewed. When asked what happened with her nurses in March, she stated some of the nurses "told lies about me." Resident #13 stated: "They sent some of them back in here to apologize to me about how they treated me." She stated she asked for one particular nurse not to take care of her anymore, and the next thing she remembers is OSM #4 coming in to talk with her. She stated OSM #4 told her that residents are not allowed to say which nurses will or will not give them medications, and that she should tell whomever administers her medications thank you. When asked to describe her response to OSM #4, Resident #13 stated: "What else was I supposed to say? I just said okay. My daughter

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had already told me not to get in any trouble. Just keep my mouth shut and do what they tell me. It's what I did."

On 4/26/17 at 6:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the interim regional director of clinical services, were informed of this concern. Policies and procedures regarding resident concerns/grievances were requested.

A review of the facility policy entitled "Concern Process" revealed, in part, the following: "Upon identification of a patient or representative concern, staff completes the Concern Form identifying the issue and forward the form to the Administrator or designee. During the morning Care Keepers meeting, the Administrator or designee logs the concern on the Concern Log and on the Morning Meeting agenda. The administrator or designee copies and forwards the concern form to the appropriate department head for follow-up and resolution during the morning meeting...Once the root cause of the concern is identified, corrective action is taken to resolve the issue for the identified party as well as potential systemic changes to reduce risk of recurrence or occurrence for others. The assigned department head contacts the appropriate party once resolution has been completed."

No further information was provided prior to exit.

(1) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day

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F 165	Continued From page 10 tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.	F 165		
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.	F 167	F167 1. On May 8, 2017, the Administrator posted a notice of the availability of the last three preceding year's survey results and updated the binder with their corresponding plan of corrections. 2. On May 8, 2017, the Chief Clinical Officer re-educated the current Administrator on posting a notice of the availability of the last three preceding year's survey results with their corresponding plan of corrections. 3. The Administrator will conduct random reviews of the survey book to ensure the last three preceding year's survey results are available weekly times four weeks and then monthly times two months. 4. The Administrator/designee will report the monitoring results to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	5-8-17

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(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to post a notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections.

A notice was not posted to the residents and responsible parties that the results of the previous three years of survey results, with the plan of corrections, were available for review.

The findings include:

Observations were made of the survey results book in the front lobby on 04/25/17 at approximately 7:30 a.m., 04/25/17 at approximately 11:30 a.m. and on 4/25/17 at 3:00 p.m. A framed sign that documented, "ATTENTION: SURVEY RESULTS ARE POSTED AT THE RECEPTIONIST'S DESK" was standing on a corner cabinet in the lobby across from the main entrance door to the facility. Observation of the receptionist's desk in the facility's lobby revealed a black three ring binder. The cover of the black binder documented, "(Name of City and State) Annual State Inspection Survey Results." The three ring binder contained survey results and plan of corrections from the annual survey ending on 06/17/16 and the survey results and plan of corrections from the revisit survey ending on 08/10/16. Further observation of the contents of the book failed to evidence the survey results and plan of corrections for the previous three years.

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An interview was conducted with ASM (administrative staff member) #1, the administrator, on 04/25/17 at 3:10 p.m. When asked who is responsible for posting the survey results, ASM #1 stated, "I am." When asked about the framed sign in the lobby posting the availability of the survey results for the previous three years ASM #1 stated she didn't know it needed to be posted." When asked were the survey results for the previous three years were located ASM #1 stated they're at the receptionist's desk. An observation of the receptionist's desk was conducted with ASM #1. Observation of the receptionist's desk failed to evidence survey results for the previous three years. ASM #1 stated that the results were in a white binder. ASM #1 asked OSM (other staff member) # 23, the receptionist, where the white binder was. At 3:35 p.m. OSM #23 presented this surveyor with a white binder. The cover on the binder documented, "Annual State Inspection Survey Results 2015, 2014 & (and) 2013." The white three ring binder contained survey results and plan of corrections from the revisit survey ending on 07/29/15, the annual surveys ending on 06/12/15, 06/19/2014 and 06/30/13. When asked where the white binder was found OSM # 23 stated, "It was in the business office because there isn't enough room on my desk."

Review of the facility's admission agreement revealed documentation regarding access to the resident's clinical record. The admission agreement documented, "Examination of Survey Results. You have the right to examine the results of the most recent survey results of the nursing home conducted by federal or state surveyors and the nursing home's plan to correct deficiencies, if any."

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F 167	Continued From page 13 On 04/27/17 at 3:25 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 167		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of	F 226	F226 1.Employee #11 identified with a hire date of 1-21-16 is no longer employed with Fredericksburg Health and Rehab. Employee #12 with a hire date of 1-21-16 had a license verification performed by the facility on 12-29-16 and reverified on 5-12-17. Employee CNA #13 with a hire date of 11-7-16 is a Licensed Practical Nurse, licensed verified on 10-31-16 and the facility did not obtain reference checks prior to employment. 2. The Human Resource Coordinator will conduct an audit of current employees to ensure appropriate screening per the abuse policy prior to employment. 3. The Administrator re-educated the Human Resource Coordinator on the Abuse policy. The Administrator/Human Resource Coordinator will conduct random audits of new employees' files weekly times four weeks and then monthly times two months. 4. The Administrator/Human Resource Coordinator will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	6-5-17

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resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to screen employees per their abuse policy prior to employment for three of five employee records reviewed, CNA [certified nursing assistant] #12, CNA #11 and CNA #13.

The facility staff failed to obtain license verification or sworn statement on one of five employee records reviewed, CNA #12 and did not obtain reference checks on two of five employees prior to employment, CNA #11 and CNA #13.

The findings include:

Review of CNA (certified nursing assistant) #12's employment record documented that the employee was hired on 1/21/16. The license was verified on 12/29/16, eleven months later. There was no evidence of documentation regarding the employee's sworn statement. A copy of the partial employee's schedule was obtained on 4/27/17 at 10:10 a.m. from OSM (other staff member) #6, payroll and human resource, OSM # 6 stated, "This is what corporate sent." The schedule was dated from 5/23/16 to 12/29/16. The employee worked with residents a total of 603.61 hours during that time frame.

Review of the CNA #13's employee record documented the employee was hired on 11/7/16. The license was verified on 12/29/16 almost two

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months later. There was no evidence of documentation regarding reference checks.

Review of CNA #11's employee record documented that the employee was hired on 1/21/16. There was no evidence of documentation regarding reference checks being completed.

An interview was conducted on 4/26/17 at 11:15 a.m. OSM #6. When asked who obtained reference checks, OSM #6 stated, "We just took over HR (human resources) two weeks ago. The HR person is supposed to get the references." When asked why they do reference checks, OSM #6 stated, "To make sure that these people are good employees." When asked when they obtain a background check, OSM #6 stated, "I'm not sure but they need to have a criminal background check before they start working." When asked why licenses were verified, OSM #6 stated, "To make sure they have a valid license and there's nothing against it like resident abuse."

On 4/26/17 at 6:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 4/28/17 at 9:50 ASM #1, the administrator. When asked why reference checks were completed on employees, ASM #1 stated, "We do reference checks to validate employees work history and character. To confirm what they have put on their resume." When asked why license verification and a background checks were completed, ASM #1 stated, "Barrier crimes for background check and we check the license to confirm they can operate

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in the scope of their practice."

Review of the facility's policy titled, "Resident Abuse" documented, "POLICY: It is inherent in the nature and dignity of each resident at Facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The management of the Facility recognizes these rights and hereby establishes the following statements, policies and procedures to protect these rights and to establish a disciplinary policy, which policy, which results in the fair and timely treatment of occurrences of resident abuse. Screening. Persons applying for employment with Facility will be screened for a history of abuse, neglect, or mistreating residents to include: A. References from previous or current employers (with applicant permission). B. Criminal Background check. C. Abuse check with appropriate licensing board and registries, prior to hire. D. Swore Disclosure Statement prior to hire. E. Verify license or registration prior to hire."

No further information was provided prior to exit.

F 240 SS=D — 483.10(a)(1)(2) CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE — F 240

(a)(1) A facility must treat each resident with respect and dignity 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.

(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of

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F 240	Continued From page 17 condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility staff interview, facility document review and clinical record review, it was determined that the facility staff failed to treat a resident with dignity and respect, enhancing the quality of life for one of 32 residents in the survey sample, Resident #13. After Resident #13 told the facility social worker that she did not want a particular nurse administering her medications, the social worker suggested to the resident that she should take medications by whomever offers them to her, and that she should tell that nurse thank you. The findings include: Resident #13 was admitted to the facility on 6/5/15 and readmitted on 3/31/17 with diagnoses including, but not limited to: Diabetes, bipolar disorder (1), congestive heart failure, and schizoaffective disorder (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 2/6/17, she was coded as having no cognitive impairment for making daily decisions. A review of the progress notes for Resident #13 revealed the following entry written 3/15/17 by OSM (other staff member) #4, the social worker: "SW (social worker) met with resident to discuss issues of concern that resident has voiced to staff over the past week. Suggested resident	F 240	F240 1. Resident #13 grievance initiated and resolved. 2. The Social Services Director re-educated the Social Services Assistant on the concern process. 3. The Social Service Director/Social Service Assistant will communicate concerns in stand up to ensure concern forms are completed and follow-up occurred. A random review of concern forms will be audited three times a week times four weeks and then monthly times two months. 4. The Social Services Director/ designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	6-5-17

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compromise, receive her meds (medications) from any of the nurses, and offer a thank you. Resident said she would. SW to observe and monitor."

A review of the facility grievance/concern log revealed no evidence of any concerns expressed by Resident #13 during March 2017.

On 4/26/17 at 9:45 a.m., OSM #5, the social services director, was interviewed. She stated her role, once a concern is expressed by a resident through staff, is to log it in the concern log and proceed to resolve the concern. She stated staff members fill out a form with the details of the concern, and then they submit the form to the social workers. OSM #5stated: "When we receive any type of concern, we meet with the necessary departments and inform them. They work to resolve the issue, and then they contact the complainant." She stated she records any follow up actions on the concern log. OSM #5 stated: "I now do [the logs] month by month. I put the resolution and the action plan in the log." When asked to locate the log entry regarding concerns expressed by Resident #13 in March 2017, OSM #5reviewed the log and stated: "I don't see any. If it's not given to me as a grievance, it does not go on the log." OSM #5 stated OSM #4 "would have more information" on Resident #13.

On 4/26/17 at 10:05 a.m., OSM #4 was interviewed. After reviewing the above referenced note she had written on 3/15/17, she was asked to provide the details of the concerns expressed by Resident #13 in the week prior to 3/15/17. OSM #4 stated: "It was something that occurred on a Sunday. It goes back to a personal

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relationship [Resident #13] had established with the nursing staff. She had wanted not to have some particular nurses assigned to her. I told her I always say thank you when I get a med, and I told her I expected her to say thank you." When asked to clarify exactly what she stated to the resident about the need for the resident to express gratitude to the staff, OSM #4 stated: "That is not being respectful. Whatever nurse offers the medication, you need to accept it and offer a thank you. I told her that's the only way we are going to get past this." When asked if it is a resident's responsibility to "get past" anything with the staff, or if, rather, it is the staff's responsibility to navigate around the resident, OSM #4 stated: "Well don't you say thank you when someone offers you something? It is just courtesy." When asked if she talked to any of the nurses named by Resident #13, she stated she had not. She stated she did not put it on the concern log. When asked why she had not logged the concern, OSM #4 stated: "When they seek us out with a particular complaint, I will put it on that. I feel like you are violating their right to confide certain things with me if I put everything they say on the log."

On 4/26/17 at 12:50 p.m., Resident #13 was interviewed. When asked what happened with her nurses in March, she stated some of the nurses "told lies about me." Resident #13 stated: "They sent some of them back in here to apologize to me about how they treated me." She stated she asked for one particular nurse not to take care of her anymore, and the next thing she remembers is OSM #4 coming in to talk with her. She stated OSM #4 told her that residents are not allowed to say which nurses will or will not give them medications, and that she should tell

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whomever administers her medications thank you. When asked to describe her response to OSM #4, Resident #13 stated: "What else was I supposed to say? I just said okay. My daughter had already told me not to get in any trouble. Just keep my mouth shut and do what they tell me. It's what I did." Resident #13 stated she is "just trying to do what I have to do to get out of here. I am trying to be nice."

On 4/26/17 at 6:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the interim regional director of clinical services, were informed of this concern. Policies and procedures regarding resident concerns/grievances were requested.

On 4/27/17 at 11:40 a.m., LPN (licensed practical nurse) #11, a unit manager, was interviewed. When asked to review the note written by OSM #4 on 3/15/17, she did so and stated: "I did not know anything about this." When asked if the resident's concern should have been investigated further, LPN #11 stated: "Absolutely. The social worker should have at least looked into it." When asked if it is appropriate for a social worker to tell a resident to accept medications from whomever administers them and to say thank you, LPN #11 stated: "No, it is not appropriate in any way."

A review of the facility policy entitled "Concern Process" revealed, in part, the following: "Upon identification of a patient or representative concern, staff completes the Concern Form identifying the issue and forward the form to the Administrator or designee. During the morning Care Keepers meeting, the Administrator or designee logs the concern on the Concern Log

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F 240	Continued From page 21 and on the Morning Meeting agenda. The administrator or designee copies and forwards the concern form to the appropriate department head for follow-up and resolution during the morning meeting...Once the root cause of the concern is identified, corrective action is taken to resolve the issue for the identified party as well as potential systemic changes to reduce risk of recurrence or occurrence for others. The assigned department head contacts the appropriate party once resolution has been completed." No further information was provided prior to exit.	F 240		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide medically related social services to one of 32 residents in the survey sample, Resident #13. The facility social worker failed to investigate and follow up on Resident #13's concern about a nurse providing her care. The findings include: Resident #13 was admitted to the facility on 6/5/15 and readmitted on 3/31/17 with diagnoses	F 250		

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including, but not limited to: Diabetes, bipolar disorder (1), congestive heart failure, and schizoaffective disorder (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 2/6/17, she was coded as having no cognitive impairment for making daily decisions.

A review of the progress notes for Resident #13 revealed the following entry written 3/15/17 by OSM (other staff member) #4, the social worker: "SW (social worker) met with resident to discuss issues of concern that resident has voiced to staff over the past week. Suggested resident compromise, receive her meds (medications) from any of the nurses, and offer a thank you. Resident said she would. SW to observe and monitor."

A review of the facility grievance/concern log revealed no evidence of any concerns expressed by Resident #13 during March 2017.

On 4/26/17 at 9:45 a.m., OSM #5, the social services director, was interviewed. She stated her role, once a concern is expressed by a resident through staff, is to log it in the concern log and proceed to resolve the concern. She stated staff members fill out a form with the details of the concern, and then they submit the form to the social workers. OSM #5 stated: "When we receive any type of concern, we meet with the necessary departments and inform them. They work to resolve the issue, and then they contact the complainant." She stated she records any follow up actions on the concern log. OSM #5 stated: "I now do [the logs] month by month. I put the resolution and the action plan in the log." When asked to locate the log entry regarding

1. Resident #13 grievance initiated and resolved.
2. The Social Services Director re-educated the Social Services Assistant on the concern process, conducting investigations and resolutions.
3. The Social Service Director/Social Service Assistant will communicate concerns in stand-up to ensure concern forms are initiated, investigations conducted and follow-up occurred. A random review of concern forms will be audited three times a week times four weeks and then monthly times two months.
4. The Social Services Director/ Designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.

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concerns expressed by Resident #13 in March 2017, OSM #5 reviewed the log and stated: "I don't see any. If it's not given to me as a grievance, it does not go on the log." OSM #5 stated OSM #4 "would have more information" on Resident #13.

On 4/26/17 at 10:05 a.m., OSM #4 was interviewed. After reviewing the above referenced note she had written on 3/15/17, she was asked to provide the details of the concerns expressed by Resident #13 in the week prior to 3/15/17. OSM #4 stated: "It was something that occurred on a Sunday. It goes back to a personal relationship [Resident #13] had established with the nursing staff. She had wanted not to have some particular nurses assigned to her. I told her I always say thank you when I get a med, and I told her I expected her to say thank you." When asked to clarify exactly what she stated to the resident about the need for the resident to express gratitude to the staff, OSM #4 stated: "That is not being respectful. Whatever nurse offers the medication, you need to accept it and offer a thank you. I told her that's the only way we are going to get past this." When asked if it is a resident's responsibility to "get past" anything with the staff, or if, rather, it is the staff's responsibility to navigate around the resident, OSM #4 stated: "Well don't you say thank you when someone offers you something? It is just courtesy." When asked if she talked to any of the nurses named by Resident #13, OSM #4 stated she had not. She stated she did not put it on the concern log. When asked why she had not logged the concern, OSM #4 stated: "When they seek us out with a particular complaint, I will put it on that. I feel like you are violating their right to confide certain things with me if I put everything

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they say on the log."

On 4/26/17 at 12:50 p.m., Resident #13 was interviewed. When asked what happened with her nurses in March, she stated some of the nurses "told lies about me." Resident #13 stated: "They sent some of them back in here to apologize to me about how they treated me." She stated she asked for one particular nurse not to take care of her anymore, and the next thing she remembers is OSM #4 coming in to talk with her. She stated OSM #4 told her that residents are not allowed to say which nurses will or will not give them medications, and that she should tell whomever administers her medications thank you. When asked to describe her response to OSM #4, Resident #13 stated: "What else was I supposed to say? I just said okay. My daughter had already told me not to get in any trouble. Just keep my mouth shut and do what they tell me. It's what I did." Resident #13 stated she is "just trying to do what I have to do to get out of here. I am trying to be nice."

On 4/26/17 at 6:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the interim regional director of clinical services, were informed of this concern. Policies and procedures regarding responsibilities of the social worker were requested.

On 4/27/17 at 11:40 a.m., LPN (licensed practical nurse) #11, a unit manager, was interviewed. When asked to review the note written by OSM #4 on 3/15/17, she did so and stated: "I did not know anything about this." When asked if the resident's concern should have been investigated further, LPN #11 stated: "Absolutely. The social

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worker should have at least looked into it." When asked if it is appropriate for a social worker to tell a resident to accept medications from whomever administers them and to say thank you, LPN #11 stated: "No, it is not appropriate in any way."

A review of the facility document entitled "Social Services Director" revealed, in part, the following: "The primary duties of this position are to plan, organize, develop and direct the overall operation of the facility's Social Service department according to federal, state, and local guidelines. The ideal candidates will possess good communications and interpersonal skills to interact with the facility's residents and work with the staff members to ensure residents' needs are maintained on an individual basis."

No further information was provided prior to exit.

(1) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.

(1) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day

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F 250	Continued From page 26 tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.	F 250		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 252	F252 1. Resident #2 wheelchair armrests were replaced on April 27, 2017. 2. The Plant Operations Director/ designee will inspect current residents' wheelchairs to ensure armrests are of free from tears. 3. The Administrator re-educated the Interdisciplinary Team on submitting work order requisitions as indicated. Resident care equipment to include wheelchairs will be randomly reviewed by the Interdisciplinary Team during care keeper rounds weekly times four weeks and then monthly times two months. 4. The Interdisciplinary Team will report the audit results monthly to the Quality Assurance Performance Improvement Committee for continued compliance and/or revision.	6-5-17

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 32 residents in the survey sample, Resident #2.

The facility staff failed to maintain Resident #2's wheelchair armrests in good repair.

The findings include:

Resident #2 was admitted to the facility on 8/30/16 and readmitted to the facility on 1/23/17. Resident #2's diagnoses included but were not limited to: multiple sclerosis, diabetes and major depressive disorder. Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/30/17, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of two or more staff with bed mobility and as being totally dependent on two or more staff with transfers.

On 4/26/17 at 1:45 p.m. and 4/27/17 at 8:45 a.m., observations of Resident #2's wheelchair were conducted. A torn area (approximately four inches long by one and a half inch wide) was observed on the right armrest; foam padding was exposed. A torn area (approximately two inches long by a half inch wide) was observed on the left armrest; foam padding was exposed. Resident #2 was in bed when these observations were made.

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On 4/27/17 at 8:48 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated the CNAs work with the residents more than other staff so CNAs normally see if wheelchair repairs are needed. CNA #1 stated if wheelchair repairs are needed then the CNAs submit maintenance work order requests. CNA #1 stated the maintenance department is quick to fix needed repairs. CNA #1 was asked if staff ever completes any audits to check wheelchairs for needed repairs. CNA #1 stated the housekeeping department cleans wheelchairs every Sunday. When CNA #1 was asked if she had noticed any repairs that were needed for Resident #2's wheelchair, she stated she had not. CNA #1 was shown Resident #2's wheelchair and stated she didn't recall noticing the torn armrests and she would let the therapy department know the wheelchair needed new armrests. CNA #1 was asked to clarify whether the maintenance department or therapy department was responsible for repairing or replacing wheelchair armrests. CNA #1 stated, "I would go to therapy. They can fix those." CNA #1 was asked if Resident #2's wheelchair looked clean, comfortable and homelike. CNA #1 stated, "I wouldn't want to have it like that."

On 4/27/17 at 8:59 a.m., therapy staff was observed replacing Resident #2's wheelchair armrests. OSM (Other staff member) #3 (the director of rehabilitation [rehab]) stated the wheelchair was personally owned by the resident. OSM #3 was asked if the rehab department or maintenance department was responsible for repairing or replacing wheelchair armrests. OSM #3 stated the rehab staff fixes a resident's wheelchair armrests if the resident is on rehab caseload but typically the maintenance

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department fixes wheelchair armrests.

On 4/27/17 at 9:02 a.m., an interview was conducted with OSM #1 (the director of maintenance). OSM #1 stated the maintenance department fixes wheelchair armrests if they are notified of an issue. OSM #1 stated the maintenance department does not complete any audits to ensure wheelchairs are in good repair. OSM #1 was asked to check his records to see if a maintenance work order regarding Resident #2's wheelchair had been submitted.

On 4/27/17 at 9:05 a.m., an interview was conducted with OSM #2 (the director of housekeeping). OSM #2 stated the housekeeping department inspects and disinfects wheelchairs at least once a week and as needed. OSM #2 stated if he notices a needed repair then he writes a maintenance request and or speaks to someone in the therapy department.

On 4/27/17 at 9:19 a.m., OSM #1 stated he had not received any maintenance work order requests regarding Resident #2's wheelchair armrests.

On 4/27/17 at 9:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. ASM #1 stated she previously had a CNA complete an audit regarding wheelchair repairs that were needed. ASM #1 was asked when the audit was completed and stated the audit was completed approximately two months ago. ASM #1 was asked to present all information regarding the audit.

On 4/27/17 at 9:37 a.m., ASM #1 presented an

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email from ASM #1 to OSM #3 dated 2/20/17 that documented, "Hi All, (Name of CNA) CNA checked all wheelchairs with residents in them on Saturday 2/18/2017. (Name of OSM #3), Can you determine if the following parts can be ordered by Therapy and billed to the facility...Left Arm rest 12. Right Arm rest 12..."

On 4/27/17 at 9:47 a.m., ASM #1 stated she couldn't find the actual wheelchair audit that was completed. ASM #1 was made aware the above findings remained a concern because Resident #2's wheelchair armrests were not repaired.

The facility document titled, "ENVIRONMENT & PLANT OPERATIONS" documented, "The Administrator must meet with the Maintenance Director and Housekeeping Supervisor to walk through and discuss the condition of the facility on a weekly basis. Maintenance and housekeeping concerns and repair schedules including, but not limited to...Resident Care Equipment...(wheelchairs)..."

No further information was presented prior to exit.

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

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

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F 279	Continued From page 31 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the 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	F 279	F279 1. Resident #8 vision care plan was initiated on April 26, 2017 and revised on April 27, 2017 after eye doctor visit. Resident #26 is no longer a resident of Fredericksburg Health and Rehab. 2. Review admission comprehensive assessments completed in the last 90 days to ensure care plans were developed as identified on CAA summary sheets. 3. Re-education provided to RNAC on May 19, 2017 by Vice President of Clinical Reimbursement and Therapy. RNAC to re-educate the interdisciplinary team. RNAC/ designee will review 10% of admission comprehensive assessment triggered CAA's are care planned based on care plan decisions monthly times three months. 4. The RNAC/designee will report audits monthly to the Quality Assurance Performance Improvement Committee to ensure continued compliance and/or revision.	6-5-17

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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, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop a comprehensive care plan from the triggered CAA (care assessment area) of the MDS (minimum data set) assessment for two of 32 residents in the survey sample, Resident #8 and #26.

1. The facility staff failed to develop a vision care plan for the triggered care area of visual function on the CAA of Resident #8's admission minimum data set (MDS) with an assessment reference date (ARD) of 4/13/17.

2. The facility staff failed to develop a comprehensive care plan for the triggered care area of pressure ulcers on the CAA of Resident 26's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/12/2016.

The findings include:

1. Resident #8 was admitted to the facility on 3/25/17 and readmitted on 4/6/17 with diagnoses that included but were not limited to: stroke, indigestion, weakness, respiratory failure,

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difficulty swallowing and high blood pressure.

The most recent MDS, an admission assessment, with an ARD of 4/13/17 coded the resident as usually being able to make self-understood and sometimes understand others. The resident's brief interview for mental status was coded "00" indicating the resident was unable to answer any question correctly. Section B of the MDS titled, "Hearing Speech and Vision", documented, "B 1000. Vision, Ability to see in adequate light (with glasses or other visual appliances)." The number two was entered into the box indicating that the resident was moderately impaired visually. The CAA section of the MDS documented, "03. Visual Function. A. Care Area Triggered. (An "x" was in the box indicating the area was triggered). B. Care Planning Decision. (An "x" was in the box)."

Review of the care plan initiated on 3/31/17 did not evidence documentation of a vision care plan. An interview was conducted on 4/26/17 at 1:15 p.m. with LPN (licensed practical nurse) #4. When asked who used the care plans, LPN #4 stated, "Everybody, the nurses, MDS." When asked why residents had care plans, LPN #4 stated, "To address their needs. With a care plan you know if they're a one person assist, how they're eating. It's all addressed in the care plan."

An interview was conducted on 4/26/17 at 4:30 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked if she developed the comprehensive care plan from the CAA, RN #2 stated she did. When asked if vision had triggered in the CAA of Resident #8's admission minimum data set (MDS) with an assessment reference date (ARD) of 4/13/17, RN #2 stated it

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had. When asked to review Resident #8's care plan for vision, RN #2 stated, "I don't see one for her vision." When asked why the residents had care plans, RN #2 stated, "So we know how to care for our residents. If you were an agency nurse you would want to know what to do for that resident." When asked what resource she used to complete the MDS assessment, RN #2 stated they used the RAI (resident assessment instrument).

On 4/26/17 at 6:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "CARE PLAN PREPARATION" documented, "A care plan directs the patient's nursing care from admission to discharge."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)
(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

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2. The facility staff failed to develop a comprehensive care plan for the triggered care area of pressure ulcers on the CAA of Resident 26's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/12/2016.

Resident #26 was admitted to the facility on 7/5/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, thrombocytopenia (a condition in which your blood has a lower than normal number of blood cell fragments called platelets [1]), hip fracture, peripheral vascular disease (poor blood circulation to the lower extremities), anemia (low red blood cell count, atrial fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (affecting the lungs).

Resident #26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/16 coded Resident #26 as scoring a 0 (zero) out of a possible score of 15 on the BIMS (brief interview for mental status), indicating that Resident #26 was severely cognitively impaired with daily decisions about care. Resident #26 was also coded in Section M, Skin Conditions, as having two unhealed pressure ulcers at the time of the assessment, an unstageable* wound with slough and/or eschar* measuring 5.0 cm (centimeters) x 10.0 cm and an unstageable wound with suspected deep tissue injury*.

Further review of Resident #27's MDS assessments revealed, in part, an admission assessment with an ARD of 7/12/16. Section V -

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Care Area Assessment (CAA) Summary of the admission assessment documented that "16. Pressure Ulcer" was checked as a triggered care area under column "A" and also checked under column "B. Care Planning Decision." The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan." Section V, Column B for Resident #27's MDS was checked for pressure ulcer.

A review of Resident #27's comprehensive care plan dated 7/5/16 did not reveal any documentation to evidence that pressure ulcers were care planned at the time of admission. Further review of Resident #27's care plan revealed, in part, the following documentation; "Focus: Pressure ulcer actual or at risk due to Assistance required in bed in bed mobility. Date Initiated: 7/29/2016.

On 4/27/17 at 3:55 p.m. an interview was conducted with RN (registered nurse) #2, the MDS coordinator. RN #2 was asked how she determined what would be placed on the care plan. RN #2 stated, "The care plan is determined by the CAA triggered areas, the medical diagnoses and medications taken. New admissions have an interim care plan in the first 24 hours which is used until the comprehensive care plan is completed." RN #2 was asked if triggered areas on the CAA would always be care planned. RN #2 stated, "Yes and no, it depends on why the CAA triggered. We make that decision." RN #2 was shown the care plan for

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Resident #26 and Section V of his admission MDS assessment with an ARD of 7/12/16. RN #2 was asked whether or not pressure ulcers should have been care planned based on the results of the CAA. RN #2 stated, "It should have been care planned, I don't know why it wasn't."

On 4/27/17 at 5:20 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim regional director of clinical services and ASM #4, the owner. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above concerned. A policy regarding care plan development was requested at this time.

On 4/28/17 at approximately 9:45 a.m. an interview was conducted with LPN (licensed practical nurse) #18, the MDS coordinator. LPN #18 was asked to describe the purpose of the care plan. LPN #18 stated, "The purpose of developing a plan of care is to make the resident's life better, guide aides and nurses to meet their needs. There should be specific goals and needs in mind. The care plan should reflect the current care."

A review of the facility policy titled "Care Plan Preparation" documented, in part, the following; "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, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation, and evaluation. A nursing care plan should be written for each patient, preferably within 24 hours of admission.

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Implementation: Based on an analysis of the data, determine which nursing diagnoses will guide your patient care."

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

*This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.
Pressure Injury:
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

[1] This information was obtained from the following website:
https://www.nhlbi.nih.gov/health/health-topics/topics/thcp

F 280 SS=E — 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP — F 280

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to

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F 280	Continued From page 39 be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 280	F280 1. Resident #1 care plan was updated on April 26, 2017 to include high risk for falls. Resident #8 care plan was revised on April 26, 2017. Resident #2 care plans were revised on April 27, 2017. Resident #14 care plan was reviewed and revised on May 22, 2017. 2. The RNAC/designee will review current falls, wounds, and urinary catheter care plans to ensure care plans are current. 3. Re-education provided to RNAC May 19, 2017 by Vice President of Clinical Reimbursement and Therapy. RNAC/designee to re-educate the Interdisciplinary Team. RNAC/designee will audit comprehensive care plans of urinary catheters, falls, and wounds to ensure review and revision as indicated monthly times three months. 4. The RNAC/designee will report audits monthly to the Quality Assurance Performance Improvement Committee to ensure continued compliance and/or revision.	6-5-17

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(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for four of 32 residents in the survey sample, Residents #1, #8, #2, and #14,

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1. The facility staff failed to review Resident #1's comprehensive care plan to ensure it included a fall plan of care.

2. The facility staff failed to revise Resident #8's comprehensive care plan after the urinary catheter was removed.

3. The facility staff failed to revise Resident #2's comprehensive care plan following the development of a pressure injury on the sacrum on 12/7/16, and the development of pressure injuries on the right heel and left buttock on 4/19/17.

4. The facility staff failed to review and revise Resident #14's comprehensive care plan after two skin alterations were found on 2/3/17 and 3/22/17.

The findings include:

1. The facility staff failed to review Resident #1's comprehensive care plan to ensure it included a fall plan of care.

Resident #1 was admitted to the facility on 10/22/16 with diagnoses that included: Parkinson's disease (1), movement disorder, difficulty swallowing, dementia and urinary retention. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/18/17 coded the resident as having scored an 11 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance for all activities of daily living.

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Review of Resident #1's care plan initiated on 10/24/16, did not evidence a care plan related to falls.

Review of Resident #1's fall risk dated 2/12/17 documented the resident's fall score as 15. It further documented, "TOTAL SCORE (Total Score above 10 represents HIGH RISK)."

Review of a post fall analysis form for Resident #1 dated 1/10/17 documented, "Trying to transfer self from w/c (wheelchair) to bed. IDT (interdisciplinary team) Review and Recommendations....Remove air mattress (1/12/17), lay down at regular intervals." An interview was conducted on 4/25/17 at 1:25 p.m. with LPN #4, the resident's nurse. When asked who used the care plans, LPN #4 stated, "Everybody, the nurses, MDS." When asked who updated the care plan, LPN #4 stated, "Anybody can." When asked when a care plan would be updated, LPN #4 stated, "When there's a change in condition, a fall, and medication." When asked to review Resident #1's care plan for a fall plan, LPN #4 stated, "He had a fall? I don't see one."

An interview was conducted on 4/26/17 at 4:20 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked if a care plan would be updated after a fall, ASM #2 stated yes. When asked to review Resident #1's care plan, ASM #2 stated, "I know we updated the care plan. It was resolved on 4/13 (17). Why did they do that, he's a huge fall risk. Usually when we do falls I review the care plan that's part of our falls committee." A request for the resolved care plan was made at that time.

Review of the resolved care plan initiated on

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1/10/17 and resolved on 4/13/17 documented, "RESOLVED: At risk for falls related to:....1/10/17 fall with no injury. Interventions. Ambulation restorative program. Labs (laboratory) as ordered."

An interview was conducted on 4/27/17 at 11:15 a.m. with LPN #11, the unit manager. When asked about the care plan, LPN #11 stated she did not know why she had resolved the care plan and that the resident was a fall risk.

On 4/26/17 at 6:30 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings

Review of the facility's policy titled, "CARE PLAN PREPARATION" documented, "A care plan directs the patient's nursing care from admission to discharge. Nurses update and revise the plan throughout the patient's stay and the document becomes part of the permanent record."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)
(1) Fundamentals of Nursing Lippincott Williams

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& Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

(1) Parkinson disease is a progressive disorder of the nervous system. The disorder affects several regions of the brain, especially an area called the substantia nigra that controls balance and movement. This information was obtained from: https://ghr.nlm.nih.gov/condition/parkinson-disease#definition

2. The facility staff failed to revise Resident #8's comprehensive care plan after the urinary catheter was removed.

Resident #8 was admitted to the facility on 3/25/17 and readmitted on 4/6/17 with diagnoses that included but were not limited to: stroke, indigestion, weakness, respiratory failure, difficulty swallowing and high blood pressure.

The most recent MDS, an admission assessment, with an ARD of 4/13/17 coded the resident as usually being able to make self-understood and sometimes understand others. The resident's brief interview for mental status was coded "00" indicating the resident was unable to answer any question correctly. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the physician's orders dated April 2017, documented, "Discontinue foley cath (catheter) tonight in the evening..."

Review of the April 2017 treatment administration record documented, "Reinsert foley if no voiding

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(urinating) in 8 hrs. (hours) Order date 04/11/2017." The 4/11/17 box was initialed.

Review of the nurse's notes for 4/11/17 did not evidence documentation that the urinary catheter needed to be re-inserted. Further review of the nurse's notes documented that the resident was incontinent of urine.

Review of the care plan initiated on 3/27/17 documented, "Focus. Alteration in elimination of bowel and bladder related to Diuretic (fluid pill) Use, Indwelling Urinary Catheter. Interventions. foley catheter to straight drainage as ordered."

An observation of Resident #8 was made on 4/25/17 at 12:55 p.m., 1:30 p.m. and 4:08 p.m. and on 4/26/17 at 7:56 a.m. and 1:10 p.m. There was no urinary catheter seen during any of these observations.

An interview was conducted on 4/26/17 at 1:15 p.m. with LPN (licensed practical nurse) #4. When asked who used the care plans, LPN #4 stated, "Everybody, the nurses, MDS." When asked why residents had care plans, LPN #4 stated, "To address their needs. With a care plan you know if they're a one person assist, how they're eating. It's all addressed in the care plan." When asked who updated the care plan, LPN #4 stated, "We (the nurses) can."

An interview was conducted on 4/26/17 at 4:30 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked if she developed the comprehensive care plan from the CAA, RN #2 stated she did. When asked why the residents had care plans, RN #2 stated, "So we know how to care for our residents. If you were an agency

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nurse you would want to know what to do for that resident." When asked what resource she used to complete the MDS, RN #2 stated they used the RAI (resident assessment instrument).

On 4/26/17 at 6:30 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

3. The facility staff failed to revise Resident #2's comprehensive care plan following the development of a pressure injury on the sacrum (1) on 12/7/16, and the development of pressure injuries on the right heel and left buttock on 4/19/17.

Resident #2 was admitted to the facility on 8/30/16 and readmitted to the facility on 1/23/17. Resident #2's diagnoses included but were not limited to: multiple sclerosis, diabetes and major depressive disorder. Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/30/17, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of two or more staff with bed mobility and as being totally dependent on two or more staff with transfers.

Review of Resident #2's clinical record revealed a clinical health status form that documented Resident #2 presented with a stage one pressure injury (2) "across buttocks" on 12/7/16. Pressure ulcer (injury) records documented Resident #2 developed an unstageable pressure injury (2) on the right medial heel and an unstageable

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pressure injury on the left buttock on 4/19/17.

Review of Resident #2's comprehensive care plan initiated on 1/23/17 revealed documentation regarding other pressure injuries but failed to reveal the care plan was revised regarding the above pressure injuries.

On 4/26/17 at 4:40 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the wound care nurse). LPN #1 was asked when residents' care plans are revised regarding the development of pressure ulcers. LPN #1 stated care plans are revised in the weekly interdisciplinary team meetings by the director of nursing or one of the unit managers, when a pressure ulcer is found.

On 4/26/17 at 4:52 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she checks to ensures orders for wounds are implemented and care plans are updated at the weekly wound meetings.

On 4/26/17 at 6:35 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the concern that Resident #2's care plan was not revised following the development of all pressure ulcers.

No further information was presented prior to exit.

(1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis..." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.

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(2) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon,

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purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 4. The facility staff failed to review and revise Resident #14's comprehensive care plan after two skin alterations were found on 2/3/17 and 3/22/17.

Resident #14 was admitted to the facility on 3/4/13 and readmitted on 7/5/15 with diagnoses that included but were not limited to gastroparesis [1], generalized anxiety disorder, history of mental and behavioral disorders, high blood pressure, and type II diabetes. Resident #14's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #14 was coded as being cognitively intact in the ability to make daily decisions, scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded as being independent with transfers, and ambulation; and independent with supervision only with dressing, eating, toileting,

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and bathing.

Review of Resident #14's Non-Decubitus Skin Condition Sheet dated 2/3/17 documented the following: "Description (Type of Skin Condition, site, size, drainage, odor, color) other: Cellulitis, Lower leg, 0.8x 3.0 x 0.1 cm (centimeters) moderate serous, 0 (zero) odor, pink, foam dressing every other day." This area was documented as "healed" on 2/20/17.

Review of Resident #14's Non-Decubitus Skin condition sheet dated 3/22/17 documented the following: "Date: 3/22/17. Site: L (Left calf) Size: 11.0 x 3.5 Drainage: Light Serous. Odor: 0 (zero) Color: Red."

Review of the nursing notes dated 2/6/17 revealed a note that documented the following: "Wound Note: Tx (treatment) in place for wound on Right leg. Wound Dr. (doctor) has also been consulted for Monday. RP (responsible party) and MD (Medical doctor) aware."

Further review of the nursing notes dated 3/23/17 revealed a note that documented the following: "Wound note: resident was seen by wound Dr. on 3/22/17, for a wound on her left calf, measures 11.0 x 3.5 with light sero-sanguineous exudate. 10 % (percent) granulation tissue and 90 % skin. Current treatment is medihoney Mondays, Wednesdays, and Fridays. RP and MD aware."

Review of Resident #14's skin care plan dated 11/9/16 did not address the above skin conditions. The following was documented: "The resident has the potential for impaired skin integrity/pressure ulcer at risk due to: DX (diagnoses) of Diabetes and Anemia, Edema at

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lower extremity. Skin will remain intact thru (through) next review. Interventions: Conduct weekly skin inspections (This intervention was initiated on 1/11/17), Diabetic foot monitoring (This intervention was initiated on 5/18/16 and revised on 1/16/17), Encourage Resident to take a shower, keep area clean (This intervention was initiated on 5/18/16 and revised on 1/16/17), Encourage Resident to wear proper size shoes (This intervention was initiated on 5/18/16 and revised on 1/16/17)."

On 4/26/17 at 12:12 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3. When asked when the care plan would be updated, LPN #3 stated that the care plan would be updated with any new changes in the resident's condition. When asked if this included new skin areas, LPN #3 stated that it did. When asked who would update the care plan if a new skin area was found, LPN #3 stated that the nurse who found the area would be responsible. LPN #3 stated that the care plan should address the date of when the skin alteration was found and location of the alteration. LPN #3 stated that she was not familiar with Resident #14.

On 4/26/17 at 1:45 p.m., an interview was conducted with LPN #4, a nurse who frequently works with Resident #14. When asked who was responsible for updating the care plan when a new skin alteration is found, LPN #4 stated the nurse who discovers a skin alteration should be updating the care plan. When asked what the care plan would say for a new skin area, LPN #4 stated, "It should have the location and date of when the area was found." When asked if the treatment for the skin area would also be on the care plan, LPN #4 stated, "Yes." When asked

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who found the skin areas to Resident #14 on 2/3/17 and 3/22/17, LPN #4 stated, "I would talk to the wound nurse."

On 4/26/17 at 4:32 p.m., an interview was conducted with LPN #1, the wound care nurse. LPN #1 stated that Resident #14 has cellulitis and she is always getting blisters that pop and heal. When asked who was responsible for updating the care plan when a new skin area is found, LPN #1 stated, "It is supposed to be a team effort." LPN #1 stated that she wasn't sure if she was ultimately responsible. LPN #1 stated that Resident #14's new skin areas found on 2/3/17 and 3/22/17 should have been on the care plan.

On 4/26/17 at 5:02 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked if the care plan should be updated after a new skin alteration is found, ASM #2 stated that the care plan should address the problem area and the date that it was found. When asked how long it should take for the care plan to be updated, ASM #2 stated that the care plan should be updated the same day or within 24 hours.

On 4/26/17 at 5:26 p.m., ASM #1, the administrator and ASM #2, the DON, were made aware of the above concerns. No further information was presented prior to exit. ASM #2 stated that the facility uses Lippincott as a Nursing Standard of Practice.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a

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communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

No further information was presented prior to exit.

[1] Gastroparesis-Delayed gastric emptying, disorder that slows or stops the movement of food from the stomach to the small intestine. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0027317/.

F 281 SS=E 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional

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standards of practice for seven of 32 residents in the survey sample, Residents #8, #4, #2, #13, #3, #19 and #26.

1. The facility staff failed to clarify a physician's order for Resident #8's route of medication.

2. Resident # 4's February 2017 and April 2017 Physician Order Sheets (POS) were not reconciled at the end of month changeover to reflect Resident # 4's order for Dialysis.

3. The facility staff failed to transcribe a physician's order for skin prep to Resident #2's right heel pressure injury on 4/19/17. The order was not transcribed until 4/25/17.

4. The facility staff failed to transcribe a physician's recommendations into orders on 3/26/17 for Resident #13.

5. The facility staff failed to clarify the parameters for administration of PRN (as needed) pain medication for Resident # 3.

6. The facility staff failed to obtain a physician's order prior to the administration of Calazime [1] paste to Resident #19's sacral wound.

7. Resident #26 was ordered an antibiotic to treat a wound infection and the facility staff failed to transcribe the order onto the MAR (medication administration record). Resident #26 was not administered the medication as ordered.

The findings include:

1. The facility staff failed to clarify a physician's order for Resident #8's route of medication.

1. Resident #8 medication administration records were clarified to indicate correct route. Resident #4 physician order sheets were updated with dialysis. Resident #2 were transcribed and implemented. Resident #13 remains on psych caseload. Resident #3 orders were clarified. Resident #19 is discharged. Resident #26 is discharged
2. Re-education provided to RNAC on May 19, 2017 by Vice President of Clinical Reimbursement and Therapy. RNAC/designee to re-educate the nursing staff on professional standards of quality. 6-5-17 Newly hired nursing staff will be educated during orientation.
3. The Director of Nursing/RNAC/ designee will review physician orders three times a week times four weeks and then monthly times three months.
4. The Director of Nursing/RNAC/ designee will report audit results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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Resident #8 was admitted to the facility on 3/25/17 and readmitted on 4/6/17 with diagnoses that included but were not limited to: stroke, indigestion, weakness, respiratory failure, difficulty swallowing and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an ARD of 4/13/17 coded the resident as usually being able to make self-understood and sometimes understand others. The resident's brief interview for mental status was coded "00" indicating the resident was unable to answer any question correctly. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as having a feeding tube.

Review of the care plan initiated on 3/25/17 documented, "Focus. Resident is at increased risk of nutrition/hydration imbalance RT (related to) inability to support own nutrition & hydration, dependent on Tube Feeding. Interventions. NPO (nothing by mouth)."

Review of the physician's orders dated April 2017 documented,
"Lasix Tablet 20 MG (milligrams) [1] Give 1 tablet by mouth one time a day Order Date 4/06/2017.
Senna Tablet (Sennosides) [2] Give 17.2 mg by mouth one time a day.
SEROquel Tablet 25 MG [3] Give 1 tablet by mouth at bedtime.
Cipro Suspension [4] Give 500 mg by mouth two times a day. Order Date 04/06/17.
Keppra Tablet 500 MG [5] Give 1 tablet by mouth two times a day. Order Date 04/06/2017.
Metoprolol Tartrate Tablet 25 MG [6] Give 1 tablet by mouth two times a day. Order Date

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04/06/2017.
All meds medications via PEG (feeding tube) until cleared by SLP (speech language pathologist) for PO (by mouth) meds. Order Date 4/15/17."

Review of the April 2017 medication administration record (MAR) documented, "Lasix Tablet 20 MG (milligrams) [1] Give 1 tablet by mouth one time a day Order Date 4/06/2017.
Senna Tablet (Sennosides) [2] Give 17.2 mg by mouth one time a day.
SEROquel Tablet 25 MG [3] Give 1 tablet by mouth at bedtime.
Cipro Suspension [4] Give 500 mg by mouth two times a day. Order Date 04/06/17.
Keppra Tablet 500 MG [5] Give 1 tablet by mouth two times a day. Order Date 04/06/2017.
Metoprolol Tartrate Tablet 25 MG [6] Give 1 tablet by mouth two times a day. Order Date 04/06/2017.
All meds medications via PEG (feeding tube) until cleared by SLP (speech language pathologist) for PO (by mouth) meds. Order Date 4/15/17." The medications were documented as being given by mouth until 4/25/17.

An interview was conducted on 4/25/17 at 1:00 p.m. with RN (registered nurse) #6. When asked how Resident #8 received her medications, RN #6 stated that the medications were given through the feeding tube. When asked to review the April MAR for Resident #8, RN #6 stated, "Oh, it says by mouth. They must have put the order in wrong." When asked what staff did if there was a question about a physician's order, RN #6 stated, "If they question it they should notify the doctor to clarify it."

An interview was conducted on 4/25/17 at 1:05

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p.m. with LPN (licensed practical nurse) #18, the resident's night nurse. When asked now the resident received her medications, LPN #18 stated, "All of her meds should be through her tube (Peg tube)." When asked what she would do if some of the medications were ordered as by mouth and some through the feeding tube, LPN #18 stated, "Then give them as ordered." When asked to review the April 2017 MAR (medication administration record), LPN #18 stated, "I see that there are some meds (medications) written to be given by mouth." When asked what staff would do if they had a question about the order, LPN #18 stated, "We need to call the doctor to clarify it." When asked what the five rights of medication administration were, LPN #18 stated, "Right patient, right med, right route and right time."

An interview was conducted on 4/25/17 at 1:15 p.m. with LPN #4. When asked what a nurse should do if a resident with a feeding tube had medications ordered to be given by mouth and also through the Peg tube, LPN #4 stated, "If they're not eating you would have to call and clarify the order. In nursing you never assume, you never know."

On 4/26/17 at 6:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Medication Orders" documented, "The following steps are initiated to completed documentation and receive the medications: a. Clarify the order. Procedures. A. Elements of the Medication Order 1) Medication orders specify the following....e. Route

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of administration. B.. Any dose or order that appears inappropriate considering the resident's age, condition, allergies, or diagnosis is verified by nursing with the attending physician."

No further information was provided prior to exit.

[1] LASIX® (furosemide) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=eadfe464-720b-4dcd-a0d8-45dba706bd33
[2] Senna is a popular herbal laxative that is available without prescription. Senna is generally safe and well tolerated, but can cause adverse events including clinically apparent liver injury when used in high doses for longer than recommended periods. This information was obtained from: https://livertox.nih.gov/Senna.htm
[3] SEROQUEL is indicated for the treatment of schizophrenia. Seroquel is indicated for the acute treatment of manic episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=c17aa1e0-8b69-4c46-8502-9e3e07d461b3
[4] CIPRO is indicated in adult patients for treatment of skin and skin structure infections caused by Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, methicillin-susceptible Staphylococcus aureus, methicillin-susceptible Staphylococcus epidermidis, or Streptococcus

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pyogenes. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=888dc7f9-ad9c-4c00-8d50-8ddfd9bd27c0

[5] KEPPRA is indicated for adjunctive therapy in the treatment of: Partial onset seizures in patients one month of age and older with epilepsy (1.1) Myoclonic seizures in patients 12 years of age and older with juvenile myoclonic epilepsy (1.2) Primary generalized tonic-clonic seizures in patients 6 years of age and older with idiopathic generalized epilepsy (1.3) This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3CA9DF05-A506-4EC8-A4FE-320F1219AB21

[6] Metoprolol succinate is indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure lowers the risk of fatal and non-fatal cardiovascular events, primarily strokes and myocardial infarctions. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=44f64f0e-1b68-4478-1fb7-c1bc9402deec

2. Resident # 4's February 2017 and April 2017 Physician Order Sheets (POS) were not reconciled at the end of month changeover to reflect Resident # 4's order for Dialysis.

Resident # 4 was admitted to the facility on 2/5/15 and again on 2/21/17 with diagnoses that included but were not limited to, end stage renal disease (requiring dialysis), anemia, high blood pressure, dementia, depression, gastroesophageal reflux disease, osteoarthritis and asthma.

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Resident # 4's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/3/17. Resident # 4 was coded as being understood by others and being able to understand others. Resident # 4 was coded as scoring a 14 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was cognitively intact.

A review of Resident # 4's clinical record revealed the signed physician order sheet (POS) for April 2017. The POS for April 2017 did not document an order for dialysis treatment.

During an interview on 4/26/17 at 11:00 a.m. with LPN (licensed practical nurse) # 4, LPN # 4 stated that when a resident is admitted the order for dialysis is on the admission orders and then it should appear on the POS every month thereafter.

During an interview on 4/26/17 at 12:40 p.m. with LPN # 3, LPN # 3 was asked about dialysis orders; LPN # 3 stated that the orders come with a resident when they are admitted, on the admission orders. RN (registered nurse) # 1, the assistant director of nurses, was standing nearby and joined the conversation. Both LPN # 3 and RN # 1 agreed that someone on dialysis should have a physician order. Both agreed that the order should be on the POS. RN # 1 reviewed the current signed POS for April 2017 and could not find an order for dialysis. Review of the POS for February 2017 did document an order for dialysis. RN # 1 stated that the POS's are printed by Medical records and the Unit Manager at turnover. They are checked to make sure any new orders are on the POS and the POS is also

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compared to the previous POS to make sure all the orders are still on the POS unless the order had a "Stop Date". RN # 1 reviewed the telephone orders to see if there was a change in Resident # 4's dialysis order, and there was not a change. RN # 1 then compared the previous signed POS (February 2017) to see if the dialysis order had a "Stop Date", it did not. RN # 1 stated there was no "Stop Date" so the order for dialysis should have appeared on the April 2017 POS.

During the end of day interview on 4/26/17 at 6:30 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nurses, and ASM # 3, interim regional director of clinical services, this concern was revealed and a request was made for the facility policy.

During an interview on 4/27/17 at 2:20 p.m. with ASM # 3, a pharmacy policy was presented. ASM # 3 stated, "This is all we have." This policy was reviewed. The title of the policy is: "Non-Controlled Medication Order Documentation" documented the following under "E. Documentation of the Medication Order: 1...d. Renewed or Recapitulated (recapped) Orders (to continue a medication therapy beyond a previous order with limited duration)...2. Medication orders are recapped on a monthly basis when the prescriber signs the physician order summary. A designated nurse reviews the order summary before giving it to the prescriber to sign..."

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

3. The facility staff failed to transcribe a physician's order for skin prep to Resident #2's

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right heel pressure injury on 4/19/17. The order was not transcribed until 4/25/17.

Resident #2 was admitted to the facility on 8/30/16 and readmitted to the facility on 1/23/17. Resident #2's diagnoses included but were not limited to: multiple sclerosis, diabetes and major depressive disorder. Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/30/17, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of two or more staff with bed mobility and as being totally dependent on two or more staff with transfers.

Review of Resident #2's clinical record revealed a physician's order dated 4/6/17 for skin prep (1) to be applied to the resident's heels every day shift. The order was discontinued on 4/19/17.

Review of Resident #2's pressure ulcer (injury) records revealed the resident developed an unstageable pressure injury (2) on the left lateral heel on 4/19/17 and an unstageable pressure injury on the right medial heel on 4/19/17. (Note: review of the resident's clinical record revealed prevention interventions were previously implemented and the resident's physician deemed pressure injuries were unavoidable. Also, clinical record review and interviews with staff and Resident #2 revealed the resident was non-compliant with turning and repositioning). The wound care physician's initial evaluation of the right heel wound and left heel wound dated 4/19/17 documented the areas as unstageable deep tissue injuries and the wound care physician recommended skin prep to each heel every shift.

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A physician's order dated 4/19/17 documented an order for skin prep to the left heel every day shift. There was no treatment order for Resident #2's right heel. Resident #2's April 2017 TAR documented skin prep was applied to the resident's left heel once a day each day from 4/19/17 through 4/25/17. There was no skin prep treatment documented for the resident's right heel from 4/19/17 through 4/25/17.

Resident #2's comprehensive care plan initiated on 1/23/17 failed to document information regarding a right heel pressure injury.

On 4/25/17 at 5:23 p.m., ASM (administrative staff member) #2 (the director of nursing) and LPN (licensed practical nurse) #1 (the wound care nurse) were asked to provide evidence that treatment for Resident #2's right heel pressure injury was implemented on 4/19/17 when the wound was identified.

A physician's order dated 4/25/17 documented, apply skin prep to Resident #2's right heel every day shift.

On 4/26/17 at 4:05 p.m., an interview was conducted with LPN #1. LPN #1 stated she only documented skin prep to Resident #2's left heel instead of skin prep to both heels when she transcribed the 4/19/17 physician's order that was documented onto the April 2017 TAR. LPN #1 was asked if she could verify that nurses applied skin prep to both heels since the order on the TAR only documented to apply skin prep to the left heel and there was no directive to apply skin prep to the right heel. LPN #1 stated the nurses follow the TAR to complete treatments when she isn't at the facility so she could not confirm skin

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prep was applied to both of Resident #2's heels. LPN #1 stated she meant to document to apply skin prep to both heels on the 4/19/17 order that was transcribed to the April 2017 TAR but she made a transcription error.

On 4/26/17 at 6:35 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above findings.

On 4/27/17 at 7:43 a.m., ASM #1 was asked to provide the facility standard of practice regarding transcription. ASM #1 state the facility followed the Lippincott manual.

On 4/27/17 at 12:18 p.m., ASM #5 (the facility owner) stated there was no standard of practice regarding transcription in the Lippincott manual.

No further information was presented prior to exit.

(1) "SKIN-PREP is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films..." This information was obtained from the website: http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/

(2) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and

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shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

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4. The facility staff failed to transcribe a physician's recommendations into orders on 3/26/17 for Resident #13.

Resident #13 was admitted to the facility on 6/5/15 and readmitted on 3/31/17 with diagnoses including, but not limited to: Diabetes, bipolar disorder (1), congestive heart failure, and schizoaffective disorder (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 2/6/17, she was coded as having no cognitive impairment for making daily decisions.

A review of the physician's progress notes for Resident #13 revealed the following from a note signed and dated by the physician on 3/26/17: "Plan: 1. Continue current pain mgx (management). Consult palliative care if needed...3. Psych (psychology) evaluation for med (medication) adjustment."

A review of Resident #13's clinical record revealed no evidence of palliative care consult or psychology evaluation for Resident #13 after 3/26/17.

A review of the records for consults/visits from outside providers revealed no evidence that Resident #13 was scheduled for a psychology evaluation or palliative care consult after 3/26/17.

On 4/26/17 at 10:50 a.m., LPN (licensed practical nurse) #12 was asked to locate evidence of the palliative care consult and psychology evaluation as recommended by the physician on 3/26/17. After looking through Resident #13's chart, she stated: "I don't see anything." When asked what

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the physician's recommendation for the palliative care consult "as needed" meant, she stated: "To be honest, I'm not really sure. I'm not sure if it means if the resident needs it, I'm not sure when we should do it. It needs more explanation." When asked what needed to be done regarding the recommendation for a palliative care consult, LPN #12 stated: "It needed to be clarified." She stated that the recommendation for a psychology evaluation should have been transcribed as a physician order and the resident's name placed in the consult book. She stated a psychology services provider is in the building each week and sees the residents whose names are in the consult book.

On 4/26/17 at 6:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the interim regional director of clinical services, were informed of this concern. Information regarding the facility's professional standard for order transcription was requested.

On 4/27/17 at 11:40 a.m., LPN #11, a unit manager, was asked to review the 3/26/17 physician recommendations for Resident #13. When asked to locate evidence that these recommendations were followed, after reviewing Resident #13's chart, LPN #11 stated: "I can't find anything." She stated the recommendation for the palliative care consult should have been clarified, then written as an order and followed by the nursing staff. She stated that the recommendation for the psychology evaluation should have been written as an order and followed by the nursing staff.

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No further information was provided prior to exit.

(1) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.

5. The facility staff failed to clarify the parameters for administration of PRN (as needed) pain medication for Resident # 3.

Resident # 3 was admitted to the facility on 05/06/14 with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4), depression, hypertension (5), bipolar (6), hemiplegia (7), seizure disorder (8) and obesity.

Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/21/17, coded Resident # 3 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living.

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The POS (Physician's Order Sheet) For Resident # 3 dated 01/2017 documented, "Acetaminophen Tablet (9) 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016."

"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."

"Tramadol Tablet (12) 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."

The eMAR (electronic medication administration record) for Resident # 3 dated "January 2017 documented,
"Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Ketorolac Tromethamine Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016. D/C (discontinue) 01/17/2017."

"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."

"Tramadol Tablet 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."

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The eMAR dated January 2017 revealed the following:
Acetaminophen was administered on: 01/03/17 at 2:30 p.m., 01/12/17 at 11:31 a.m., 01/15/17 at 9:40 a.m., 01/17/17 at 8:47 a.m., 01/18/17 at 8:21 a.m., 01/19/17, at 8:34 a.m., 01/20/17 at 8:19 a.m., 01/21/17 at 8:35 a.m., 01/23/17 at 8:28 a.m., 01/24/17 at 11:44 a.m., 01/25/17 at 10:25 a.m., 01/28/17 at 8:57 a.m. 01/29/17 at 8:56 a.m. and 01/31/17 9:17 a.m..
Ketorolac was tromethamine was administered on: 01/03/17 at 2:37 p.m., 01/04/17 at 3:17 p.m., 01/06/17 at 12:33 a.m., 01/07/17 at 2:04 a.m., 10/08/17 at 2:57 p.m., 01/10/17 at 8:46 a.m. and on 01/15/17 at 12:06 a.m.
Oxycodone was administered on 01/01/17 at 1:43 a.m., 01/02/17 at 6:09 p.m., 01/05/17 at 4:05 a.m., 01/06/17 at 11:14 a.m., 01/08/17 at 8:51 a.m., 01/11/17 at 9:02 a.m., 01/13/17 at 6:15 a.m., 01/16/17 at 5:01 a.m., 01/19/17 at 5:01 a.m., 01/20/17 at 2:37 a.m., 01/21/17 at 4:00 a.m., 01/26/17 at 3:41 p.m., 01/27/17 at 12:10 a.m., 01/29/17 at 2:31 a.m. and 8:42 p.m. and on 01/30/17 1:12 a.m.
Tramadol was administered on 01/05/17 at 5:30 a.m., 01/06/17 at 4:30 p.m., 01/09/17 at 4:01 a.m., 01/16/17 at 12:37 a.m., 01/17/17 at 12:14 p.m., 01/18/17 at 11:38 a.m., 01/19/17 at 11:16 a.m., 01/20/17 at 10:49 a.m., 01/21/17 at 11:59 a.m., 01/23/17 at 1:05 p.m., 01/24 at 4:09 a.m., 01/25/17 at 3:09 a.m., 01/26/17 at 5:43 a.m., 01/27/17 at 1:06 p.m. and 01/31/17 at 3:01 a.m.

The eMAR for Resident # 3 dated "February 2017 documented,
"Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

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"Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016. D/C (discontinue) 02/02/2017."

"Tramadol Tablet 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016. D/C 02/02/2017."

The eMAR dated February 2017 revealed the following:
Acetaminophen was administered on: 02/01/17 at 9:02 a.m., 02/02/17 at 9:12 a.m., 02/03/17 at 4:57 p.m., 02/04/17 at 6:22 a.m., 02/06/17 at 1:01 a.m., 02/07/17 at 4:10 a.m. and 4:58 p.m., 02/08/17 at 4:48 p.m., 02/09/17 at 4:18 a.m., 02/10/17 at 5:09 a.m. and 4:40 p.m., 02/12/17 at 1:06 a.m., 02/14/17 at 5:22 a.m., 02/15/17 at 1:46 a.m., 02/16/17 at 5:45 p.m., 02/ 17/17 5:00 p.m., 02/18/17 at 4:06 a.m. and 5:15 p.m., 02/20/17 at 4:40 p.m., 02/21/17 at 5:20 p.m., 02/25/17 at 4:29 p.m. and 02/26/17 at 4:25 p.m.;
Oxycodone was administered on 02/01/17 at 12:00 a.m.
Tramadol was administered on 02/01/17 at 12:04 p.m. and 4:08 p.m. and on02/02/17 at 6:07 a.m.

The eMAR for Resident # 3 dated "March 2017 documented, "Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

The eMAR dated March 2017 revealed the following:
Acetaminophen was administered on: 03/02/17 at 3:47 p.m., 03/04/17 at 4:46 a.m., 03/06/17 at 3:08

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a.m., 03/10/17 at 4:21 a.m., 03/14/17 at 12:01 p.m., 03/19/17 at 4:50 p.m., 03/20/17 at 6:38 a.m. and 4:32 p.m., 03/21/17 at 4:38 a.m. and 1:57 p.m., 03/22/17 at 4:38 a.m. and 9:32 a.m., 03/24/17 at 3:20 a.m. and 4:42 p.m., 03/25 at 4:30 p.m., 03/26/17 at 4:35 a.m., 03/27/17 at 3:52 a.m. and 11:43 a.m., 03/29/17 at 4:57 a.m., 03/30/17 at 4:50 a.m. and 03/31/17 at 8:27 a.m.

The eMAR for Resident # 3 dated "April 2017 documented, "Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

The eMAR dated April 2017 revealed the following:
Acetaminophen was administered on: 04/01/17 at 4:56 a.m. and 3:42 p.m., 04/02/17 at 1:33 p.m., 04/04/17 at 4:28 a.m. and 5:11 p.m., 04/05/17 at 4:24 a.m. and 8:58 a.m., 04/06/17 at 3:29 p.m., 04/07/17 at 4:31 a.m. and 5:00 p.m., 04/08/17 at 4:00 p.m., 04/09/17 at 4:50 a.m., 12:40 p.m. an d 5:09 p.m., 04/10/17 at 6:51 p.m., 04 11/17 at 12:39 a.m., 4;47 p.m., 04/12/17 at 5:00 p.m., 04/13/17 at 4:18 p.m., 04/14/17 at 5:00 p.m., 04/16/17 at 5:14 a.m. and 6:31 p.m., 04/17/17 at 4:30 p.m., 04/18/17 at 4:45 p.m., 04/19/17 at 4:27 a.m. and 2:42 p.m., 04/21/17 at 4:55 p.m., 04/24/17 at 3:34 p.m., 04/25/17 at 1:30 p.m. and 04/26 at 4:59 a.m.

On 04/26/17 at 11:20 a.m. an interview was conducted with LPN (licensed practical nurse) # 12. When asked to describe the procedure of administering PRN (as needed) pain medication LPN # 12 stated, "I would ask where the pain is, what type of pain, determine the level of pain on a scale of one to ten, based on the level of pain

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would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. When asked how it is determined what PRN pain medication should be administered, LPN # 12 stated, "If there are several pain meds (medications) there needs to be a parameter on the physician's order. If there are no parameters, I would get clarification from the physician before giving the medication." When asked to describe parameters, LPN # 12 stated, "You would give one pain medication for mild pain another pain medication for moderate pain. It would depend on the resident's pain level." After reviewing the eMARs dated January, February, March and April 2017 and physician's orders for Resident # 16's PRN pain medications, LPN # 12 was asked if there was documentation of parameters. LPN # 12 stated, "There are no parameters."

On 04/26/17 at 11:45 a.m. an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing. When asked how it is determined what PRN pain medication should be administered RN # 2 stated, "If there are several pain meds (medications) there needs to be a parameter on the physician's order. If there are no parameters, I would get clarification from the physician before giving the medication." When asked to describe parameters, RN # 1 stated, "You would give one pain medication for mild pain another pain medication for moderate pain. It would depend on the resident's pain level." After reviewing the eMARs dated January, February, March and April 2017 and physician's orders for Resident # 16's PRN pain medications, RN # 1 was asked if there was documentation of parameters. RN # 1 stated, "There are no

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parameters." After reviewing the order for oxycodone as needed for pain use for severe pain and the tramadol for as needed for moderate pain, RN # 1 was asked what pain level was moderate and severe pain on the one to ten pain scale that is used to assess a resident's pain. RN # 1 stated, "I don't know what number it would be on the pain scale."

On 04/27/17 at 3:25 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

1. A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html

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#summary.

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

6. A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

7. Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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

9. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the

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joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

10. Used for the short-term relief of moderately severe pain and should not be used for longer than 5 days, for mild pain, or for pain from chronic (long-term) conditions. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693001.html.

(11) Used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

(12) Used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

6. The facility staff failed to obtain a physician's order prior to the administration of Calazime [1] paste to Resident #19's sacral wound.

Resident #19 was admitted to the facility on 3/27/17 with diagnoses that included but were not limited to high blood pressure, failure to thrive, hallucinations, major depressive disorder, liver cancer, and anxiety disorder. Resident #19's most recent MDS (minimum data set) was an admission MDS with an ARD (Assessment

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Reference Date) of 4/3/17. Resident #19 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #19 was coded as requiring extensive assistance with one person physical assist with transfers, ambulation, dressing and limited assistance from one staff member with locomotion on and off the unit.

Review of Resident #19's hospital notes dated 3/27/17 documented the following: "Wound 1 Site: Buttocks, Left, Wound 1 (one) Type Pressure Ulcer, Wound Stage 1. Wound 2 Site: Buttocks, Right, Wound 2 (two) Type: Pressure Ulcer. Wound Stage: 1."

Review of the nursing notes revealed the following note dated 3/27/17 at 10:29 p.m.: "Resident denies pain this shift...Resident refused full skin assessment, refused to let this writer remove bandage on sacrum, states that there is an open area there but the dressing was just placed today. Scab on great right toe, blanachable redness on right heel, multiple scratches and bruises on bilateral arms and legs, tattoos on arms. Skin tear on right arm 2 cm (centimeters) wide, abrasion to left arm, applied antibiotic ointment and covered with dry bandage..."

Review of Resident #19's Pressure Ulcer Record dated 3/28/17 revealed the following: " Date first observed: 3/28/17, Site: Sacrum, Stage: 2 (Two), Size: 6.0 x 8.0 x 0.1 cm (centimeters), Drainage: Light Serous, Odor: 0 (zero), Current Treatment Plan: Barrier Cream q (every) shift and PRN (as needed)." This report was signed by the wound care nurse, LPN (licensed practical nurse) #1.

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Review of Resident #19's clinical record revealed that the wound care physician had visited Resident #19 on 3/29/17. The following was documented from the visit: "Stage 2 Pressure Wound Sacrum. Wound Size: 1.5 x 0.7 x Not Measurable cm (centimeters), Dressing: House Barrier Cream - Q shift (every) shift and PRN (as needed)...Assessment plan and recommendations: Add: House Barrier Cream -Q shift and PRN, Off-load wound..."

Review of Resident #19's telephone physician orders revealed that an order for Calazime paste was not initiated until 3/31/17 (two days after the wound care physician visit). The following was documented: "Apply Calazime paste to sacral wound every shift and PRN (as needed) for Skin integrity." This order was confirmed by the wound care nurse, LPN #1.

Review of Resident #19's March 2017 TAR (treatment administration record) revealed that the Calazime paste was placed on the TAR on 3/31/17 (4 days after admission and two days after the wound care physician visit).

On 4/27/17 at 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the wound care nurse. When LPN #1 was asked what treatment was in place prior to the order for Barrier Cream on 3/31/17, LPN #1 stated, "Calazime Cream is what we used prior to the wound care physician's visit on 3/29. I saw him first on 3/28 and there was no dressing. I remember wiping the barrier cream off him to measure and assess the wound. Apparently he told the admitting nurse that he was using the Calazime Cream in the hospital so we decided to

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continue with that treatment. The wound care doctor then agreed with the treatment in place when he came in." When asked if an order we needed for Calazime cream, LPN #1 stated, "I didn't think we needed an order because it is barrier cream." When asked how nursing would know to apply the barrier cream if it was not placed on the TAR until 3/31/17, LPN #1 stated, "He was very adamant about letting us know that he needed his cream." When asked why the order for the Calazime cream did not get put into the system until 3/31/17, LPN #1 stated, "I didn't get the order in properly. I probably should have done that sooner." LPN #1 stated that the nurse who admitted Resident #19 was no longer employed with the facility.

On 4/27/17 at 3:15 p.m., a copy of the facility's standing orders was requested by RN (registered nurse) #1, the unit manager. RN #1 stated, "We don't have standing skin orders, every cream that is medicated needs an order." When asked if Calazime cream would need a physician's order, RN #1 stated, "Yes, that cream would need a physician's order."

On 4/27/17 at 3:18 p.m., an interview was conducted ASM (Administrative staff member) #1, and ASM #2, the DON (Director of Nursing). ASM #2 stated that the facility does not have standing orders for wound treatments and that there should have been a physician's order for the Calazime Cream.

On 4/27/17 at 3:18 p.m., ASM #1, the administrator and ASM #2, the DON were made aware of the above concerns. No further information was presented prior to exit.

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The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration. A medication order is required for you to administer any medication to a patient. Once you receive and process a medication, place the physician's or health care provider's complete order on the appropriate medication form, the MAR. The MAR includes the patient's name, room, and bed number, as well as the names, dosages, frequencies, and routes of administration for each medication.

[1] Calazime paste- "Uses: Provides temporary relief from skin irritations, itching and discomfort in the peri-anal area, for the temporary relief of pain. Active ingredients: Calamine 3.5 % (Percent), Menthol 0.2 %, Zinc Oxide 20%...Purpose: Protectant, Analgesic." This information was obtained by the National Institutes of Health. dailymed.nlm.nih.gov/dailymed/getFile.cfm?setid=20160209_1295cfcc-5b61-481b-964b-f53ffd0cb58e.pdf.

7. Resident #26 was ordered an antibiotic to treat a wound infection and the facility staff failed to transcribe the order onto the MAR (medication administration record). Resident #26 was not administered the medication as ordered.

Resident #26 was admitted to the facility on 7/5/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, thrombocytopenia [1] (a condition in which your blood has a lower than normal number of blood cell fragments called platelets), hip fracture,

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peripheral vascular disease (poor blood circulation to the lower extremities), anemia (low red blood cell count, atrial fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (affecting the lungs).

Resident #26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/16 coded Resident #26 as a 0 (zero) out of a possible score of 15 on the BIMS (brief interview for mental status) indicating that Resident #26 was severely cognitively impaired with daily decisions about care. Resident #26 was also coded in Section M, Skin Conditions, as having two unhealed pressure ulcers at the time of the assessment, an unstageable wound with slough and/or eschar measuring 5.0 cm (centimeters) x 10.0 cm and an unstageable wound with suspected deep tissue injury.

A review of Resident #26's clinical record revealed, in part, a physician's order dated 8/17/16 that documented, in part, the following; "8/17/16 Bactrim DS (an oral antibiotic medication) 1 tab (tablet) po (by mouth) BID (two times per day) x 7d (for seven days)." The order was signed by the physician and hand written below the order was: "faxed & (and) noted 8/17/16)."

A review of Resident #26's nurse's notes revealed, in part, the following note; "8/17/16 1310 (1:10 p.m.) Type: General Note: New order for Bactrim DS 1 tab (tablet) PO (by mouth) BID (twice a day) x (times) 7 day and wound culture to heel." The note was not electronically signed by a nurse, unable to determine the name of the nurse.

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The nursing notes also document that Resident #26 was taking an antibiotic on the following dates; 8/18/16 through 8/26/16, a total of nine days. There was no entry on Resident #26's MAR that evidences the administration of Bactrim during this time period.

On 4/26/17 at 6:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the interim regional director of clinical services, were informed of this concern. Information regarding the facility's professional standard for order transcription was requested.

A copy of the August pharmacy manifest was again requested from ASM (administrative staff member) #2, the director of nursing on 4/27/16 at 10:15 a.m.

On 4/27/17 at 1:35 p.m. an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to review the nursing notes between 8/18/16 and 8/26/16 and to explain why the nursing staff were documenting "antibiotic given" during this time period without an order on the MAR. LPN #4 reviewed the notes and stated, "I don't know why they would document that without an order. I can't remember what was going on back then."

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

Complaint Deficiency

[1] This information was obtained from the

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following website:
https://www.nhlbi.nih.gov/health/health-topics/topics/thcp

F 282 SS=E 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to follow the written plan of care for seven of 32 residents in the survey sample, Resident #26, #5, #2, #14, #3, #16, and #1

1. The facility staff failed to conduct weekly skin assessments on Resident #26 as required in the care plan.

2.a. The facility staff failed to attempt non-pharmacological interventions prior to the administration of pain medication for Resident #5.

2.b. The facility staff failed to obtain Resident #5's weights per the comprehensive care plan.

3. The facility staff failed to follow Resident #2's

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F 282 1. Resident #26 is discharged. Resident #5 care plan updated. Resident #2 is currently receiving therapy. Resident #14 care plan updated. Resident #3 is discharged. Resident #1 meal consumption will be monitored by nurses.
2. Re-education provided to RNAC on May 19, 2017 by Vice President of Clinical Reimbursement and Therapy. RNAC/designee to re-educate the interdisciplinary team on following the written plan of care. Newly hired nursing staff will be educated during orientation. 6-5-17
3. The Director of Nursing/designee will review staff following the written care plan weekly times four weeks and then monthly times two months.
4. The Director of Nursing/designee will report the audits monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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care plan for restorative nursing services.

4. For , facility staff failed to follow Resident #14's plan of care and attempt non-pharmacological interventions prior to the administration of PRN (as needed) pain medications in April of 2017.

5. The facility staff failed to follow the comprehensive care plan for pain for Resident # 3.

6 a. The facility staff failed to follow the comprehensive care plan for incontinence care and transfers for Resident # 16.

6b. The facility staff failed to follow the comprehensive care plan for transfers of Resident # 16.

7. The facility staff failed to monitor Resident #1's meal consumption per the care plan initiated on 10/28/16.

The findings include;

1. The facility staff failed to conduct weekly skin assessments on Resident #26 as required in the care plan.

Resident #26 was admitted to the facility on 7/5/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, thrombocytopenia [1] (a condition in which your blood has a lower than normal number of blood cell fragments called platelets), hip fracture, peripheral vascular disease (poor blood circulation to the lower extremities), anemia (low red blood cell count, atrial fibrillation (an abnormal

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heart rhythm) and chronic obstructive pulmonary disease (affecting the lungs).

Resident #26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/16 coded Resident #26 as a 0 (zero) out of a possible score of 15 on the BIMS (brief interview for mental status) indicating that Resident #26 was severely cognitively impaired with daily decisions about care. Resident #26 was also coded in Section M, Skin Conditions, as having two unhealed pressure ulcers at the time of the assessment, an unstageable* wound with slough and/or eschar* measuring 5.0 cm (centimeters) x 10.0 cm and an unstageable wound with suspected deep tissue injury*.

A review of Resident #26's comprehensive care plan dated 7/5/2016 revealed, in part, the following documentation initiated on 7/29/16 and 8/31/16: "Focus: Pressure ulcer actual due to: Pressure ulcer actual: DTI (deep tissue injury) Left heel. Date Initiated 7/29/2016. Skin assessment to be completed per (name of facility) policy. Date Initiated: 7/29/2016. Conduct weekly skin inspection Date Initiated: 8/31/2016. Revision on: 10/12/2016. Weekly Wound assessment: Date Initiated: 8/31/2016. Revision on: 10/12/2016."

Further review of Resident #26's clinical record revealed, in part, weekly skin reviews were not completed between the following dates; 7/5/16 - 8/2/16; 8/17/16 to 8/31/16;

Review of Resident #26's nursing notes revealed, in part, that beginning on 7/29/16 Resident #26 developed an unstageable DTI (deep tissue

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injury) on the left heel and on 8/8/16 Resident #26 developed an unstageable DTI on the right heel. These wounds are not reflected on the following weekly skin reviews; 8/2/16; 8/29/16, 10/6/16 and 10/13/16.

On 4/26/17 at 10:05 a.m. an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked the purpose of the care plan. LPN #4 stated, "To put in interventions to meet the needs of the residents." LPN #4 was asked if the staff was expected to provide care based on the guidance of the plan of care. LPN #4 stated that they were.

On 4/26/17 at 4:55 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked how often skin assessments were done in the facility. ASM #2 stated that per policy the skin assessments were done weekly. ASM #2 was asked what a skin assessment entailed. ASM #2 stated that the nurse should look at the skin from head to toe and document any new or old findings.

On 4/27/17 at 3:00 p.m. an interview was conducted with RN (registered nurse) #6. RN #6 was asked how often skin assessment should be conducted. RN #6 stated, "Weekly skin assessments are done weekly and are assigned by shift and room. The skin assessments used to be done on the computer, now we do them on paper."

On 4/27/17 at 5:20 p.m. an end of day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim regional director of clinical services and

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ASM #4, the owner. ASM #1, ASM #2, ASM #3 and ASM #4 were all made aware of the above findings. A policy was requested on following the care plan at this time.

No further information was provided by completion of the survey.

Complaint Deficiency

[1] This information was obtained from the following website:
https://www.nhlbi.nih.gov/health/health-topics/topics/thcp

* This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

2.a. The facility staff failed to attempt non-pharmacological interventions prior to the administration of pain medication for Resident #5 per the comprehensive care plan.

Resident #5 was admitted to the facility on 4/6/17, with a readmission on 4/15/17, with diagnoses that included but were not limited to: lymphedema

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(an accumulation of lymph in tissues leading to swelling, it occurs most often in the legs (1)), seizures, gastric ulcer, anxiety disorder, kidney disease, Parkinson's disease, high blood pressure, rheumatoid arthritis (chronic destructive disease characterized by joint inflammation (2)), and heart failure.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 4/22/17, coded the resident as being moderately impaired to make daily decisions, scoring a 10 on the BIMS (brief interview for mental status) scale of 0-15. The resident was coded as requiring supervision of one staff member for all of her activities of daily living except bathing in which she required total assistance of one staff member.

The comprehensive care plan dated, 6/16/16 with a revision date on 2/2/17, documented in part, "Focus: (Resident #5) needs pain management and monitoring related to: Rheumatoid arthritis and bilateral lower extremity lymphedema and cellulitis." The "Interventions" documented in part, "Administer pain medication as ordered. Attempt Non-pharmacological interventions PRN (as needed) such as but not limited to: relaxation, light touch, imagery, exercise, music, reposition, back rub, rest and pet therapy."

The physician orders dated, 4/17/17, documented, "Oxycodone HCL (hydrochloride) (used to treat moderate to severe pain (3)) Tablet 20 mg (milligrams) ; Give 1 tablet by mouth every 4 hours as needed for pain."

The MAR (medication administration record) for

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April 2017 documented the resident received Oxycodone on 18 occasions since her readmission on 4/17/17.

Review of the nurse's notes from 4/17/17 through 4/26/17, did not reveal any documentation of non-pharmacological interventions attempted prior to the administration of the Oxycodone.

An interview was conducted with Resident #5 on 425/17 at approximately 4:10 p.m. Resident #5 was asked what staff do when she complains of pain. Resident #5 stated, "They ask me where the pain is and ask me to rate it on a scale of one to ten (ten being the worse pain a person ever has) and then they go check the computer to see if it's time for me to have it (pain medication)." When asked if the nurse offers anything such as a back rub or repositioning, Resident #5 stated, "We are just lucky to get the pills."

An interview was conducted with LPN (licensed practical nurse) #9 on 4/25/17 at 3:36 p.m. LPN #9 was asked what she does when a resident complains of pain. LPN #9 stated, "First you assess the location, type and have the resident rate the pain (on the scale of one to ten), and how long they've had the pain. It depends on the resident's orders we medicate them per the physician orders." When asked if there is anything that is offered before a medication is given, LPN #9 stated, "We offer diversional things, snacks, one to one attention, unless it is true pain then we just give the medication." When asked where the non-pharmacological interventions attempted prior to administering the pain medication is documented, LPN #9 stated, "There is a section on the MAR or in a general nurse's note." When asked the purpose of the

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care plan, LPN #9 stated, "It's how we are going to provide care to the resident."

An interview was conducted with RN (registered nurse) #1, the assistant director of nursing, on 4/25/17 at 3:47 p.m. When asked what is expected of the nurses when a resident complains of pain, RN #1 stated, "They assess the pain, ask the resident to rate it on a pain scale, call the doctor for medication." When asked if they offer anything prior to administering the pain medication, RN #1 stated, "We can try repositioning, maybe a referral to the therapy department." When asked where this is documented, RN #1 stated, "It should be documented in the MAR or a progress note." When asked the purpose of the care plan, RN #1 stated, "It's how we provide individualized care to each resident."

The administrator, director of nursing and administrative staff member (ASM) #3, the interim regional director of clinical services, were made aware of the above concern on 4/26/17 at 6:37 p.m.

2.b. The facility staff failed to obtain Resident #5's weights per the comprehensive care plan.

The comprehensive care plan dated, 6/16/16 and revised on 2/2/17, documented in part, "Focus: Potential for weight fluctuations as related to hx (history) edema, diuretic use." The "Interventions" documented in part, "Weights as ordered."

The physician order dated, 4/15/17, documented, "Daily weights every day shift for monitoring."

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Review of the MAR for April 2017 documented, "Daily Weights every day shift for monitoring." The weights were not documented on 4/18/17, 4/20/17, 4/21/17 and 4/25/17.

An interview was conducted with LPN #9 on 4/25/17 at 3:36 p.m. When asked where daily weights should be documented, LPN #9 stated, "Either on the MAR or in the vital signs tab in the computer."

An interview was conducted with RN #1 on 4/25/17 at 3:47 p.m. When asked where daily weights should be documented, RN #1 stated, "In the vital signs tab in the computer."

A review of the vital signs tab in the electronic medical record failed to evidence any documentation for the missing weights.

The administrator, director of nursing and administrative staff member (ASM) #3, the interim regional director of clinical services, were made aware of the above concern on 4/26/17 at 6:37 p.m.

3. The facility staff failed to follow Resident #2's care plan for restorative nursing services.

Resident #2 was admitted to the facility on 8/30/16 and readmitted to the facility on 1/23/17. Resident #2's diagnoses included but were not limited to: multiple sclerosis, diabetes and major depressive disorder. Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/30/17, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of two or more staff with bed mobility and as being

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totally dependent on two or more staff with transfers. Resident #2's current MDS was in progress and could not be compared to the former MDS assessment.

The most recent rehabilitation (rehab) documentation completed for Resident #2 was a therapy screen signed by a physical therapist on 1/24/17 that documented, "Type of screen: (a circle around the word 'Readmit')...No change in functional status noted. Will con't (continue) to monitor with nursing..."

Resident #2's comprehensive care plan revised on 2/24/17 documented, "Resident requires restorative nursing services for AROM (active range of motion), Transfers, and Bed mobility...Goal: I will maintain my current ROM (range of motion)...Interventions: Resident to participate in AROM program to include use of NuStep (exercise device) or Omni Cycle (exercise device) to maintain and or improve strength for self care activities 15 Min (Minutes) a day times 6-7 days a week. Resident to participate in bed mobility with the use if (sic) bed raiis, bed control and trapeze to maintain and or improve independence with repositioning self in bed. Resident to participate in transfers with gait belt, slide board, with MOD (moderate) assist times 2 and verbal cues for safe transfer ability. Resident to be seen 15 minutes a day times 6-7 days a week..."

On 4/25/17 at 2:11 p.m., an interview was conducted with RN (registered nurse) #1 (the staff development coordinator). RN #1 stated in the past, there were designated restorative programs with two full time CNAs (certified nursing assistants) who provided the programs;

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however the facility was undergoing an integrated program where all CNAs were being trained to provide restorative nursing programs during and after care. RN #1 stated the restorative nursing program process changed about five to six weeks prior to the survey. RN #1 stated the MDS department was responsible for the oversight of the program.

On 4/25/17 at 2:14 p.m., an interview was conducted with RN #2 (the MDS coordinator responsible for the oversight of the restorative nursing program). RN #2 stated in the past if a resident declined, the nursing staff would collaborate with the rehab department who would create a restorative nursing plan for the resident. RN #2 stated in the past, monthly restorative meetings were held with two full time restorative CNAs who would report updates regarding residents' progress in the restorative programs. RN #2 stated the restorative CNAs documented restorative notes on paper from December 2016 to March 2017. RN #2 stated since then, a new company had taken over and a new system was in place. RN #2 stated as of early to mid-March the facility has a whole new manual and there are no longer two full time restorative CNAs. RN #2 stated all CNAs are being trained to provide restorative services. RN #2 was asked to describe the current documentation used to evidence restorative programs. RN #2 stated the facility did not currently provide restorative services to any residents because CNAs were being trained to provide the services. RN #2 was asked what was done for residents who currently needed restorative services. RN #2 stated the rehab department had screened residents who were previously receiving active restorative services. When asked if a resident should

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receive restorative services if he/she was care planned to receive services, RN #2 stated, "Yes." RN #2 stated Resident #2's care plan was not updated. RN #2 was asked to provide evidence that the rehab department had evaluated Resident #2 when the former restorative program was discontinued.

On 4/25/17 at 2:50 p.m., an interview was conducted with OSM (other staff member) #3 (the director of rehab) regarding the restorative nursing program. OSM #3 stated at that moment she couldn't say any resident was receiving restorative nursing services. OSM #3 stated she thought the CNAs were currently trained on range of motion and walking programs and she thought during the previous day RN #2 stated she was ready to resume walking and range of motion programs. OSM #3 stated during the transition from the former restorative program to the current program the rehab department had been monitoring the status of residents and during this period, the rehab department had not been notified by nursing that any resident had presented with a decline. OSM #3 stated the rehab department had worked with some residents who were previously receiving restorative services. When asked who was monitoring residents, OSM #3 stated CNAs and nurses notify the rehab department when residents have a change in status. OSM #3 was asked when the rehab department last evaluated Resident #2. OSM #3 stated the last time Resident #2 was formally evaluated by the rehab department was in December 2016 and at that time the resident did not present with any change in functional status and could assist with bed mobility. OSM #3 confirmed no evaluation of Resident #2 had been completed by the rehab

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department since the transition of the restorative program. OSM #3 stated no one had relayed the need for a screen so the rehab department had not evaluated the resident since the transition.

On 4/25/17 at 3:20 p.m., RN #2 stated she talked to the director of rehab and no evaluation was completed for Resident #2 during the transition of the restorative program. RN #2 was asked to provide all of Resident #2's restorative documentation.

On 4/25/17 at 3:40 p.m., RN #2 presented Resident #2's restorative documentation. Restorative notes documented range of motion and bed mobility services were offered to Resident #2 on 2/27/17, 2/28/17, 3/1/17, 3/2/17, 3/3/17, 3/6/17, 3/7/17, 3/8/17, 3/9/17 and 3/10/17. No further restorative documentation to evidence restorative services were provided any other dates or an evaluation was completed to determine the resident could be removed from the restorative program was presented.

On 4/26/17 at 6:35 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

No further information was presented prior to exit.

4. For Resident #14, facility staff failed to follow the plan of care and attempt non-pharmacological interventions prior to the administration of PRN (as needed) pain medications in April of 2017.

Resident #14 was admitted to the facility on

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3/4/13 and readmitted on 7/5/15 with diagnoses that included but were not limited to gastroparesis [1], generalized anxiety disorder, history of mental and behavioral disorders, high blood pressure, and type two diabetes. Resident #14's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #14 was coded as being cognitively intact in the ability to make daily decisions, scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded as being independent with transfers, and ambulation; and independent with supervision only with dressing, eating, toileting, and bathing.

Review of Resident #14's most recent POS (Physician Order Sheet) documented the following orders: "Percocet Tablet [2] 10-325 MG (milligrams) (Oxycodone- Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain." This order was initiated on 8/4/16.

"Tylenol Tablet [3] 325 mg (milligrams) (Acetaminophen) Give 2 tablets by mouth every 6 hours as needed for Pain related to OTHER CHRONIC PAIN." This order was initiated on 12/3/15.

Review of Resident #14's April 2017 MAR (Medication Administration Record) documented that Resident #14 received Percocet 10-325 mg on the following dates and times:

4/1/17 at 4:19 a.m., 11:19 a.m., 4:21 p.m.
4/2/17 at 1:01 a.m., 4:42 p.m.
4/3/17 at 1:40 p.m., 6:55 p.m. 11:45 p.m.
4/4/17 at 4:10 a.m., 12:05 p.m., 3:50 p.m.
4/5/17 at 12:18 a.m., 4:20 a.m., 10:59 p.m., and

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3:07 p.m.,
4/6/17 at 12:43 a.m., 11:01 a.m., 3:14 p.m.,
4/7/17 at 1:33 a.m., 7:08 a.m., 1:05 p.m., 5:10 p.m.
4/8/17 at 9:02 a.m., 11:18 a.m., 5:05 p.m.,
4/9/17 at 4:19 a.m., 12:10 p.m., 4:15 p.m.,
4/10/17 at 1:29 a.m., 11:30 a.m., 3:32 p.m.,
4/11/17 at 12:47 a.m., 12:34 p.m., 4:45 p.m.,
4/12/17 at 12:15 a.m., 11:09 a.m., and 4:10 p.m.,
4/13/17 at 7:30 a.m., 2:19 p.m.,
4/14/17 at 12:57 a.m., 5:15 a.m., 11:34 a.m.,
4/15/17 at 12:00 a.m., 4:15 a.m., 5:15 p.m.,
4/16/17 at 12:22 a.m., 4:54 a.m., 12:30 p.m., 5:39 p.m.;
4/17/17 at 5:11 a.m., 11:46 a.m., 4:20 p.m., 11:43 p.m.,
4/18/17 at 5:12 a.m., and 9:15 a.m.,
4/19/17 at 12:07 a.m., 4:07 a.m., 11:54 a.m., 4.00 p.m., and 10:45 p.m.,
4/20/17 at 10:04 a.m., and 4:24 p.m.,
4/23/17 at 2:46 a.m., and 12:23 p.m.,
4/24/17 at 2:30 a.m., and 3:56 p.m.,
4/25/17 at 12:05 a.m.,
4/26/17 at 12:45 a.m., 4:46 a.m.

Review of Resident #14's April 2017 MAR documented that Resident #14 received Tylenol 325 mg on the following dates and times:

4/2/17 at 4:33 a.m.,
4/12/17 at 2:24 p.m.,
4/16/17 at 3:29 p.m.,
4/17/17 at 1:35 p.m.

Documentation could not be found evidencing non-pharmacological interventions were attempted prior to the administration of PRN Percocet and Tylenol.

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Review of Resident #14's Pain care plan dated 11/09/16 documented the following: Needs Pain Management and monitoring related to: History of Chronic Pain, Multiple right and left sided rib fracture, Radius fracture, Ulnar Styloid fracture, S/P (status post) Motor Vehicle Accident in 2012. Has diagnoses of severe depression...Interventions: Will not experience a decline in function related to pain through next review...Interventions: ...Implement the patient's preferred non-pharmacological pain relief strategies as needed."

On 4/26/17 at 1:25 p.m., an interview was conducted with Resident #14. Resident #14 stated that nursing staff did not attempt other interventions prior to administering pain medications. Resident #14 stated that when she requests pain medication, nursing will give her the pill.

On 4/26/17 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who administered Percocet on some of the occasions in April. When asked the process prior to the administration of a prn pain medication, LPN #4 stated, "I ask the pain level at that time, and see if I can distract or divert their attention. I try to take their mind of the pain and see if that works." When asked if she attempts non-pharmacological interventions before administering every prn pain medication, LPN #4 stated, "No. Some people will ask for their pill." LPN #4 stated that she won't always attempt non-pharmacological interventions prior to administering pain medications for residents who requests pain medication. When asked if she documents non-pharmacological interventions attempted prior to the administration of pain

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medication when she does attempt non-pharmacological interventions, LPN #4 stated, "I should. I don't." When asked if non-pharmacological interventions should be attempted if the resident's care plan documents instructions to do so, LPN #4 stated, "Yes, but I don't think the care plan usually addresses that." LPN #4 was shown Resident #14's care plan. When asked if her care plan was followed, LPN #4 stated, "No."

On 4/16/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that the facility uses Lippincott as a standard of practice.

The following quotation is found in Lippincott's Nursing Procedures 6th edition (p. 128): "A nursing care plan serves as a database for planning assignments, giving change of shifts reports, conferring with the doctor or other members of the health care team, planning patient discharge, and documenting patient care..."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...

No further information was presented prior to exit.

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5. The facility staff failed to follow the comprehensive care plan for pain for Resident # 3.

Resident # 3 was admitted to the facility on 05/06/14 with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4), depression, hypertension (5), bipolar (6), hemiplegia (7), seizure disorder (8) and obesity.

Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/21/17, coded Resident # 3 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) For Resident # 3 dated 01/2017 documented, "Acetaminophen Tablet (9) 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016."

"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."

"Tramadol Tablet (12) 50 MG. Give 2 (two) tablet

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by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."

The eMAR (electronic medication administration record) for Resident # 3 dated "January 2017 documented, "Acetaminophen Tablet (9) 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016. D/C (discontinue) 01/17/2017."

"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."

"Tramadol Tablet 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."

The eMAR dated January 2017 revealed the following:
Acetaminophen was administered on: 01/03/17 at 2:30 p.m., 01/12/17 at 11:31 a.m., 01/15/17 at 9:40 a.m., 01/17/17 at 8:47 a.m., 01/18/17 at 8:21 a.m., 01/19/17, at 8:34 a.m., 01/20/17 at 8:19 a.m., 01/21/17 at 8:35 a.m., 01/23/17 at 8:28 a.m., 01/24/17 at 11:44 a.m., 01/25/17 at 10:25 a.m., 01/28/17 at 8:57 a.m. 01/29/17 at 8:56 a.m. and 01/31/17 9:17 a.m..
Ketorolac was tromethamine was administered on: 01/03/17 at 2:37 p.m., 01/04/17 at 3:17 p.m., 01/06/17 at 12:33 a.m., 01/07/17 at 2:04 a.m., 10/08/17 at 2:57 p.m., 01/10/17 at 8:46 a.m. and on 01/15/17 at 12:06 a.m.

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Oxycodone was administered on 01/01/17 at 1:43 a.m., 01/02/17 at 6:09 p.m., 01/05/17 at 4:05 a.m., 01/06/17 at 11:14 a.m., 01/08/17 at 8:51 a.m., 01/11/17 at 9:02 a.m., 01/13/17 at 6:15 a.m., 01/16/17 at 5:01 a.m., 01/19/17 at 5:01 a.m., 01/20/17 at 2:37 a.m., 01/21/17 at 4:00 a.m., 01/26/17 at 3:41 p.m., 01/27/17 at 12:10 a.m., 01/29/17 at 2:31 a.m. and 8:42 p.m. and on 01/30/17 1:12 a.m.
Tramadol was administered on 01/05/17 at 5:30 a.m., 01/06/17 at 4:30 p.m., 01/09/17 at 4:01 a.m., 01/16/17 at 12:37 a.m., 01/17/17 at 12:14 p.m., 01/18/17 at 11:38 a.m., 01/19/17 at 11:16 a.m., 01/20/17 at 10:49 a.m., 01/21/17 at 11:59 a.m., 01/23/17 at 1:05 p.m., 01/24 at 4:09 a.m., 01/25/17 at 3:09 a.m., 01/26/17 at 5:43 a.m., 01/27/17 at 1:06 p.m. and 01/31/17 at 3:01 a.m.

The eMAR for Resident # 3 dated "February 2017 documented,
"Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016. D/C (discontinue) 02/02/2017."

"Tramadol Tablet 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016. D/C 02/02/2017."

The eMAR dated February 2017 revealed the following:
Acetaminophen was administered on: 02/01/17 at 9:02 a.m., 02/02/17 at 9:12 a.m., 02/03/17 at 4:57 p.m., 02/04/17 at 6:22 a.m., 02/06/17 at 1:01

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a.m., 02/07/17 at 4:10 a.m. and 4:58 p.m., 02/08/17 at 4:48 p.m., 02/09/17 at 4:18 a.m., 02/10/17 at 5:09 a.m. and 4:40 p.m., 02/12/17 at 1:06 a.m., 02/14/17 at 5:22 a.m., 02/15/17 at 1:46 a.m., 02/16/17 at 5:45 p.m., 02/ 17/17 5:00 p.m., 02/18/17 at 4:06 a.m. and 5:15 p.m., 02/20/17 at 4:40 p.m., 02/21/17 at 5:20 p.m., 02/25/17 at 4:29 p.m. and 02/26/17 at 4:25 p.m.;
Oxycodone was administered on 02/01/17 at 12:00 a.m.
Tramadol was administered on 02/01/17 at 12:04 p.m. and 4:08 p.m. and on02/02/17 at 6:07 a.m.

The eMAR for Resident # 3 dated "March 2017 documented, "Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

The eMAR dated March 2017 revealed the following:
Acetaminophen was administered on: 03/02/17 at 3:47 p.m., 03/04/17 at 4:46 a.m., 03/06/17 at 3:08 a.m., 03/10/17 at 4:21 a.m., 03/14/17 at 12:01 p.m., 03/19/17 at 4:50 p.m., 03/20/17 at 6:38 a.m. and 4:32 p.m., 03/21/17 at 4:38 a.m. and 1:57 p.m., 03/22/17 at 4:38 a.m. and 9:32 a.m., 03/24/17 at 3:20 a.m. and 4:42 p.m., 03/25 at 4:30 p.m., 03/26/17 at 4:35 a.m., 03/27/17 at 3:52 a.m. and 11:43 a.m., 03/29/17 at 4:57 a.m., 03/30/17 at 4:50 a.m. and 03/31/17 at 8:27 a.m.

The eMAR for Resident # 3 dated "April 2017 documented, "Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

The eMAR dated April 2017 revealed the

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following:
Acetaminophen was administered on: 04/01/17 at 4:56 a.m. and 3:42 p.m., 04/02/17 at 1:33 p.m., 04/04/17 at 4:28 a.m. and 5:11 p.m., 04/05/17 at 4:24 a.m. and 8:58 a.m., 04/06/17 at 3:29 p.m., 04/07/17 at 4:31 a.m. and 5:00 p.m., 04/08/17 at 4:00 p.m., 04/09/17 at 4:50 a.m., 12:40 p.m. an d 5:09 p.m., 04/10/17 at 6:51 p.m., 04 11/17 at 12:39 a.m., 4;47 p.m., 04/12/17 at 5:00 p.m., 04/13/17 at 4:18 p.m., 04/14/17 at 5:00 p.m., 04/16/17 at 5:14 a.m. and 6:31 p.m., 04/17/17 at 4:30 p.m., 04/18/17 at 4:45 p.m., 04/19/17 at 4:27 a.m. and 2:42 p.m., 04/21/17 at 4:55 p.m., 04/24/17 at 3:34 p.m., 04/25/17 at 1:30 p.m. and 04/26 at 4:59 a.m.

The "Progress Notes" for Resident # 3 dated 01/01/2017 through 04/24/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of acetaminophen, oxycodone, ketorolac tromethamine and tramadol.

The care plan for Resident # 3 dated 07/12/16 documented, "Focus: Resident has a Dx (diagnoses) of CVA (cerebral vascular accident - stroke) with left hemiparesis, paralysis, Chronic Pain, Syndrome, and Backache. Reports that she experiences moderate to severe pain, which makes it hard for her to sleep at night, and limits her daily activities. Receives PRN (as needed) pain medication/Pain management and monitoring. Date Initiated: 07/12/2016." Under "Interventions" it documented, "Provide non-pharmacological interventions as needed. Date Initiated: 07/12/2016."

On 04/26/17 at 11:20 a.m. an interview was

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conducted with LPN (licensed practical nurse) # 12. When asked to describe the procedure of administering PRN (as needed) pain medication LPN # 12 stated, "I would try non-pharmacological interventions like repositioning, turning down the lights or television prior to giving the pain medication." When asked how often the non-pharmacological interventions should be attempted, LPN # 12 stated, "It's every time before giving the medication." After reviewing the MARs dated January, February, March and April 2017 and the progress notes dated 01/01/17 through 04/24/17 for Resident # 3, LPN # 12 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 12 stated, "There isn't anything. If it wasn't documented it wasn't done." When asked to describe the purpose of the care plan LPN # 12 stated, "It provides an outline of the care we should provide. If it's on the care plan it needs to be followed." After reviewing the care plan for Resident # 3's pain, LPN # 12 was asked if the care plan was followed for non-pharmacological interventions. LPN # 12 stated, "No, it wasn't followed for pain."

On 04/26/17 at 11:45 a.m. an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing. When asked to describe the procedure of administering PRN pain medication RN # 1 stated, "Check the MAR to determine when the last pain med (medication) was given, attempt non-pharmacological interventions every time, if not working call physician for adjustment of pain regimen, document all of it on the eMAR. Reassess the resident approximately 30 to 45 minutes after giving the medication to determine if it was

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effective. After reviewing the MARs dated January, February, March and April 2017 and the progress notes dated 01/01/17 through 04/24/17 for Resident # 3, RN # 1 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. RN # 1 stated, "No, it wasn't done." When asked to describe the purpose of the care plan, RN # 1 stated, "To provide a plan of care for the resident. A guide to provide staff that is not familiar with the resident to meet the resident's needs and informing families of the resident's current status." After reviewing the care plan for Resident # 3's pain, RN # 1 was asked if the care plan was followed for non-pharmacological interventions. RN # 1 stated, "No, it's not being followed."

On 04/27/17 at 3:25 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
1. A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This

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information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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

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

6. A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

7. Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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

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9. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

10. Used for the short-term relief of moderately severe pain and should not be used for longer than 5 days, for mild pain, or for pain from chronic (long-term) conditions. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693001.html.

(11) Used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

(12) Used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

6a. The facility staff failed to follow the

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comprehensive care plan for incontinence care of Resident # 16.

Resident # 16 was admitted to the facility on 11/23/13 with a readmission of 101/07/17 with diagnoses that included but were not limited to: dementia (1), hypertension (2), diabetes mellitus (3), gastroesophageal reflux disease (4) and Parkinson's disease (5).

Resident # 16's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/21/17, coded Resident # 16 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three being severely impaired of cognition for making daily decisions. Resident # 16 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 04/24/17 at approximately 12:30 p.m. Resident # 16's husband requested to speak with this surveyor on 4/25/17 at approximately 8:30 a.m. regarding care of Resident # 16.

On 04/25/17 at 8:40 a.m. a conversation and interview was conducted with Resident # 16's husband. Resident # 16's husband stated he had concerns regarding incontinence care for Resident # 16 (spouse). He stated he visits every day arriving at approximately 7:30 to 8:00 a.m., feeds Resident # 16 her breakfast and lunch and leaves at 1:30 p.m. He stated he has found his wife lying in urine and soaked when he comes in to visit.

On 4/25/17 at 2:30 p.m. an observation was conducted of CNA (certified nursing assistant) # 6 providing incontinence care to Resident # 16.

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Resident # 16 was lying in bed and was soaked through her brief with urine. When asked when Resident # 16 was last changed CNA # 6 stated, "I haven't changed her until now." CNA # 6 further stated that the resident's husband had been visiting and may have changed Resident # 16 or had someone else change her. When asked how often a resident who is incontinent should be changed, CNA # 6 stated, "They should be checked every hour and a half to two hours."

On 4/25/17 at 2:40 p.m. an interview was conducted with CNA # 6 in the presence of ASM (administrative staff member) # 2, the director of nursing. When asked if she was assigned to Resident # 16, CNA # 6 stated, "Yes." When asked to describe the procedure for incontinence care, CNA # 6 stated, "Go in and check the resident every two hours. Introduce yourself, tell the resident what you are about to do and proceed to do it." When asked when the last time was that she had provided Resident # 16 with incontinence care, CNA # 6 stated, "After breakfast but before lunch about 9:30 (a.m.). I had given her a shower. I rechecked back sometime after eleven and asked the husband if (Resident # 16) needed to be changed." When asked if she physically checked Resident # 16 to determine if she required incontinence care, CNA # 6 stated, "No I asked the husband." When asked if that was part of the process, CNA # 6 stated, "No." When asked if she had physically checked Resident # 16 between 9:30 a.m. and 2:30 p.m., CNA # 6, stated "No." When asked if she followed the two hour check procedure for incontinence, CNA # 6 stated, "No. It's what I should have followed." When asked about the two hour check for incontinence care described by CNA # 6, ASM # 2 stated CNA # 6 was correct

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and that it should be followed.

The care plan for Resident # 16 dated 05/09/16 documented, "Focus: I have a physical functioning deficit related to: Self care impairment, Mobility impairments. (Resident # 16) has dx (diagnoses) of Parkinson's Disease and Dementia." Under "Interventions" it documented, "Requires staff assistance with toileting and or incontinence care. Date Initiated: 03/22/2017."

On 4/27/17 at 9:40 a.m. an interview was conducted with CNA # 6. When asked to describe continent and incontinence, CNA # 6 stated, "Continence is when the resident is dry when I check them and incontinence is when they are wet when I checked them." After reviewing the care plan for Resident # 16's incontinence care, CNA # 6 was asked if she followed the care plan. CNA # 6 stated, "No."

On 4/27/17 at 10:00 a.m. an interview was conducted with LPN (licensed practical nurse) # 11, unit manager. When asked to describe continent and incontinence LPN # 11 stated, "Continent is someone who is able to hold their urine and respond to the sensation of when they have to go. Incontinence is someone who does not have the ability to hold their urine and/or don't have the sensation to know when they are wet." After informing LPN #11 of the incident of CNA # 6 not providing timely incontinence care and reviewing the care plan for Resident # 16's incontinence care, LPN # 11 was asked if the care plan was followed. LPN # 6 stated, "No. The care plan should have been followed." When asked to describe the purpose of the care plan, LPN # 11 stated, "It's a road map, guide that tells

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you how to take care of the resident."

On 04/27/17 at 3:25 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

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

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6b. The facility staff failed to follow the comprehensive care plan for transfers of Resident # 16.

The facility's ADL (activities of daily living) tracking sheets for Resident # 16 dated March 22, 2017 through March 31, 2017 was reviewed. Under "Intervention / Task" it documented, "ADL Transferring." Of 12 opportunities to implement a two-person transfer, Resident # 16 was coded as being transferred using one-person two times.

The facility's ADL (activities of daily living) tracking sheets for Resident # 16 dated April 01, 2017 through April 26, 2017 was reviewed. Under "Intervention / Task" it documented, "ADL Transferring." Of 50 opportunities to implement a two-person transfer, Resident # 16 was coded as being transferred using one-person 28 times.

The care plan for Resident # 16 dated 05/09/16 documented, "Focus: I have a physical functioning deficit related to: Self-care impairment, Mobility impairments. (Resident # 16) has dx (diagnoses) of Parkinson's Disease and Dementia." Under "Interventions" it documented, "Requires staff assistance with transfers [Name of Mechanical Lift and 2 (two) person assist]."

On 04/27/17 at 9:40 a.m. an interview was conducted with CNA # 6 regarding the procedure to transfer Resident # 16. When asked what device and how many people are needed to transfer Resident # 16, CNA # 6 stated, "I usually do it myself. She (Resident # 16) holds my shoulders and I transfer her.' When asked where she obtains the information regarding how to transfer Resident # 16, CNA # 6 stated, "It's on

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the 'Kardex.' Sometimes I refer to it sometimes I don't." CNA # 6 then showed this surveyor the Kardex she used with a print date of 03/16/17. The Kardex documented, "Transferring: 2 (two) person assist." The Kardex with the print date of 04/26/17 provided by ASM # 2, director of nursing, documented, "Transferring: 2 (two) person assist using the sit to stand lift." When shown a copy of the Kardex for Resident # 16 with the print date of 4/26/17, CNA # 6 stated, "I don't have that one, this is the only one I have." When asked if she receives a new kardex each day, CNA # 6 stated, "This is the only one I have."

On 4/27/17 at 10:00 a.m. an interview was conducted with LPN (licensed practical nurse) # 11, unit manager. When asked to describe the purpose of the care plan, LPN # 11 stated, "It's a road map, guide that tells you how to take care of the resident." After reviewing the ADL tracking sheets dated 03/22/17 through 04/26/17, LPN # 11 was asked if Resident # 16 was being transferred using a two-person assist and a (Name of Mechanical Lift) according to the care plan, LPN # 11 stated, "I can't say if it's being used all the time. The care plan should be followed."

On 04/27/17 at 3:25 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

7. The facility staff failed to monitor Resident #1's meal consumption per the care plan initiated on 10/28/16.

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Resident #1 was admitted to the facility on 10/22/16 with diagnoses that included: Parkinson's disease (1), movement disorder, difficulty swallowing, dementia and urinary retention.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 4/18/17 coded the resident as having scored an 11 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance for all activities of daily living. The resident was coded as requiring extensive assistance of one staff member for eating.

Review of the resident's care plan initiated on 10/28/16 documented, "Focus. Inadequate Oral Food/Beverage Intake due to: Parkinson's, tremors, SOB (shortness of breath), Altered Diet. hx (history) of family bringing in outside foods against dietary consistency (sic) restrictions, resident noncompliant (sic) with dietary consistency restrictions, resident has periods of time when mouth spasms and will not open, Requires extra time to eat, hx of variable PO (by mouth) intake. Interventions. Allow extra time and assistance to eat. Monitor meal consumption. Supplements as ordered, Weights as ordered."

Review of the resident's ADL (activities of daily living) sheet for March 2017 documented that Resident #1's meal consumption for 30 out of 93 meals were not documented.

Review of the resident's ADL sheet for April documented that meal consumption for 16 out of 78 meals was not documented.

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Review of the resident's weights from 10/22/16 to 3/7/17 documented that Resident #1 weight had dropped from 189.6 pounds to 169.6 pounds, a weight loss of approximately 11 percent.

An interview was conducted on 4/28/17 at 8:50 a.m. with CNA (certified nursing assistant) #19. When asked to review the ADL sheets and to explain what the blank spaces beside the meals meant, CNA #19 stated, "They weren't charted in." When asked why staff charted the amount of food a resident consumed, CNA #19 stated, "So we can track what they eat in case they lose weight." When asked if it was possible to accurately track Resident #1's food consumption, CNA #19 stated, "Not with the blank space."

An interview was conducted on 4/28/17 at 9:25 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff monitors resident's food consumption, ASM #2 stated, "It would be in his ADLs." ASM #2 reviewed the March and April 2017 ADL sheets for Resident #1. When asked if that was considered sufficient for monitoring, ASM #2 stated, "The kiosk might have been down and it might be in the chart." A request was made at this time for any documentation evidencing Resident #1's food consumption.

No further documentation was provided prior to exit.

Review of the facility's policy titled "Restorative Dining" did not evidence documentation regarding charting meal consumption.

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F 282	Continued From page 117 Parkinson disease is a progressive disorder of the nervous system. The disorder affects several regions of the brain, especially an area called the substantia nigra that controls balance and movement. This information was obtained from: https://ghr.nlm.nih.gov/condition/parkinson-disease#definition	F 282		
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 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.	F 309	F309 1. Resident #7 orders updated. Resident #26 is discharged. Resident #14 care plan updated. Resident #3 is discharged. Resident #1care plan updated. Resident #5 care plan updated. 2. The Director of Nursing/designee will re-educate nursing staff on providing care to maintain the highest well-being. 3. The Director of Nursing/designee will randomly audit quality of care; antibiotic therapy, pain management, vital signs, weights and dialysis three times a week times four weeks and then monthly times four months. 4. The Director of Nursing/designee will report the audits results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.	6-5-17

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(I) 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 staff interview, resident interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to maintain the highest level of practicable well-being for five of 32 residents in the survey sample, Resident #7, #26 #14, #3 and #5

1. The facility staff failed to obtain physician ordered daily weights for Resident #7 as ordered.

2. The facility staff failed to administer an antibiotic medication (Bactrim DS) to Resident #26 after receiving an order for Bactrim DS to be administered for seven days.

3. The facility staff failed to attempt non-pharmacological interventions prior to the administration of PRN (as needed) pain medication to Resident #14 in April of 2017.

4. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 3.

5a. The facility staff failed to offer non-pharmacological interventions prior to administering pain medication and failed to follow up with the resident on the effectiveness of the

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medication for Resident #5.

5b. The facility staff failed to obtain daily weights per the physician orders for Resident #5.

5c. The facility staff failed to obtain vital signs as ordered by the physician every shift for Resident #5.

The findings include;

1. The facility staff failed to obtain daily weights on Resident #7 as ordered by the physician on 3/30/17.

Resident #7 was admitted to the facility on 8/16/16 with a readmission on 3/26/17 with diagnoses that included, but were not limited to; severe peripheral vascular disease (poor blood flow to the lower extremities), high blood pressure, coronary artery disease (a disease impacting the vessels of the heart), chronic obstructive pulmonary disease (affecting the lungs), dementia, bipolar disorder and amputations of the toes on the right foot.

Resident #7's most recent MDS (minimum data set) a five day assessment with an ARD (assessment reference date) of 4/15/17 documented that Resident #7 scored 10 of a possible 15 on the BIMS (brief interview of mental status), indicating that Resident #7 was moderately cognitively impaired with decisions regarding daily living.

A review of Resident #7's clinical record revealed, in part, a physician order dated 3/21/17 that documented the following; "Daily weight, every

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evening shift for Monitoring. Communication Method: Verbal. Order Status: Active: Order Date: 3/21/17 Start Date: 3/22/17." The orders were signed and dated by the physician on 4/2/17. There was no discontinue date on the order.

Further review of Resident #7's clinical record revealed, in part, a facility document titled "Weights and Vitals Summary" listing all the weights obtained on Resident #7 since 3/22/17. The following dates did not have a corresponding weight; 3/24/17; 3/25/17; 3/26/17; 3/30/17; 3/31/17; 4/3/17; 4/5/17; 4/6/17; 4/7/17; 4/8/17; 4/13/17; 4/16/17;

A review of Resident #7's comprehensive care plan dated 4/8/17 revealed, in part, the following documentation; "Focus: Potential for inadequate food/beverage intake and increased nutrition/hydration risk due to presence of ulcers, hx (history) IV (intravenous) abx (antibiotics), dementia, HTN (high blood pressure), COPD (chronic obstructive pulmonary disease), total dependence for ADLs (activities of daily living), including meals. Resident has hx (history) of significant wt (weight) loss. Date Initiated: 4/2/2017. Interventions: Weights per facility protocol. Date Initiated: 2/28/17. Revision on: 2/28/17."

On 4/26/17 at 1:20 p.m. ASM (administrative staff member) #2, the director of nursing, was asked if there were any residents who were on daily weights. ASM #2 stated, "I am not aware of any daily weights, they used to be done by the restorative aides but I now manage the weights and we have one aide who does all my weights for me."

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On 4/26/17 at 1:55 p.m. an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 was asked to describe her role. CNA #7 stated, "I do weights weekly and when done (with weights) I work on the floor." CNA #7 was asked how she was made aware of the weight schedules for each resident. CNA #7 stated, "(Name of the director of nursing) gives me a list each week and if there is a 5 lbs (pounds) difference in weight then I have to do a re-weight." CNA #7 was asked how often Resident #7 was to be weighed. CNA #7 stated, "I just did his yesterday, he gets done weekly." CNA #7 was asked if he was supposed to get daily weights. CNA #7 stated, "Not that I am aware of. I weigh the residents based on the list given to me." CNA #7 pulled out a list from her pocket that had all the residents requiring weekly weights for the week of 4/23/17 to 4/29/17. Resident #7's name was half way down the list and documented that on 4/25/17 he was weighed.

On 4/26/17 at approximately 6:10 p.m. an end of day meeting was held with ASM #1, the administrator, ASM #2, the director of nursing and ASM #3 the regional director of clinical services. ASM #1, ASM #2 and ASM #3 were made aware that Resident #7 had a daily weight ordered and had not been consistently weighed on a daily basis. A policy was requested at this time that addressed obtaining weights.

On 4/28/17 at 8:45 a.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to describe the process for ensuring that weights were obtained as ordered. ASM #2 stated, "When they are admitted to us

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they automatically get daily weights for two days. When Resident #7 came in on admission the nurse failed to enter a stop date after the first two days and so the MAR (medication administration record) did not reflect that. So it was an error on transcription. ASM #2 was asked who was responsible for ensuring that the daily weights were completed as ordered. ASM #2 stated that the nurses were.

A review of Resident #7's MAR revealed, in part, the following entry; "Daily weight. every evening shift for Monitoring. Order date 3/21/2017. D/C Date 4/19/17." The nurses had entered weights on all dates except for 4/5/17; 4/6/17; 4/7/17; 4/13/17 and 4/16/17.

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

2. The facility staff failed to administer an antibiotic medication (Bactrim DS) to Resident #26 after receiving an order for Bactrim DS to be administered for seven days.

Resident #26 was admitted to the facility on 7/5/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, thrombocytopenia (a condition in which your blood has a lower than normal number of blood cell fragments called platelets [1]), hip fracture, peripheral vascular disease (poor blood circulation to the lower extremities), anemia (low red blood cell count, atrial fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (affecting the lungs).

Resident #26's most recent MDS (minimum data

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set), a quarterly assessment with an ARD (assessment reference date) of 10/4/16 coded Resident #26 as a 0 (zero) out of a possible score of 15 on the BIMS (brief interview for mental status) indicating that Resident #26 was severely cognitively impaired with daily decisions about care. Resident #26 was also coded in Section M, Skin Conditions, as having two unhealed pressure ulcers at the time of the assessment, an unstageable wound with slough and/or eschar measuring 5.0 cm (centimeters) x 10.0 cm and an unstageable wound with suspected deep tissue injury.

A review of Resident #26's clinical record revealed, in part, a physician's order dated 8/17/16 that documented, in part, the following; "8/17/16 Bactrim DS (an oral antibiotic medication) 1 tab (tablet) po (by mouth) BID (two times per day) x 7d (for seven days)." The order was signed by the physician and hand written below the order was "faxed & (and) noted 8/17/16)."

A review of Resident #26's nurse's notes revealed, in part, the following note; "8/17/16 1310 (1:10 p.m.) Type: General Note: New order for Bactrim DS 1 tab (tablet) PO (by mouth) BID (twice a day) x (times) 7 day and wound culture to heel." The note was not electronically signed by nurse, unable to determine the name of the nurse.

The nursing notes also document that Resident #26 is taking an antibiotic on the following dates; 8/18/16 through 8/26/16, a total of nine days. There was no entry on Resident #26's MAR that evidences the administration of Bactrim during this time period.

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On 4/26/17 at 6:37 p.m. a meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the interim regional director of clinical services. ASM #1, ASM #2 and ASM #3 were made aware of above concern. At this time documentation was requested to evidence that the antibiotic medication was administered to Resident #26 beginning on 8/18/17 and also a request was made for a copy of Resident #26's pharmacy manifest for the month of August.

A copy of the August pharmacy manifest was again requested from ASM (administrative staff member) #2, the director of nursing on 4/27/16 at 10:15 a.m.

On 4/27/17 at 1:35 p.m. an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to review the nursing notes between 8/18/16 and 8/26/16 and to explain why the nursing staff was documenting "antibiotic given" during this time period without an order on the MAR. LPN #4 reviewed the notes and stated, "I don't know why they would document that without an order. I can't remember what was going on back then."

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

Complaint Deficiency

[1] This information was obtained from the following website: https://www.nhlbi.nih.gov/health/health-topics/topics/thcp

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3. The facility staff failed to attempt non-pharmacological interventions prior to the administration of PRN (as needed) pain medication to Resident #14 in April of 2017.

Resident #14 was admitted to the facility on 3/4/13 and readmitted on 7/5/15 with diagnoses that included but were not limited to gastroparesis [1], generalized anxiety disorder, history of mental and behavioral disorders, high blood pressure, and type two diabetes. Resident #14's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #14 was coded as being cognitively intact in the ability to make daily decisions, scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded as being independent with transfers, and ambulation; and independent with supervision only with dressing, eating, toileting, and bathing.

Review of Resident #14's most recent POS (Physician Order Sheet) documented the following orders: "Percocet Tablet [2] 10-325 MG (milligrams) (Oxycodone- Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain." This order was initiated on 8/4/16.

"Tylenol Tablet [3] 325 mg (milligrams) (Acetaminophen) Give 2 tablets by mouth every 6 hours as needed for Pain related to OTHER CHRONIC PAIN." This order was initiated on 12/3/15.

Review of Resident #14's April 2017 MAR (Medication Administration Record) documented

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that Resident #14 received Percocet 10-325 mg on the following dates and times:

4/1/17 at 4:19 a.m., 11:19 a.m., 4:21 p.m.,
4/2/17 at 1:01 a.m., 4:42 p.m.,
4/3/17 at 1:40 p.m., 6:55 p.m. 11:45 p.m.,
4/4/17 at 4:10 a.m., 12:05 p.m., 3:50 p.m.,
4/5/17 at 12:18 a.m., 4:20 a.m., 10:59 p.m., and 3:07 p.m.,
4/6/17 at 12:43 a.m., 11:01 a.m., 3:14 p.m.,
4/7/17 at 1:33 a.m., 7:08 a.m., 1:05 p.m., 5:10 p.m.
4/8/17 at 9:02 a.m., 11:18 a.m., 5:05 p.m.,
4/9/17 at 4:19 a.m., 12:10 p.m., 4:15 p.m.,
4/10/17 at 1:29 a.m., 11:30 a.m., 3:32 p.m.,
4/11/17 at 12:47 a.m., 12:34 p.m., 4:45 p.m.,
4/12/17 at 12:15 a.m., 11:09 a.m., and 4:10 p.m.,
4/13/17 at 7:30 a.m., 2:19 p.m.,
4/14/17 at 12:57 a.m., 5:15 a.m., 11:34 a.m.,
4/15/17 at 12:00 a.m., 4:15 a.m., 5:15 p.m.,
4/16/17 at 12:22 a.m., 4:54 a.m., 12:30 p.m., 5:39 p.m.,
4/17/17 at 5:11 a.m., 11:46 a.m., 4:20 p.m., 11:43 p.m.,
4/18/17 at 5:12 a.m., and 9:15 a.m.,
4/19/17 at 12:07 a.m., 4:07 a.m., 11:54 a.m., 4.00 p.m., and 10:45 p.m.,
4/20/17 at 10:04 a.m., and 4:24 p.m.,
4/23/17 at 2:46 a.m., and 12:23 p.m.,
4/24/17 at 2:30 a.m., and 3:56 p.m.,
4/25/17 at 12:05 a.m.,
4/26/17 at 12:45 a.m., 4:46 a.m.

Review of Resident #14's April 2017 MAR documented that Resident #14 received Tylenol 325 mg on the following dates and times:

4/2/17 at 4:33 a.m.,
4/12/17 at 2:24 p.m.,

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4/16/17 at 3:29 p.m.,
4/17/17 at 1:35 p.m.

Documentation could not be found that evidenced non-pharmacological interventions were attempted prior to the administration of PRN Percocet and Tylenol.

Review of Resident #14's Pain care plan dated 11/09/16 documented the following: Needs Pain Management and monitoring related to: History of Chronic Pain, Multiple right and left sided rib fracture, Radius fracture, Ulnar Styloid fracture, S/P (status post) Motor Vehicle Accident in 2012. Has diagnoses of severe depression...Interventions: Will not experience a decline in function related to pain through next review...Interventions: ...Implement the patient's preferred non-pharmacological pain relief strategies as needed."

On 4/26/17 at 1:25 p.m., an interview was conducted with Resident #14. Resident #14 stated that nursing staff did not attempt other interventions prior to administering pain medications. Resident #14 stated that when she requests pain medication, nursing will give her the pill.

On 4/26/17 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who administered Percocet on some of the occasions in April. When asked about the process staff follows prior to the administration of a prn pain medication, LPN #4 stated, "I ask the pain level at that time, and see if I can distract or divert their attention. I try to take their mind off the pain and see if that works." When asked if she attempts non-pharmacological interventions

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before administering every prn pain medication, LPN #4 stated, "No. Some people will ask for their pill." When asked if she documents non-pharmacological interventions attempted prior to the administration of pain medication when she does attempt non-pharmacological interventions, LPN #4 stated, "I should. I don't." When asked if non-pharmacological interventions should be attempted if the resident's care plan documents instructions to do so, LPN #4 stated, "Yes, but I don't think the care plan usually addresses that." LPN #4 was shown Resident #14's care plan. When asked if her (Resident #14's) care plan was followed, LPN #4 stated, "No."

On 4/26/17 at 4:30 p.m., an interview was conducted with LPN #1, a nurse who administered Percocet on some of the occasions in April. When asked the process prior to administering prn pain medication, LPN #1 stated that alternate actions should be attempted to alleviate pain prior to administering pain medications. LPN #1 stated, "(Name of Resident #14) will say that she did other interventions before requesting pain medications. She will refuse non-pharmacologicals." When asked if it was documented that Resident #14 refused non-pharmacological interventions anywhere in the clinical record, LPN #1 stated, "It's so routine I didn't document."

On 4/26/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Pain Assessment"

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documents in part, the following: "...4. A Pain flow record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they have pain. Record the following: a. Date and time b. Site/location c. Type of pain d. intensity e. Precipitating/aggravating f. Interventions-non-med/medication g. intensity of pain after intervention h. Side effects I. Initials"

No further information was provided prior to exit.

4. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 3.

Resident # 3 was admitted to the facility on 05/06/14 with diagnoses that included but were not limited to: neuromuscular dysfunction of the bladder (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4), depression, hypertension (5), bipolar (6), hemiplegia (7), seizure disorder (8) and obesity.

Resident # 3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/21/17, coded Resident # 3 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) For Resident # 3 dated 01/2017 documented, "Acetaminophen Tablet (9) 325 MG (milligram) Give 2 (two) tablets

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by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016."

"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."

"Tramadol Tablet (12) 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."

The eMAR (electronic medication administration record) for Resident # 3 dated "January 2017 documented,
"Acetaminophen Tablet (9) 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016. D/C (discontinue) 01/17/2017."

"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."

"Tramadol Tablet (12) 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."

The eMAR dated January 2017 revealed the following:

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Acetaminophen was administered on: 01/03/17 at 2:30 p.m., 01/12/17 at 11:31 a.m., 01/15/17 at 9:40 a.m., 01/17/17 at 8:47 a.m., 01/18/17 at 8:21 a.m., 01/19/17, at 8:34 a.m., 01/20/17 at 8:19 a.m., 01/21/17 at 8:35 a.m., 01/23/17 at 8:28 a.m., 01/24/17 at 11:44 a.m., 01/25/17 at 10:25 a.m., 01/28/17 at 8:57 a.m. 01/29/17 at 8:56 a.m. and 01/31/17 9:17 a.m..
Ketorolac was tromethamine was administered on: 01/03/17 at 2:37 p.m., 01/04/17 at 3:17 p.m., 01/06/17 at 12:33 a.m., 01/07/17 at 2:04 a.m., 10/08/17 at 2:57 p.m., 01/10/17 at 8:46 a.m. and on 01/15/17 at 12:06 a.m.
Oxycodone was administered on 01/01/17 at 1:43 a.m., 01/02/17 at 6:09 p.m., 01/05/17 at 4:05 a.m., 01/06/17 at 11:14 a.m., 01/08/17 at 8:51 a.m., 01/11/17 at 9:02 a.m., 01/13/17 at 6:15 a.m., 01/16/17 at 5:01 a.m., 01/19/17 at 5:01 a.m., 01/20/17 at 2:37 a.m., 01/21/17 at 4:00 a.m., 01/26/17 at 3:41 p.m., 01/27/17 at 12:10 a.m., 01/29/17 at 2:31 a.m. and 8:42 p.m. and on 01/30/17 1:12 a.m.
Tramadol was administered on 01/05/17 at 5:30 a.m., 01/06/17 at 4:30 p.m., 01/09/17 at 4:01 a.m., 01/16/17 at 12:37 a.m., 01/17/17 at 12:14 p.m., 01/18/17 at 11:38 a.m., 01/19/17 at 11:16 a.m., 01/20/17 at 10:49 a.m., 01/21/17 at 11:59 a.m., 01/23/17 at 1:05 p.m., 01/24 at 4:09 a.m., 01/25/17 at 3:09 a.m., 01/26/17 at 5:43 a.m., 01/27/17 at 1:06 p.m. and 01/31/17 at 3:01 a.m.

The eMAR for Resident # 3 dated "February 2017 documented, "Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

"Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed

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for pain use for severe pain. Order Date: 10/18/2016. D/C (discontinue) 02/02/2017."

"Tramadol Tablet 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016. D/C 02/02/2017."

The eMAR dated February 2017 revealed the following:
Acetaminophen was administered on: 02/01/17 at 9:02 a.m., 02/02/17 at 9:12 a.m., 02/03/17 at 4:57 p.m., 02/04/17 at 6:22 a.m., 02/06/17 at 1:01 a.m., 02/07/17 at 4:10 a.m. and 4:58 p.m., 02/08/17 at 4:48 p.m., 02/09/17 at 4:18 a.m., 02/10/17 at 5:09 a.m. and 4:40 p.m., 02/12/17 at 1:06 a.m., 02/14/17 at 5:22 a.m., 02/15/17 at 1:46 a.m., 02/16/17 at 5:45 p.m., 02/ 17/17 5:00 p.m., 02/18/17 at 4:06 a.m. and 5:15 p.m., 02/20/17 at 4:40 p.m., 02/21/17 at 5:20 p.m., 02/25/17 at 4:29 p.m. and 02/26/17 at 4:25 p.m.;
Oxycodone was administered on 02/01/17 at 12:00 a.m.
Tramadol was administered on 02/01/17 at 12:04 p.m. and 4:08 p.m. and on02/02/17 at 6:07 a.m.

The eMAR for Resident # 3 dated "March 2017 documented, "Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

The eMAR dated March 2017 revealed the following:
Acetaminophen was administered on: 03/02/17 at 3:47 p.m., 03/04/17 at 4:46 a.m., 03/06/17 at 3:08 a.m., 03/10/17 at 4:21 a.m., 03/14/17 at 12:01 p.m., 03/19/17 at 4:50 p.m., 03/20/17 at 6:38 a.m. and 4:32 p.m., 03/21/17 at 4:38 a.m. and 1:57

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p.m., 03/22/17 at 4:38 a.m. and 9:32 a.m., 03/24/17 at 3:20 a.m. and 4:42 p.m., 03/25 at 4:30 p.m., 03/26/17 at 4:35 a.m., 03/27/17 at 3:52 a.m. and 11:43 a.m., 03/29/17 at 4:57 a.m., 03/30/17 at 4:50 a.m. and 03/31/17 at 8:27 a.m.

The eMAR for Resident # 3 dated "April 2017 documented, "Acetaminophen Tablet 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."

The eMAR dated April 2017 revealed the following:
Acetaminophen was administered on: 04/01/17 at 4:56 a.m. and 3:42 p.m., 04/02/17 at 1:33 p.m., 04/04/17 at 4:28 a.m. and 5:11 p.m., 04/05/17 at 4:24 a.m. and 8:58 a.m., 04/06/17 at 3:29 p.m., 04/07/17 at 4:31 a.m. and 5:00 p.m., 04/08/17 at 4:00 p.m., 04/09/17 at 4:50 a.m., 12:40 p.m. an d 5:09 p.m., 04/10/17 at 6:51 p.m., 04 11/17 at 12:39 a.m., 4;47 p.m., 04/12/17 at 5:00 p.m., 04/13/17 at 4:18 p.m., 04/14/17 at 5:00 p.m., 04/16/17 at 5:14 a.m. and 6:31 p.m., 04/17/17 at 4:30 p.m., 04/18/17 at 4:45 p.m., 04/19/17 at 4:27 a.m. and 2:42 p.m., 04/21/17 at 4:55 p.m., 04/24/17 at 3:34 p.m., 04/25/17 at 1:30 p.m. and 04/26 at 4:59 a.m.

The "Progress Notes" for Resident # 3 dated 01/01/2017 through 04/24/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of acetaminophen, oxycodone, ketorolac tromethamine and tramadol.

The care plan for Resident # 3 dated 07/12/16 documented, "Focus: Resident has a Dx (diagnoses) of CVA (cerebral vascular accident -

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stroke) with left hemiparesis, paralysis, Chronic Pain, Syndrome, and Backache. Reports that she experiences moderate to severe pain, which makes it hard for her to sleep at night, and limits her daily activities. Receives PRN (as needed) pain medication/Pain management and monitoring. Date Initiated: 07/12/2016." Under "Interventions" it documented, "Provide non-pharmacological interventions as needed. Date Initiated: 07/12/2016."

On 04/26/17 at 11:20 a.m. an interview was conducted with LPN (licensed practical nurse) # 12. When asked to describe the procedure of administering PRN (as needed) pain medication, LPN # 12 stated, "I would ask where the pain is, what type of pain, determine the level of pain on a scale one to ten, based on the level of pain would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. I would try non-pharmacological interventions like repositioning, turning down the lights or television prior to giving the pain medication." When asked how often the non-pharmacological interventions should be attempted, LPN # 12 stated, "It's every time before giving the medication." After reviewing the MARs dated January, February, March and April 2017 and the progress notes dated 01/01/17 through 04/24/17 for Resident # 3, LPN # 12 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. LPN # 12 stated, "There isn't anything. If it wasn't documented it wasn't done."

On 04/26/17 at 11:45 a.m. an interview was

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conducted with RN (registered nurse) # 1, the assistant director of nursing. When asked to describe the procedure of administering PRN pain medication, RN # 1 stated, "Do a pain assessment, location, intensity, observe nonverbal cues, use pain scale one to ten, ten being most severe. Check the MAR to determine when the last pain med (medication) was given, attempt non-pharmacological interventions every time, if not working call physician for adjustment of pain regimen, document all of it on the eMAR. Reassess the resident approxlmately 30 to 45 minutes after giving the medication to determine if it was effective. After reviewing the MARs dated January, February, March and April 2017 and the progress notes dated 01/01/17 through 04/24/17 for Resident # 3, RN # 1 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. RN # 1 stated, "No, it wasn't done."

On 04/27/17 at 3:25 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:

1. A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information

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was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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

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

6. A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

7. Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

8. Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in

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the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

9. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

10. Used for the short-term relief of moderately severe pain and should not be used for longer than 5 days, for mild pain, or for pain from chronic (long-term) conditions. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693001.html.

(11) Used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

(12) Used to relieve moderate to moderately severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

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5a. The facility staff failed to offer non-pharmacological interventions prior to administering pain medication and failed to follow up with the resident on the effectiveness of the medication for Resident #5.

Resident #5 was admitted to the facility on 4/6/17, with a readmission on 4/15/17, with diagnoses that included but were not limited to: lymphedema (an accumulation of lymph in tissues leading to swelling, it occurs most often in the legs (1)), seizures, gastric ulcer, anxiety disorder, kidney disease, Parkinson's disease, high blood pressure, rheumatoid arthritis (chronic destructive disease characterized by joint inflammation (2)), and heart failure.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 4/22/17, coded the resident as being moderately impaired to make daily decisions, scoring a 10 on the BIMS (brief interview for mental status) scale of 0-15. The resident was coded as requiring supervision of one staff member for all of her activities of daily living except bathing in which she required total assistance of one staff member.

The physician orders dated, 4/17/17, documented, "Oxycodone HCL (hydrochloride) (narcotic used to treat moderate to severe pain (3)) Tablet 20 mg (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain."

The MAR (medication administration record) for April 2017 documented the resident received Oxycodone on the following dates and times:

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4/17/17 at 3:50 p.m.
4/18/17 at 8:37 a.m.
4/19/17 at 3:30 a.m., 9:55 a.m., 4:05 p.m. and 8:39 p.m.
4/20/17 at 7:47 a.m., 4:39 p.m. and 10:40 p.m.
4/21/17 at 8:48 a.m., 4:45 p.m.
4/22/17 at 10:01 a.m.
4/23/17 at 8:03 a.m. and 12:29 p.m.
4/24/17 at 6:29 a.m.
4/25/17 at 8:17 a.m. and 2:00 p.m.

The nurse's notes documented the following:
4/17/17 at 5:39 p.m., documented, "Effective."
4/18/17 at 1:55 p.m., documented, "Effective."
4/19/17 at 6:57 a.m., 1:12 p.m., 7:16 p.m. and 9:26 p.m., documented, "Effective."
4/20/17 at 11:56 a.m., 10:39 p.m., documented, "Effective."
4/21/17 at 1:13 a.m., documented, "Effective."
4/21/17 at 4:52 p.m., documented, "Effective."
This appears to be the documentation for the 8:48 a.m. administration of the Oxycodone.
4/21/17 - there was no documentation of the effectiveness of the Oxycodone administered at 4:45 p.m.
4/22/17 - there was no documentation of the effectiveness of the Oxycodone administered at 10:01 a.m.
4/23/17 at 12:25 p.m. and 2:00 p.m., documented, "Effective."
4/24/17 at 3:49 p.m. documented, "Effective."
4/25/17 at 1:00 p.m. 6:59 p.m., documented, "Effective."

Review of the nurse's notes from 4/17/17 through 4/26/17, did not reveal any documentation of non-pharmacological interventions attempted prior to the administration of the Oxycodone.

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The comprehensive care plan dated, 6/16/16 with a revision on 2/2/17, documented in part, "Focus: (Resident #5) needs pain management and monitoring related to: Rheumatoid arthritis and bilateral lower extremity lymphedema and cellulitis." The "Interventions" documented in part, "Administer pain medication as ordered. Attempt Non-pharmacological interventions PRN (as needed) such as but not limited to: relaxation, light touch, imagery, exercise, music, reposition, back rub, rest and pet therapy."

An interview was conducted with Resident #5 on 425/17 at approximately 4:10 p.m. Resident #5 was asked what staff do when she complains of pain. Resident #5 stated, "They ask me where the pain is and ask me to rate it on a scale of one to ten (ten being the worse pain a person ever has) and then they go check the computer to see if it's time for me to have it (pain medication)." When asked if the nurse offers anything such as a back rub or repositioning, Resident #5 stated, "We are just lucky to get the pills." When asked if the nurse comes back and asks if the pain medication was effective, Resident #5 stated, "No, they never come back." This was verified by Resident #5's roommate who has a BIMS of 15.

An interview was conducted with LPN (licensed practical nurse) #9 on 4/25/17 at 3:36 p.m. LPN #9 was asked what she does when a resident complains of pain. LPN #9 stated, "First you assess the location, type and have the resident rate the pain (on the scale of one to ten), and how long they've had the pain. It depends on the resident's orders we medicate them per the physician orders." When asked if there is anything that is offered before a medication is given, LPN #9 stated, "We offer diversional

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things, snacks, one to one attention, unless it is true pain then we just give the medication." When asked where the non-pharmacological interventions attempted prior to administering the pain medication is documented, LPN #9 stated, "There is a section on the MAR or in a general nurse's note." When asked the purpose of the care plan, LPN #9 stated, "It's how we are going to provide care to the resident."

An interview was conducted with RN (registered nurse) #1, the assistant director of nursing, on 4/25/17 at 3:47 p.m. When asked what is expected of the nurses when a resident complains of pain, RN #1 stated, "They assess the pain, ask the resident to rate it on a pain scale, call the doctor for medication." When asked if they offer anything prior to administering the pain medication, RN #1 stated, "We can try repositioning, maybe a referral to the therapy department." When asked where this is documented, RN #1 stated, "It should be documented in the MAR or a progress note." When asked the purpose of the care plan, RN #1 stated, "It's how we provide individualized care to each resident."

The administrator, director of nursing and administrative staff member (ASM) #3, the interim regional director of clinical services, were made aware of the above concern on 4/26/17 at 6:37 p.m.

No further information was provided prior to exit.

5b. The facility staff failed to obtain daily weights per the physician orders for Resident #5.

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The physician order dated, 4/15/17, documented, "Daily weights every day shift for monitoring."

Review of the MAR for April 2017 documented, "Daily Weights every day shift for monitoring." The weights were not documented on 4/18/17, 4/20/17, 4/21/17 and 4/25/17.

The review of the vital signs tab in the electronic medical record failed to document the missing weights.

The comprehensive care plan dated, 6/16/16 and revised on 2/2/17, documented in part, "Focus: Potential for weight fluctuations as related to hx (history) edema, diuretic use." The "Interventions" documented in part, "Weights as ordered."

An interview was conducted with LPN #9 on 4/25/17 at 3:36 p.m. When asked where daily weights should be documented, LPN #9 stated, "Either on the MAR or in the vital signs tab in the computer."

An interview was conducted with RN #1 on 4/25/17 at 3:47 p.m. When asked where daily weights should be documented, RN #1 stated, "In the vital signs tab in the computer."

The facility policy, "Weighing the Resident" documented in part, "At a minimum, all residents of the facility shall be weighed upon admission and monthly unless ordered otherwise by the physician or as directed by the weight committee."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby,

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Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

The administrator, director of nursing and administrative staff member (ASM) #3, the interim regional director of clinical services, were made aware of the above concern on 4/26/17 at 6:37 p.m.

No further information was provided prior to exit.

5c. The facility staff failed to obtain vital signs as ordered by the physician every shift for Resident #5.

The physician order dated, 4/23/17, documented, "Take vital signs every shift."

The MAR for April 2017 documented, "Take vital signs every shift." The vital signs were not documented for the day shift on 4/25/17.

The comprehensive care plan dated, 6/16/16 and revised on 2/2/17, documented in part, "Focus: Resident at risk for alterations in respiratory or cardiac status r/t (related to) shortness of breath and CHF (congestive heart failure)." The "Interventions" documented in part, "Observe and document vital signs, specifically respiratory pattern, rate, rhythm, effort and use of accessory muscles."

An interview was conducted with LPN #9 on 4/25/17 at 3:36 p.m. When asked where vital

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signs are documented when ordered by the physician, LPN #9 stated, "If the doctor ordered them, then they would be on the MAR."

An interview was conducted with RN #1, the assistant director of nursing, on 4/25/17 at 3:47 p.m. When asked where vital signs are documented when ordered by the physician, RN #1 stated, "They should be in the weight/vital signs tab in the computer." When asked why we should obtain the vital signs, RN #1 stated, "First, it's a physician order and second they are obviously monitoring something."

Review of the Vital signs tab section of the electronic record did not reveal any documented vital signs for the day shift on 4/25/17. The nurse's notes did not document the vital signs for that shift.

The facility policy, "Vital Signs Flow" documented in part, "Policy: Vital signs may be recorded on the Vital Signs Flow Sheet this may be in (name of computer program) electronic documentation. Record the following items as indicated by resident condition: date, time, B/P (blood pressure), temperature, pulse, respirations and O2 (oxygen) sat (saturation)."

The administrator, director of nursing and administrative staff member (ASM) #3, the interim regional director of clinical services, were made aware of the above concern on 4/26/17 at 6:37 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the

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F 309	Continued From page 145 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 345. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 511. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/	F 309		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement restorative nursing services for one of 32 residents in the survey sample, Resident #2. The facility staff failed to provide restorative nursing services per Resident #2's care plan and failed to evaluate Resident #2 prior to discontinuing the services. The findings include: Resident #2 was admitted to the facility on 8/30/16 and readmitted to the facility on 1/23/17. Resident #2's diagnoses included but were not limited to: multiple sclerosis, diabetes and major depressive disorder. Resident #2's most recent MDS (minimum data set), a significant change in	F 311	F311 1. Resident #2 was evaluated and currently receiving physical therapy and occupational services. Resident #2 care plan is current. 2. Current residents with restorative nursing care plan were re-evaluated by therapy. Residents identified as no change were referred to restorative nursing services. 3. The RNAC/designee will re-educate licensed staff on implementing restorative services and evaluating prior to discharge. The RNAC/designee will randomly audit the restorative program to ensure implementation and discontinuance of restorative services monthly times three months. 4. The RNAC/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	6-5-17

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status assessment with an ARD (assessment reference date) of 1/30/17, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of two or more staff with bed mobility and as being totally dependent on two or more staff with transfers. Resident #2's current MDS was in progress and could not be compared to the former MDS assessment.

The most recent rehab (rehabilitation) documentation completed for Resident #2 was a therapy screen signed by a physical therapist on 1/24/17 that documented, "Type of screen: (a circle around the word 'Readmit')...No change in functional status noted. Will con't (continue) to monitor with nursing..."

Resident #2's comprehensive care plan revised on 2/24/17 documented, "Resident requires restorative nursing services for AROM (active range of motion), Transfers, and Bed mobility...Goal: I will maintain my current ROM (range of motion)...Interventions: Resident to participate in AROM program to include use of NuStep (exercise device) or Omni Cycle (exercise device) to maintain and or improve strength for self-care activities 15 Min (Minutes) a day times 6-7 days a week. Resident to participate in bed mobility with the use if (sic) bed rails, bed control and trapeze to maintain and or improve independence with repositioning self in bed. Resident to participate in transfers with gait belt, slide board, with MOD (moderate) assist times 2 and verbal cues for safe transfer ability. Resident to be seen 15 minutes a day times 6-7 days a week..."

On 4/25/17 at 2:11 p.m., an interview was

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conducted with RN (registered nurse) #1 (the staff development coordinator). RN #1 stated in the past, there were designated restorative programs with two full time CNAs (certified nursing assistants) who provided the programs; however the facility was undergoing an integrated program where all CNAs were being trained to provide restorative nursing programs during and after care. RN #1 stated the restorative nursing program process changed about five to six weeks prior to the survey. RN #1 stated the MDS department was responsible for the oversight of the program.

On 4/25/17 at 2:14 p.m., an interview was conducted with RN #2 (the MDS coordinator responsible for the oversight of the restorative nursing program). RN #2 stated in the past if a resident declined, the nursing staff would collaborate with the rehab department who would create a restorative nursing plan for the resident. RN #2 stated in the past, monthly restorative meetings were held with two full time restorative CNAs who would report updates regarding residents' progress in the restorative programs. RN #2 stated the restorative CNAs documented restorative notes on paper from December 2016 to March 2017. RN #2 stated since then, a new company had taken over and a new system was in place. RN #2 stated as of early to mid-March the facility has a whole new manual and there are no longer two full time restorative CNAs. RN #2 stated all CNAs are being trained to provide restorative services. RN #2 was asked to describe the current documentation used to evidence restorative programs. RN #2 stated the facility did not currently provide restorative services to any residents because CNAs were being trained to provide the services. RN #2 was

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asked what was done for residents who currently needed restorative services. RN #2 stated the rehab department had screened residents who were previously receiving active restorative services. When asked if a resident should receive restorative services if he/she was care planned to receive services, RN #2 stated, "Yes." RN #2 stated Resident #2's care plan was not updated. RN #2 was asked to provide evidence that the rehab department had evaluated Resident #2 when the former restorative program was discontinued.

On 4/25/17 at 2:50 p.m., an interview was conducted with OSM (other staff member) #3 (the director of rehab) regarding the restorative nursing program. OSM #3 stated at that moment she couldn't say any resident was receiving restorative nursing services. OSM #3 stated she thought the CNAs were currently trained on range of motion and walking programs and she thought during the previous day RN #2 stated she was ready to resume walking and range of motion programs. OSM #3 stated during the transition from the former restorative program to the current program the rehab department had been monitoring the status of residents and during this period, the rehab department had not been notified by nursing that any resident had presented with a decline. OSM #3 stated the rehab department had worked with some residents who were previously receiving restorative services. When asked who was monitoring residents, OSM #3 stated CNAs and nurses notify the rehab department when residents have a change in status. OSM #3 was asked when the rehab department last evaluated Resident #2. OSM #3 stated the last time Resident #2 was formally evaluated by the rehab

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department was in December 2016 and at that time the resident did not present with any change in functional status and could assist with bed mobility. OSM #3 confirmed no evaluation of Resident #2 had been completed by the rehab department since the transition of the restorative program. OSM #3 stated no one had relayed the need for a screen so the rehab department had not evaluated the resident since the transition.

On 4/25/17 at 3:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2 regarding the status of Resident #2's ADL (activity of daily living). When asked if Resident #2 had presented with an ADL decline LPN #2 stated she would say yes and she thought the resident was getting weaker and weaker. LPN #2 stated the resident used to wheel himself down the hall but now he didn't do that. LPN #2 stated a lot of times Resident #2 refused to get up in the wheelchair. LPN #2 further stated Resident #2 used to assist more with turning. When asked what should be done if an ADL decline is noticed, LPN #2 stated, "We let the doctor know." When asked if Resident #2 was referred to rehab for an ADL decline, LPN #2 stated she didn't know.

On 4/25/17 at 3:20 p.m., RN #2 stated she talked to the director of rehab and no evaluation was completed for Resident #2 during the transition of the restorative program. RN #2 was asked to provide all of Resident #2's restorative documentation.

On 4/25/17 at 3:40 p.m., RN #2 presented Resident #2's restorative documentation. Restorative notes documented range of motion and bed mobility services were offered to Resident #2 on 2/27/17, 2/28/17, 3/1/17, 3/2/17,

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3/3/17, 3/6/17, 3/7/17, 3/8/17, 3/9/17 and 3/10/17. No further restorative documentation to evidence restorative services were provided any other dates or an evaluation was completed to determine the resident could be removed from the restorative program was presented.

On 4/26/17 at 6:35 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The facility document titled, "Restorative Nursing Program" documented, "Implementation of restorative interventions is provided by Certified Nursing Assistants, under the supervision of a licensed nurse. A CNA providing restorative care should be training in rehabilitation, demonstrate good written and oral communication skills, responsibility and sensitivity. In addition to carrying out resident-specific rehabilitation interventions, it is the responsibility of the CNA to, on a daily basis, document the specific tasks completed, the time it takes to deliver the interventions, and to document weekly a summary of each resident's progress, functional status/goal achievement, assistive devices used and the resident's response to treatment...Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record..."

No further information was presented prior to exit.

F 311

F 312 SS=D 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

F 312

(a)(2) A resident who is unable to carry out

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activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
This REQUIREMENT is not met as evidenced by:
Based on observation, family interview, staff interview, and clinical record review, it was determined that the facility staff failed to provide assistance for one of 32 residents in the survey sample, (Resident #1) who was coded as requiring extensive assistance of staff for ADLs (activities of daily living).

The facility staff failed to provide assistance with eating to Resident #1 during the lunch meal on 4/26/17.

The findings include:

Resident #1 was admitted to the facility on 10/22/16 with diagnoses that included: Parkinson's disease (1), movement disorder, difficulty swallowing, dementia and urinary retention.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/18/17 coded the resident as having an 11 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance for all activities of daily living. The resident was coded as requiring extensive assistance of one staff member for eating.

Review of the resident's care plan initiated on 10/28/16 documented, "Focus. Inadequate Oral

1. Resident #1 received assistance with meals.
2. The RNAC/designee will re-educate nursing staff on providing ADL care for dependent residents.
3. The Director of Nursing/designee will randomly observe residents requiring extensive assistance to ensure residents receive appropriate support with eating weekly times four weeks and then monthly times four months.
4. The Director of Nursing/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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Food/Beverage Intake due to: Parkinson's, tremors, SOB (shortness of breath), Altered Diet. hx (history) of family bringing in outside foods against dietary consitency (sic) restrictions, resident nocompliant (sic) with dietary consistency restrictions, resident has periods of time when mouth spasms and will not open, Requires extra time to eat, hx of variable PO (by mouth) intake. Interventions. Allow extra time and assistance to eat. Monitor meal consumption. Supplements as ordered, Weights as ordered."

An observation was made of Resident #1 on 4/26/17 at 1:50 p.m. The resident was sitting on the edge of the bed with his lunch tray on the bedside table. Resident #1's hands were shaking and he was drooling. The resident was attempting to get food onto the spoon without success. The food was pureed and the plate was full. When asked if he was hungry, Resident #1 nodded "yes." When asked if anyone had tried to help him eat, Resident #1 shook his head "no." When asked if his food was cold, Resident #1 nodded "yes." At that time CNA (certified nursing assistant) #7 entered the room. CNA #7 stated, "This (the residents lunch tray) has been here since lunch time." When asked what time lunch was served, CNA #7 stated, "Around noon." CNA #7 took the resident's tray, was observed entering pantry and returned to Resident #1's room, placed the tray on the over bed table and stated, that she had reheated the food. CNA #7 then exited the room without assisting Resident #1.

On 4/26/17 at 2:00 p.m. an interview was conducted with CNA #9, the resident's aide. When asked how staff knew if a resident needed to be fed, CNA #9 stated, "We have a Kardex." When asked if Resident #1 needed assistance

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eating, CNA #9 stated, "I didn't check the Kardex." When asked how often she checked to see how residents were to eat their meals, CNA #9 stated, "Every time I go past I check." CNA #9 was asked to observe Resident #1. When asked if she thought he could use assistance with eating, CNA #9 stated, "Yes." When asked if she had attempted to feed the resident, CNA #9 stated she had not. CNA #9 went into the Resident's room and asked him if he would like to finish his lunch. Resident #1 nodded "yes." CNA #9 attempted to feed the resident but the resident was unable to open his mouth at that time. CNA #9 removed the tray and exited Resident #1's room. The food on the tray had not been eaten.

On 4/27/17 at 12:50 p.m., Resident #1was observed in the Bistro during lunch. The resident was served his tray at 1:05 p.m. Resident #1 was able to spoon his food from the tray into his mouth. He attempted to drink from the juice container five separate times and was able to get three sips of juice. He was not offered assistance from staff until 1:30 p.m. He consumed approximately 50 percent of his meal but less than 25 percent of his juice and no water.

Review of the April 2017 physician's orders documented, "2 cal (calorie) Supplement 240cc (cubic centimeters) three times a day...Order Date 02/10/2017."

Review of the April 2017 MAR (medication administration record) documented, "2 cal Supplement 240cc three times a day. Offer AM and PM snack two times a day." It was documented that the resident drank between 75 cc and 240 cc's of the 2 cal supplement three times a day and that the snack was offered twice

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a day."

Review of the resident's ADL meal sheet for March 2016 failed to evidence the amount of food the resident had consumed for 30 out of 93 meals. For 33 out of the 63 meals it was documented, "0,1" indicating that the resident was independent in feeding self and was provided set up assistance only. Further review of the ADL sheet for March 2016 documented that the resident was provided assistance of one staff member 28 times.

Review of Resident #1's ADL meal sheet for April 2016 failed to evidence the amount of food the resident consumed for 26 meals out of 81 meals. For 43 out of the 81 meals it was documented that the resident was provided set up assistance only from staff. For 64 out of the 81 meals it was documented that the resident was provided assistance from one staff member to eat. One meal did not specify how much assistance the resident received.

Review of the nurse's note dated 3/16/17 at 1:30 p.m. documented, "Resident has been freezing more, unable to talk eat, gets shakes, the event goes on about 15 minutes and has happened x (times) 3 today."

Review of the nurse's note dated 3/22/17 at 1:34 p.m. documented, "consult neurologist for increasing freeze episodes r/t (related to) Parkinson's as soon as possible."

Review of the nurse's note dated 3/27/17 at 10:57 p.m. documented, "Dr. (doctor) [neurologist] returned call Recommend Long acting Carbidopa-Levidopa...Freezing when trying to eat,

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give meds. Diet incorrect in mar (mediation administration record) per (name of speech therapist) should be thickened liquids and soft mechanical. I did not change."

Review of the speech therapy note dated 3/29/17 documented, "Patient is consuming approximately 60% of his mechanical soft textured sides and pureed meats. His consumption is greater when dining in room as he reports significant distraction associated with table mates. PATIENT HAS BEEN EXHIBITING DAILY EPISODES OF FACIAL RIGIDITY; JAW CLINCHING (sic); AND UPPER EXTREMITY TREMORS RESULTING IN POOR - FAIR PO INTAKE WITH THERAPEUTIC MEALS PLACING HIM AT CONTINUED RISK FOR WEIGHT LOSS."

Review of Resident #1's Kardex did not evidence documentation regarding assisting the resident with meals.

An interview was conducted with Resident #1 on 4/27/17 at 10:00 a.m. When asked how his meals were, the resident stated the food was cold. When asked if he received help with eating, the resident stated, "Not always." Resident #1 was asked if he was hungry, he stated, "Yes. Many times I can't eat. I have to go without food." Resident stated that his jaw would freeze up and he can't eat during those times. When asked if he was offered food after his jaw was no longer frozen, Resident #1 stated they (staff) sometimes offered food.

An interview was conducted on 4/27/16 at 11:05 a.m. with LPN #11, the unit manager. When asked how much breakfast Resident #1 ate, LPN

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#11 stated, "Three bites but I just gave him two and one-half puddings a minute ago." When asked what the plan was to meet Resident #1's nutritional requirements, LPN #11 stated, "I've educated the wife on a feeding tube but she didn't want it." When asked if Resident #1 was offered food when he was able to eat, LPN #11 stated, "It should be his nurses. I'm always offering him food but I'm not here 24 hours a day."

An interview was conducted on 4/27/17 at 1:25 p.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked how staff knew which residents needed assistance with being eating, LPN #4 stated, "Speech therapy tells us." When asked which of her residents needed assistance, LPN #4 named three residents, one being Resident #1. When asked if Resident #1 was able to feed himself, LPN #4 stated, "If he's not freezing up he can feed himself. He ate all of his breakfast yesterday." LPN #4 stated, "He usually eats in the Bistro but today he was shaking so much we had his meal sent to his room."

On 4/27/17 at 6:30 p.m. ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim regional director of clinical services and ASM #5, the owner were made aware of the findings. The group was asked if they knew that the resident complained of being hungry, the group was not aware of that.

An interview was conducted on 4/28/17 at 9:25 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff monitored resident's food consumption, ASM #2 stated, "It would be in his ADLs." ASM #2 reviewed the March and April 2017 ADL sheets

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F 312	Continued From page 157 for Resident #1. When asked if that was considered sufficient monitoring, ASM #2 stated, "The kiosk might have been down and it might be in the chart." A request was made for any documentation evidencing Resident #1's food consumption was monitored. No further information was provided prior to exit.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide the necessary treatments and services to prevent, treat, promote healing and prevent infection of pressure ulcers for five of 32 residents in the survey sample, Resident #26,	F 314	F314 1. Resident #26 is discharged. Resident #7 wound care physician recommendations implemented, soft boot to right heel, and float heels while in bed. Resident #2 has wound orders in place. Resident #19 is discharged. 2. The Director of Nursing and nursing staff completed a skin sweep on current residents on April 27, 2017. One resident was identified at risk, treatment initiated, and care plan updated. RNAC re-educated the wound RN on the wound prevention program. The wound RN will re-educate licensed nurses and newly hired nurses as part of orientation. 3. The Director of Nursing/designee will randomly audit pressure ulcers using the QAPI pressure ulcer tool; identifying Braden scores, weekly skin checks, treatment, wound documentation, pain evaluation, care plan updates, and preventative measures weekly times four weeks, then twice a month, and then monthly times one month. 4. The Director or Nursing/designee will report the audit results monthly to the Quality Assurance Performance Improvement to ensure continued compliance and/or revision.	6-5-17

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#7, #2, #19 and #13.

1 a. The facility staff failed to initiate and implement interventions on admission to prevent the development of a pressure ulcer and on 7/29/16 Resident #26 was documented by the facility staff as having a DTI* (deep tissue injury) on his left heel. The facility staff failed to initiate weekly skin assessments and wound evaluation sheets until 8/8/16. The weekly skin assessments and wound evaluation sheets that were completed did not document complete measurements or a description of the wound being assessed and failed to monitor the wound to determine if the wound was declining or improving. On 8/16/16 the facility staff documented that the left heel wound opened with purulent drainage, Bactrim (an oral antibiotic) was ordered by the physician on 8/17/16 to be administered for seven days. The facility staff failed to transcribe the order for Bactrim onto the MAR (medication administration record) and failed to administer the medication as ordered. Resident #26 was not administered an antibiotic until 8/29/16 following the results of a wound culture that was documented as positive for an infection. During the time period 7/29/16 - 9/16/16 facility documentation evidenced a worsening, odorous wound culminating into a Stage IV* ulcer described on 9/16/16 by a podiatrist as "open to bone and Achilles tendon." Resident #26's left heel wound was subsequently diagnosed with osteomyelitis [6] (an infection of the bone), resulting in harm.

1 b. The facility staff failed to initiate and implement interventions on admission and failed to develop a care plan to prevent Resident #26

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from developing an unstageable pressure injury to the right heel. The facility staff also failed to monitor and revise treatments to the wound on a continuous basis and to assess the effectiveness of the treatments in place.

2. The facility staff failed to implement measures to promote healing of a suspected deep tissue injury for Resident #7 on admission which declined to an unstageable wound on Resident #7's heel. The facility staff also failed to initiate and implement interventions recommended by the facility wound care physician for a period of 13 days. The facility staff also failed to float the residents heels. Resident #7's heels were observed directly on the mattress during the survey.

3.a. Resident #2 developed a pressure injury on the right calf on 3/9/17. The facility staff failed to implement treatment for the pressure injury until 3/17/17.

3.b. The facility staff failed to implement the wound care physician's recommendations for treatment of Resident #2's sacral (1) pressure injury from 3/15/17 through 4/25/17.

3.c. Resident #2 developed a pressure injury on the right heel on 4/19/17. The facility staff failed to implement treatment until 4/25/17.

4. For Resident #19, facility staff failed to maintain infection control practices during a dressing change and promote healing of an unstageable [1] sacral pressure wound [2].

5. The facility staff failed to assess and

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appropriately treat Resident #13's pressure injury from her admission on 4/5/17 until 4/12/17, when she was seen by the wound specialist.

The findings include:

1 a. The facility staff failed to initiate and implement interventions on admission to prevent the development of a pressure ulcer and on 7/29/16 Resident #26 was documented by the facility staff as having a DTI* (deep tissue injury) on his left heel. The facility staff failed to initiate weekly skin assessments and wound evaluation sheets until 8/8/16. The weekly skin assessments and wound evaluation sheets that were completed did not document complete measurements or a description of the wound being assessed and failed to monitor the wound to determine if the wound was declining or improving. On 8/16/16 the facility staff documented that the left heel wound opened with purulent drainage, Bactrim (an oral antibiotic) was ordered by the physician on 8/17/16 to be administered for seven days. The facility staff failed to transcribe the order for Bactrim onto the MAR (medication administration record) and failed to administer the medication as ordered. Resident #26 was not administered an antibiotic until 8/29/16 following the results of a wound culture that was documented as positive for an infection. During the time period 7/29/16 - 9/16/16 facility documentation evidenced a worsening, odorous wound culminating into a Stage IV* ulcer described on 9/16/16 by a podiatrist as "open to bone and Achilles tendon." Resident #26's left heel wound was subsequently

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diagnosed with osteomyelitis [6] (an infection of the bone), resulting in harm.

Resident #26 was admitted to the facility on 7/5/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, thrombocytopenia [1] (a condition in which your blood has a lower than normal number of blood cell fragments called platelets) hip fracture, peripheral vascular disease (poor blood circulation to the lower extremities,[*Note the resident was evaluated in the facility and found to have good blood flow to bilateral lower extremities. See the physician note dated 7/27/16]), anemia (low red blood cell count), atrial fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (affecting the lungs).

Resident #26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/16 coded Resident #26 as a 0 (zero) out of a possible score of 15 on the BIMS (brief interview for mental status) indicating that Resident #26 was severely cognitively impaired with daily decisions about care. The resident was also assessed as requiring extensive to total assist from at least one staff person for transfers, dressing, eating, toileting, hygiene and bathing. Resident #26 was also coded in Section M, Skin Conditions, as having two unhealed pressure ulcers at the time of the assessment, an unstageable* wound with slough and/or eschar measuring 5.0 cm (centimeters) x 10.0 cm and an unstageable wound with suspected deep tissue injury.

Resident #26's admission MDS with an ARD of 7/12/16 coded Resident #26 as being at risk of

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developing pressure ulcers with no admitted with or acquired existing pressure ulcers. Section V - Care Area Assessment (CAA) Summary of the admission assessment documented that "16. Pressure Ulcer" was a triggered care area under column "A" and also checked under column "B. Care Planning Decision." The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan." Section V, Column B for Resident #26's MDS was checked for pressure ulcer.

A review of Resident #26's clinical record revealed, in part, a facility document titled "Clinical Health Status" dated 7/5/16 at 1540 (3:40 p.m.), the box titled "Admission" was checked. Under the section titled "Section B Skin Conditions" a diagram of the human body had an arrow drawn, pointing to the back left hip and hand written beside the arrow was "38 staples." There were no other wounds/skin conditions documented. Under the section titled "Braden Scale (9) for Predicting Pressure Sore Risk a score of 14 was documented, indicating moderate risk.

Resident #26's comprehensive care plan dated on 7/5/16 was reviewed and did not include a care plan for skin or potential for pressure. On 7/29/16 a revision to the comprehensive care plan included the following documentation; "Focus: Pressure ulcer actual due to: Pressure ulcer actual: DTI (deep tissue injury) Left heel. Date Initiated 7/29/2016. Interventions: Assist

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with Turning and repositioning as needed. Date Initiated 7/29/2016. Revision on: 8/9/2016. Bilateral calf support device while up in wheelchair to float heels. Date Initiated: 8/8/2016. Revision on 8/8/2016. Conduct weekly skin inspection Date Initiated: 8/31/2016. Revision on: 10/12/2016. Weekly Wound assessment: Date Initiated: 8/31/2016. Revision on: 10/12/2016." Dietary to implement prostat to aid in the healing process. Date Initiated: 8/3/2016. Extended bed. Date Initiated 8/3/2016. Heel elevator device in bed. Date Initiated: 8/3/2016. Revision on: 8/8/2016. Skin assessment to be completed per (name of facility) policy. Date Initiated: 7/29/2016. Treatments as ordered Date Initiated: 07/29/2016."

A review of Resident #26's physician orders and TAR (treatment administration record) did not reveal any interventions for prevention of pressure ulcers from the time of admission on 7/5/16 until 7/29/16.

A nurse's note dated 7/27/16 at 2:07 a.m. documented, in part, "LLE (left lower extremity) 2 + (two plus) edema (swelling) noted and elevated on pillows, skin is warm to touch, site observed with no open areas."

A physician order dated 7/27/16 documented, in part, "Venous Doppler (ultrasound) to Left Lower Extremity @ (at) am (morning) on 7/27/16."

An ultrasound report dated 7/27/16 documented, in part, the following findings; "Clinical indication: Leg edema and rule out Deep Vein Thrombosis (DVT). Findings: There is no intraluminal (within the vessels) thrombus (blood clot)

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non-compressibility (blood filling issues) or other manifestation of deep vein thrombus in any of the vessels. The right common femoral vein is patent. Impression: Normal left leg vein ultrasound. No DVT." There is no further documentation on 7/27/16 or 7/28/16 regarding the status of the left lower leg.

A nurse's note dated 7/29/16 documented, in part, "Left heel mushy with moderate bleeding. Skin prep q (every) shift. Rehab (rehabilitation therapy) to eval (evaluate) for boots or pressure relieving device. RP (responsible party) and MD (medical doctor) aware of the new area."

Resident #26's clinical record revealed, in part, a weekly skin review dated 7/26/16 at 11:00 a.m. There was no documentation on the assessment related to any skin concerns.
Resident #26's TAR dated 7/1/16 - 7/31/16 documented that skin prep to the left heel was initiated and administered for a suspected DTI beginning on 7/29.

There is no evidence in the clinical record that a weekly skin assessment or a wound evaluation sheet was completed when the SDTI (suspected deep tissue injury) was identified on Resident #26's left heel.

A PT (physical therapy) Therapist Progress note dated 8/1/16 documented, in part, "Pt (patient) was working towards his functional goals and the patient did not progress as anticipated during this progress reporting period. This is likely due to was (sic) making some progress until recent onset of left heel ulcer impacting standing/ WB (weight bearing) activities. During assessment pt's heel skin integrity and pain, pt. exhibited

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tendency to slide heels on bed in an effort to resist positioning performed by PT.

Resident #26's clinical record revealed, in part, a weekly skin review dated 8/2/16 at 11:22 a.m. There was no documentation on the weekly skin review related to any skin concerns.

A nurse's note dated 8/3/16 documented, in part, "Left heel mushy with blackened area." There was no documentation to evidence that the facility staff conducted a wound evaluation assessment, staged the wound or obtained measurements of Resident #26's left heel wound.

Review of Resident #26's clinical record revealed in part the following physician orders;
- 8/3/16 "Float heels. Document if patient refuses. Every shift for Preventative."
- 8/4/16 "Bilateral heels up device when in bed, every shift for Wound Healing."
- 8/4/16 "Prostat Max (a whey based liquid protein) two times a day for DTI left heel 30 ml (milliliters)."
- 8/4/16 "House Supplement three times a day for DTI left heel 90cc (cubic centimeters)
- Med Plus (a brand name of supplement)."

A review of Resident #26's MAR dated 8/1/16 - 8/31/16 evidenced that the physician orders on 8/4/16 were initiated. The physician order to float heels was not documented as being initiated, however the nurse's notes did reveal that the left heel was being elevated either by a pillow or a device.

A physician progress note dated 8/4/16 documented, in part, "Open area L (left) heel. Receiving treatment. (L) heel decub (decubitus).

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Float heel. Nut (nutritional) support. Wnd (wound) MD (medical doctor) consult."

A nurse's note dated 8/6/16 at 13:58 (1:58 p.m.) documented, in part, "Blister area to left heel appears to be self-absorbing."

A nurse's note dated 8/6/16 at 19:13 (7:13 p.m.) documented, in part, "Blister is intact/closed."

A nurse's note dated 8/16/16 documented, in part, the following; "To resident (Resident #26) room for skin prep application to bilaterally (sic) heels. Strong odor noted when sock removed from left heel. Area open to left inner heel approx. 0.5 x 0.5 with purulent drainage. Therapy asked to look at wound for possible (sic) with recommendation to apply calcium alginate [7] to open area at present. MD (medical doctor) and RP (responsible party) made aware."

A therapy note dated 8/16/16 revealed, in part, the following documentation; "It was noted earlier by nursing that an area of the Pt's left heel wound had opened and was covered with necrotic tissue and had purulent drainage. Therefore PT has assessed wound is starting selective sharp debridement to remove necrotic tissue and promote healing. Necrotic tissue is present on the medial aspect of the left heel wound measuring 25 cm (centimeters) 2 (squared) in surface area and covered in 100% necrotic tissue."

A physician ordered dated 8/16/16 documented, in part, "Clean left heel daily, apply calcium alginate to open areas and then apply dressing every day shift." A review of Resident #26's TAR evidenced the initiation of this order starting on

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8/17/16 and discontinued on 8/31/16.
A weekly skin review completed by nursing on 8/17/16 documented, in part, the following; "Site: Left heel. Wounds followed by wound nurse." There was no documentation describing the wound, wound stage and no measurements of the wound.

A physician order dated 8/17/16 documented, in part, "8/17/16 Bactrim DS [2] (an oral antibiotic) 1 tab (tablet) PO (by mouth) BID (two times per day) x 7d (for seven days."
A review of Resident #26's nursing notes revealed documentation stating that Resident #26 was taking an antibiotic from 8/18/16 to 8/26/16, a total of nine days.

A review of Resident #26's MAR failed to reveal any documented evidence that the facility staff transcribed the order onto the MAR and did not evidence that Bactrim DS was administered to Resident #26 for seven days as ordered by the physician beginning on 8/18/16. A copy of the August pharmacy manifest was requested from ASM (administrative staff member) #2, the director of nursing on 4/26/17 at 6:10 p.m. at the end of day meeting, and on 4/27/16 at 10:15 a.m. This was not provided prior by the end of the survey process.
A review of Resident #26's clinical record revealed a wound culture with a collection date of 8/18/16. The final report of the culture dated 8/23/16 documented, in part, "HEAVY MIXED FLORA CULTURE [3]. CONTAMINATION SUGGEST REPEAT CULTURE." Hand written below the report was the following documentation; "Bactrim 8/17. Repeat cx (culture) in AM (morning) TO (telephone order) (name of physician).

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A physician order dated 8/24/16 instructed the facility staff to repeat the wound culture. The facility staff had failed to administer the Bactrim to Resident #26 between 8/17/16 and 8/24/16.
A physical therapy note dated 8/24/16 revealed, in part, "Implemented selective debridement using scissors, tweezers and gauze to left heel wound for removal of non-viable blade escar (sic) tissue. Necrotic tissue is addressed by nursing."

A wound evaluation assessment (one of three completed for Resident #26's left heel) dated 8/24/16 documented, in part, "Wound Evaluation Week 3. Length. (no entry). Width (in cm) 3.2 Depth (in cm) 0 (zero). Current preventative interventions: Pressure redistribution mattress. W/C (wheelchair) cushion. Heel boots." The facility staff failed to document a description of the wound bed the stage of the wound and measurements of the wound.
On 8/25/16 a wound culture was done as ordered for Resident #26's left heel wound. On 8/28/16 a report from the laboratory documented, in part, "Source - Left heel. Organism 1 (one) - Heavy growth gram negative rods."[8] Hand written at the bottom of the laboratory report was the following: "Cipro (an oral antibiotic) 500 mg (milligrams) PO BID x 5 (for five) days Lrg (large) growth in (L) ankle gram (-) (negative) rods." A review of the clinical record revealed, in part, a physician order dated and signed by the physician on 8/29/16 that documented; "Cipro Tablet 500 MG Give 500 mg by mouth every morning at bedtime related to BACTERIAL INFECTION, UNSPECIFIED until 9/3/2016. May give am dose now."
A nurse's note dated 8/26/16 documented, in part, "Resident (Resident #26) left the facility for

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his wound appointment." The facility staff failed to provide any documentation from the wound clinic for this visit.

A nutrition note dated 8/26/16 documented, in part; "Left heel 8/15 (date) 9.2 x 15 (cm) 8/22 (date 6.0 x 11.0 (cm) SDTI (suspected deep tissue injury)." Review of the clinical record revealed the facility staff failed to conduct wound evaluation assessments for Resident #26's left heel between 8/24/16 and 9/2/16 to evidence continuous monitoring of the wound.
A nurse's note dated 8/29/16 documented, in part, "Continues to monitored (sic) for excessive odor and drainage." There was no description of the wound, no wound stage and no measurements for this assessment.

A wound evaluation assessment dated 9/2/16 documented, in part, "Length. (no entry) Depth (in cm) 00 (zero). Width (in cm) 4. Wound bed warm to touch Skin 100%. Surrounding Tissue. Temperature warm. Current treatment: Apply skin prep q (every) shift. Date Treatment Ordered: 7/29/16." There was no documentation describing the wound bed or the stage of the wound.

A physician note dated 9/7/16 documented, in part, "(L) heel ulcer." There was no documentation describing the wound bed, the stage of the wound or the measurements of the wound.

A physical therapy note dated 9/13/16 documented, in part, "Pt (patient) has left heel wound unstageable w (with) total surface area of 50 cm 2 (squared) w depth 0 (zero) cm w minimal thin watery purple exudate (discharge), foul odor

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95% necrotic, 5 % slough."

On 9/14/16 Resident #26 was seen by a physician at the wound care clinic. The physician orders details from the wound care clinic documented instructions for cleaning and management of Resident #26's wound. A hand written physician order dated 9/14/16, signed by the wound care clinic physician and noted by the facility physician documented, in part, the following; "Change dressing daily s/p (following) clean with normal saline. Santyl (an ointment used to treat infected wounds) to wound bed. Slightly moistened gauze. Kerlix/light coban or ace wrap. Continue to float heel and keep weight off at all times turning pt q (every) 2 hours. Increase protein. X-Ray of (L) heel."

A review of Resident #26's 9/1/16 - 9/31/16 TAR revealed that the facility staff failed to administer the ordered dressing to Resident #26's left heel between 9/20/16 and 9/26/16. On these dates the facility staff documented that the dressing on Resident #26's left heel was as follows; "Cleanse left heel ulcer with 0.125% Dakin's then apply moist-dry dressing with gauze soaked in 0.125% Dakin's Soln. Wrap with kerlix and light coban or ace wrap. Change qd (every day) and prn (as needed). Order date 9/19/16." There was no documentation in the clinical record regarding this order.

Further review of the clinical record did not provide evidence that the facility staff were turning Resident #26 every two hours.

Further review of the clinical record did not provide evidence that the facility staff had increased the amount of protein in his food.

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A physician progress note dated 9/15/16 documented, in part; "L heel wound. Decubitus (a pressure injury). Float heels, wound care consult. Started Cipro (an oral antibiotic). X-ray reviewed. MRI (Magnetic resonance imaging). Continue clindamycin (an oral antibiotic ordered 9/8/16 to be administered for 14 days)."

A wound evaluation assessment dated 9/15/16 documented, in part, the following; "Depth (in cm) 0 Staging: Suspected Deep Tissue Injury. Width (in cm) 4. Additional notes: Intact deep purple DTI." The documentation did not state the location of the wound described in the assessment such as left or right heel.

A radiology report for Resident #26 dated 9/15/16 documented, in part, the following; "Examination: Heel 2V (two views) Left. Results: No comparison study is available. Mild erosive change at posterior calcaneus (sic) is concerning for osteomyelitis. Conclusion: Consider more sensitive imaging evaluation with MRI (magnetic resonance imaging) as clinically directed." Hand written at the bottom of the report is as follows; "MRI Foot. Consult podiatry." Signed and dated by the facility physician on 9/15/16.

A review of Resident #26's MAR dated 9/1/16 through 9/30/16 revealed that Resident #26 was administered Augmentin (an oral antibiotic) for 10 days starting 9/21/16 and ending on 9/30/16.
A nurse's note dated 9/23/16 documented, in part; "Wound has strong smell, when entering the room you can smell the odor even when the foot is wrapped.

A nurse's note dated 10/4/16 documented, in

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part; "Wound assessment. The left heel ulcer remains an unstageable pressure ulcer at 5.5 cm x 11 cm x unable to measure due to necrosis. 70% thick adherent necrotic and 30% granulation tissue is present on wound bed. Moderate serous exudate is noted with foul odor. Surrounding skin is macerated (the softening and breaking down of tissue in response to an infection)."

A wound culture collected on 10/4/16 and resulted on 10/8/16 documented, "Heavy growth Proteus Mirabilis [4] (a gram negative bacilla)."

A physician's verbal order dated 10/4/16 documented, in part, "PICC [5] (peripherally inserted central catheter- a long, thin, hollow tube placed into a vein above the bed of the elbow) line placement for infusion of ABT (antibiotic) therapy/infusion IV therapy. One time only until 10/4/16."

A review of Resident #26's clinical record revealed, in part, a consent titled "Peripherally Inserted Central Catheter (PICC)" signed by Resident #26's RP on 10/4/16 that documented, in part, "I consent to the placement/insertion of a PICC with catheter tip location at the superior vena cava level .... "

A report from an Infectious Disease consultant dated 10/6/16 documented, in part, "History of Present Illness: Apparently PICC line was attempted at the NH (nursing home) but patient (Resident #26) was too combative to place a line. Discussion/Summary. Patient (Resident #26) has a large left heel necrotic decubitus ulcer with osteomyelitis of the calcaneous (heel bone). This ulcer needs surgical debridement. I recommend

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that he see a podiatrist. Will order a PICC which he will likely need to have it placed at the hospital. After PICC line place, will empirically start meropenem (an IV [intravenous] antibiotic) 1 gm (gram) q 12 h (every 12 hours). Plan at least 6 weeks of IV antibiotics."

A nurse's note dated 10/7/16 documented, in part, "Spoke with RP regarding picc placement and haven't resent (sic) to IR (interventional radiology) for picc placement. Per RP she would like to think about it, I explained the benefits of obtain (sic) picc and what it could do regarding the wound to the res (resident) left foot. RP stating (sic) I need to think about it and I will let you know on Thursday after the resident podiatry apt (appointment). I also advise (sic) RP to follow up with (name of Infectious Disease physician) office regarding the picc placement."

Further review of Resident #26's clinical record did not reveal that a PICC line was placed at the hospital and did not reveal that Resident #26 was started on an antibiotic between 10/1/16 and 10/17/16.

Review of Resident #26's physician progress notes did not reveal any further discussion regarding Resident #26's refusal of the PICC line or regarding an alternate antibiotic.
Review of the clinical record revealed, in part, the following note from Resident #26's podiatrist dated 10/13/16; "Ulcer on the left side is open to bone with Achilles tendon exposed and no palpable pulse to the left foot."

A physician order dated 10/13/16 documented, in part, the following; "(L) heel decub (decubitus) with exposed calcaneous poor healing; potential

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of acute infection; (+) chronic osteo (osteomyelitis). Recommend; (L) AKA (left above knee amputation)." Signed by physician.

A nurse's note dated 10/17/16 documented, in part, the following; "Situation: When nurse entered the residents (sic) room at 08:20 am to administer medication resident appeared slightly diaphoretic (sweaty) and not responding to his name resident and skin was warm to touch. Assessment: resident lying in bed with eyes closed resident did not respond to name alone nurse administered the sternum rub and resident did open his eyes however he appeared disoriented residents skin warm to touch vitals were as follows 102.4 (temperature), 98 (heart rate), 16 (respirations), 138/104 (blood pressure), 92% (oxygen saturation). Resident was transferred at 8:45 am via stretcher to (name of hospital).

On 4/27/17 at 12:35 p.m. an interview was conducted with OSM (other staff member) #3, the therapy director. OSM #3 was asked if she remembered Resident #27. OSM #3 obtained the PT daily notes. OSM #3 stated, "We did the initial evaluation on 7/6/16 and his participation was variable secondary to impaired cognition. He had surgery on his hip with anesthesia and was struggling to recover. He was having heel pain that was impairing his progression. We did start diathermy [8] (therapeutic treatment most commonly prescribed for muscle and joint conditions. It uses a high-frequency electric current to stimulate heat generation within body tissue) and ultra sound to assist with decreasing the pain. We started diathermy on 8/2/16 and it really was not helpful, especially with addressing pain with weight bearing activities. We had been

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asked by nursing to address the wound around 8/16/16 and we did some sharp debridement. He (Resident #27) continued to decline and we ended therapy on 9/30/16. On 9/13/16 the wound was huge, with a total surface area of 50 cm squared. It was totally covered in necrotic tissue. There was a definite foul odor."

On 4/27/17 at 1:35 p.m. an interview was conducted with LPN (licensed practical) #4, a floor nurse. LPN #4 was asked what documentation she completed for a new admission. LPN #4 stated that she would complete the admission package. LPN #4 was asked if that included a skin assessment. LPN #4 stated, "I do a head to toe assessment and document anything found. We do weekly skin assessments which used to be on the computer and now they are handwritten." LPN #4 was asked if she remembered Resident #26. LPN #4 stated that she did, "he had a mushy heel, I saw it at that time, and we had a wound nurse so I told her to look at it." LPN #4 further stated, "I don't think it was opened, they moved him, his heels were elevated and he was moved to another unit." LPN #4 was asked if she remembered any interventions or treatments. LPN #4 stated, "I remember that the heel opened up, it had a foul odor and was full of infection." LPN #4 was asked to look at the documentation regarding the Bactrim order. LPN #4 was asked why the nursing staff would document the antibiotic as being given between 8/18/16 and 8/26/16 on the nurse's notes but not on the MAR. LPN #4 stated, "I am not sure what happened there it should have been on the MAR."

On 4/27/17 at 2:10 p.m. an interview was

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conducted with RN (registered nurse) #1, the staff development coordinator and assistant director of nursing. RN #1 was asked whether or not a care plan should have been in place when Resident #26 was admitted to address potential skin breakdown. RN #1 stated, "The care plan should have been initiated on 7/5/17, admission, and interventions should have been put into place at that time to address his (Resident #26's) risk to develop a pressure ulcer." RN #1 was asked to explain when wound tracking would be initiated, RN #1 stated, "Wound tracking begins once a wound is identified. For this resident (Resident #26) as soon as the wound on the heel was identified a wound tracking sheet should have been done." RN #1 was asked if she had any documentation to present regarding a care plan prior to the wound or any documentation evidencing ongoing measurements and monitoring of Resident #26's left heel wound. RN #1 stated she did not.

On 4/27/17 at 2:55 p.m. an interview was conducted with LPN #9, Resident #26's admission nurse. LPN #9 was asked to describe her process on admission. LPN #9 stated, "I do a complete skin assessment, head to toe, color, turgor and the Braden scale." LPN #9 was asked if she remembered Resident #26. LPN #9 stated that she was very familiar with the resident, but if she was busy she may have passed certain parts of the assessment on to another nurse. LPN #9 was unable to recall the circumstances of Resident #26's admission process. LPN #9 was asked if she was familiar with the Braden scale and if so what did a score of 14 indicate. LPN #9 stated, "A score of 14 would mean at risk for developing a pressure ulcer." LPN #9 was asked

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if a Braden score of 14 would trigger for preventative measures to be put into place. LPN #9 stated, "Yes, turn and reposition would be one thing we could do." LPN #9 was asked if she would put that on the care plan. LPN #9 stated, "We (the nurses) sometimes do the care plan, generally it is the unit manager."

On 4/27/17 at 3:00 p.m. an interview was conducted with RN #6, a floor nurse. RN #6 was asked how often weekly skin assessments were done. RN #6 stated, "They are done by shift and by room. Back then (last year) we did them on the computer." RN #6 was asked if she remembered Resident #26. RN #6 stated, "He was moved to my side and I remember a really bad wound on his heel." RN #6 was asked whether she remembered anything in particular about the wound / management of the wound. RN #6 stated, "We had so many different wound nurses back then. I remember it got really smelly but other than that I don't really know the details." RN #6 was asked what she would do if she saw a Braden Scale of 14. RN #6 stated, "We should start care planning for preventative measures. It really depends on their mobility. We would implement interventions if the resident was shown to be at risk." RN #6 further stated, "Skin integrity is definitely something that should be addressed. The care plan is definitely important."

On 4/27/17 at 3:55 p.m. an interview was conducted with RN #2, the MDS coordinator. RN #2 was asked to describe when a care plan would be initiated. RN #2 stated, "On admission we have an interim care plan, this has to be done in the first 24 hours. Then we use the CAAs (care area assessments), medical diagnoses and medications to develop a comprehensive care

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plan in 7 - 14 days." RN #2 was asked who was responsible for the interim care plan. RN #2 stated that the nurse on duty at the time of the admission should do it. RN #2 was asked what was included on an interim care plan. RN #2 stated, "The core areas; falls, pain, skin, anticoagulants, psychotropic drugs. Anything pertinent to needing immediate care for example diabetes, IV lines, that type of thing." RN #2 was asked whether or not a Braden score of 14 would trigger the need for a care plan for the potential for skin break down. RN #2 stated that it would. RN #2 was asked if she could explain why a care plan was not put in place for Resident #27 on admission with a Braden score of 14. RN #2 stated that she did not know but asked for the opportunity to research the question. RN #2 was asked to present any information that she had to evidence that a care plan was initiated and interventions were put in place to prevent a pressure ulcer when Resident #26 was admitted on 7/5/16.

On 4/27/17 at 5:20 p.m. an end of day meeting was held with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim director of clinical services and ASM #5, an owner. The above area of concern for harm was discussed.

The facility staff was informed that no interventions were implemented on Resident #26's admission; no care plan was put in place and no skin checks were completed from the date of admission on 7/5/16 until after Resident #26 was found to have an avoidable DTI on his left heel on 7/29/16. The staff was informed the facility staff failed to evidence Bactrim was administered to Resident #26 as ordered when

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purulent drainage from the left heel wound was found on 8/16/16. The facility staff failed to administer the ordered dressing to Resident #26's left heel between 9/20/16 and 9/26/16. They were informed of the concern there was no documented evidence of ongoing assessments, monitoring including staging and measurements of Resident #26's left heel DTI which subsequently declined to a stage IV pressure wound with osteomyelitis, resulting in harm.

On 4/28/17 at 8:45 a.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to review Resident #26's weekly wound flow sheets to explain the timeline of the wound on the left heel. ASM #2 stated that the wound was found on 7/29 and a wound evaluation sheet should have been completed by the wound nurse at that time. ASM #2 agreed that the first wound evaluation sheet was dated 8/8/16, one week after the wound had been identified on Resident #26's left heel. ASM #2 further stated, "I have no other documentation to support that this wound was properly assessed or monitored."

A review of the facility policy titled "Clinical Guideline: Skin Integrity" revealed, in part, the following documentation: Purpose: To provide a systemic approach and monitoring process for skin. To decrease pressure ulcer formation by identifying those residents who are at risk and developing interventions. General Policy: All residents will be assessed/ observed for risk of skin breakdown within 24 hours of admission - quarterly and as necessitated by change in condition. (Name of facility) develops a routine to review residents with wounds or at risk on a

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weekly basis. Documentation and Care Interventions for Skin Integrity: If identified risk present the interventions will be documented in the Immediate Plan of Care or Comprehensive Care Plan. Documentation of Weekly Skin Assessments/Observations: The nursing order for weekly observations will be entered on all residents and print out on the Treatment Administration Record. Licensed nurse to document weekly on all wounds using the "Wound Evaluation Flow Sheet." Determine care plans consistently implemented, evaluated and revised based on the needs of the resident. Continuous Quality Management: Tracking and analysis of pressure ulcers is done at least monthly through the Quality Assurance Committee. Identification of trends and / or problems associated with resident care that would impact skin integrity is discussed along with interventions for improvement. Monitoring Compliance: The flowing elements are in place to demonstrate satisfactory compliance with guideline: Wound Evaluation Flow Sheet is being used. DNS (director of nursing services) or designee evaluates wounds on a weekly basis. Physical observation reflects all care plan interventions are implemented and in place.

No further information was provided by the facility by completion of the survey process

Complaint Deficiency

(*) This information was obtained from the following website source: Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 <http://www.npuap.org.pr2.htm>.

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http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.

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

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

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage

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should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

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

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

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

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erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

References:

[1] This information was obtained from the following website: https://www.nhlbi.nih.gov/health/health-topics/topics/thcp
[2] This information was obtained from the following website; https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012241/?report=details
[3] This information was obtained from the following website: http://www.bpac.org.nz/BT/2013/June/infected-wounds.aspx
[4] This information was obtained from the following website; http://emedicine.medscape.com/article/226434-overview
[5] This information was obtained from the following website; http://www.macmillan.org.uk/information-and-support/treating/chemotherapy/being-treated-with-chemotherapy/picc-lines.html
[6] This information was obtained from the following website; http://www.mayoclinic.org/diseases-conditions/osteomyelitis/basics/definition/con-20025518
[7] This information was obtained from the following website: http://www.woundsource.com/product-category/dressings/alginates
[8] This information was obtained from the following website: https://www.cdc.gov/hai/organisms/gram-negative-bacteria.html
[9] This information was obtained from the

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following website;
https://www.in.gov/isdh/files/Braden_Scale.pdf

1 b. The facility staff failed to initiate and implement interventions on admission and failed to develop a care plan to prevent Resident #26 from developing an unstageable pressure injury to the right heel. The facility staff also failed to monitor and revise treatments to the wound on a continuous basis and to assess the effectiveness of the treatments in place.

See above for admission and MDS information.

A review of Resident #26's clinical record revealed, in part, a facility document titled "Clinical Health Status" dated 7/5/16 at 1540 (3:40 p.m.) the box titled "Admission" was checked. Under the section titled "Section B Skin Conditions" there is a picture of the human body with an arrow pointing to the back left hip and hand written beside the arrow is "38 staples." There were no other wounds/skin conditions documented. Under the section titled "Braden Scale (1) for Predicting Pressure Sore Risk a score of 14 is documented, indicating moderate risk.

Resident #26's comprehensive care plan dated on 7/5/16 was reviewed and did not include a care plan for skin or potential for pressure. On 7/29/16 a revision to the comprehensive care plan included the following documentation; "Focus: Pressure ulcer actual due to: Pressure ulcer actual: DTI (deep tissue injury) Left heel. Date Initiated 7/29/2016. Interventions: Assist with Turning and repositioning as needed. Date

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Initiated 7/29/2016. Revision on: 8/9/2016. Bilateral calf support device while up in wheelchair to float heels. Date Initiated: 8/8/2016. Conduct weekly skin inspection Date Initiated: 8/31/2016. Weekly Wound assessment: Date Initiated: 8/31/2016. Skin assessment to be completed per (name of facility) policy. Date Initiated: 7/29/2016. Treatments as ordered Date Initiated: 07/29/2016."

A review of Resident #26's TAR (treatment administration record) dated 8/1/16 through 8/31/16 revealed, in part, the following order; "Apply skin prep to bilateral heels every shift. Every shift for suspected DTI." Order date 8/3/16 D/C (discontinue) date 8/31/16.
A nurse's note dated 8/8/16 documented, in part, "Right lateral heel noted to have a hardened black area to the base of the lateral ankle. Rough and firm when palpated. No drainage at present. Edges defined. 1.8 x 4.0 cm in size." There was no further documentation regarding the wound stage.

Further review of Resident #26's clinical record did not reveal any weekly wound evaluation sheets related to a wound on the right heel.

A weekly skin review dated 8/10/16 documented, in part, the following; "Site: Right heel. Description: Area is to right lateral lower heel / ankle. Wound care in progress." There was no documentation regarding a description of the wound bed, wound staging or measurements of the wound on the right lower heel/ankle.

A weekly skin review dated 8/17/16 documented, in part; "Site: Right heel. Description; Wounds followed by wound nurse." There was no

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documentation regarding a description of the wound bed, staging or measurements of the right lower heel/ankle.

A nurse's note dated 8/24/16 documented, in part; "Treatment continues to right lateral heel. Area continues to be course and firm in texture with surrounding darkened tissue. No drainage or odor to sire (sic)."

A nutrition monthly wound note dated 8/26/16 documented, in part; "Right lateral heel DTI 8/15 (date) 3.0 x 3.2; 8/22 (date) 2.0 X 3.0."

Further review of Resident #26's TAR revealed the following entry "8/31/16 - 10/17/16 Apply skin prep to DTI (deep tissue injury) on right heel q (every) day." This was signed off on the TAR (treatment administration record) every day 8/31/16 - 10/17/16.

A nurse's note dated 9/6/16 documented, in part, "SDTI (suspected deep tissue injury) noted to R (right) heel." There was no further documentation regarding measurement or description of the wound bed.

A nurse's note dated 10/4/16 documented, in part; "Wound assessment; Resident's (Resident #26) right heel DTI is stable. It remains an intact deep purple DTI at 2.5 cm (centimeters) x 4 cm x 0 (zero)."

A nurse's note dated 10/11/16 documented, in part; "Apply skin prep to DTI on right heel q (every) day."

A podiatrist consult note dated 10/13/16

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documented, in part; "The right lateral heel has a 2.5 cm (centimeter) ulceration open to dermis and is not dressed upon arrival."

A Nurse's note dated 10/13/16 documented, in part: "Wound note: Upon return from (name of care provider) appt (appointment), resident presents with an open area to his right heel (2 x 2.5 x 0.2). Intact skin of DTI is now dislodged to expose underlying granulation and necrotic tissue on wound bed. Scant exudate is noted. surrounding skin is dry and intact. No signs of pain noted to the area by the resident." This author was no longer employed at the facility.

There were no facility physician progress notes regarding the pressure injury on the right heel.

There were no wound evaluation sheets documented in the clinical record in regards to the right heel ulcer.

On 4/27/17 at 1:35 p.m. an interview was conducted with LPN (licensed practical nurse) #4, a floor nurse. LPN #4 was asked what documentation she completed for a new admission. LPN #4 stated that she would complete the admission package. LPN #4 was asked if that included a skin assessment. LPN #4 stated, "I do a head to toe assessment and document anything found. We do weekly skin assessments which used to be on the computer and now they are handwritten." LPN #4 was asked if she remembered Resident #26. LPN #4 stated that she did, "he had a mushy heel, I saw it at that time, we had a wound nurse so I told her to look at it." LPN #4 further stated, "I don't think it was opened, they moved him, his heels were elevated and he was moved to another unit." LPN

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#4 was asked if she remembered any information regarding the right heel. LPN #4 stated that she did not.

On 4/27/17 at 2:10 p.m. an interview was conducted with RN (registered nurse) #1, the staff development coordinator and assistant director of nursing. RN #1 was asked whether or not a care plan should have been in place when Resident #26 was admitted to address potential skin breakdown. RN #1 stated, "The care plan should have been initiated on 7/5/17, admission, and interventions should have been put into place at that time to address his (Resident #26's) risk to develop a pressure ulcer." RN #1 was asked to explain when wound tracking wound be initiated, RN #1 stated, "Wound tracking begins once a wound is identified. For this resident (Resident #26) as soon as the wound on the heel was identified a wound tracking sheet should have been done." RN #1 was asked if she had any documentation to present regarding a care plan prior to the wound on the right heel or any documentation evidencing ongoing measurements and monitoring of Resident #26's right heel wound. RN #1 stated she did not.

On 4/27/17 at 2:55 p.m. an interview was conducted with LPN #9, Resident #26's admission nurse. LPN #9 was asked to describe her process on admission. LPN #9 stated that she completes a complete assessment. LPN #9 was asked if that included the skin. LPN #9 stated that it did. LPN #9 further stated, "I do a complete skin assessment, head to toe, color, turgor and the Braden scale." LPN #9 was asked if she remembered Resident #26. LPN #9 stated that she was very familiar with the resident, but if she was busy she may have passed certain parts

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of the assessment on to another nurse. LPN #9 was unable to recall the circumstances of Resident #26's admission process. LPN #9 was asked if she was familiar with the Braden scale and if so what did a score of 14 indicate. LPN #9 stated, "A score of 14 would mean at risk for developing a pressure ulcer." LPN #9 was asked if a Braden score of 14 would trigger for preventative measures to be put into place. LPN #9 stated, "Yes, turn and reposition would be one thing we could do." LPN #9 was asked if she would put that on the care plan. LPN #9 stated, "We (the nurses) sometimes do the care plan, generally it is the unit manager."

On 4/27/17 at 3:00 p.m. an interview was conducted with RN #6, a floor nurse. RN #6 was asked how often weekly skin assessments were done. RN #6 stated, "They are done by shift and by room. Back then (last year) we did them on the computer." RN #6 was asked if she remembered Resident #26. RN #6 stated, "He was moved to my side and I remember a really bad wound on his heel." RN #6 was asked whether she remembered anything in particular about the wound / management of the wound. RN #6 stated, "We had so many different wound nurses back then. I remember his wound got really smelly but other than that I don't really know the details." RN #6 was asked what she would do if she saw a Braden Scale of 14. RN #6 stated, "We should start care planning for preventative measures. It really depends on their mobility. We would implement interventions if the resident was shown to be at risk." RN #6 further stated, "Skin integrity is definitely something that should be addressed. The care plan is definitely important."

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On 4/27/17 at 3:55 p.m. an interview was conducted with RN #2, the MDS coordinator. RN #2 was asked to describe when a care plan would be initiated. RN #2 stated, "On admission we have an interim care plan, this has to be done in the first 24 hours. Then we use the CAAs (care area assessments), medical diagnoses and medications to develop a comprehensive care plan in 7 - 14 days." RN #2 was asked who was responsible for the interim care plan. RN #2 stated that the nurse on duty at the time of the admission should do it. RN #2 was asked what was included on an interim care plan. RN #2 stated, "The core areas; falls, pain, skin, anticoagulants, psychotropic drugs. Anything pertinent to needing immediate care for example diabetes, IV (intravenous) lines, that type of thing." RN #2 was asked whether or not a Braden score of 14 would trigger the need for a care plan for the potential for skin break down. RN #2 stated that it would. RN #2 was asked if she could explain why a care plan was not put in place for Resident #26 on admission with a Braden score of 14. RN #2 stated that she did not know but asked for the opportunity to research the question. RN #2 was asked to present any information that she had evidencing that a preventative pressure ulcer care plan was initiated when Resident #26 was admitted.

On 4/27/17 at 5:20 p.m. an end of day meeting was held with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim director of clinical services and ASM #5, an owner. The above area of concerns was discussed.

The facility staff was informed that no interventions were implemented on Resident

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#26's admission; no care plan was put in place and no wound evaluation assessments were completed from the date of admission on 7/5/16 until after Resident #26 was found to have an avoidable DTI (deep tissue injury) on his right heel on 8/8/16. The staff was informed of the concern that there was no documented evidence of ongoing assessments and monitoring, including staging and measurements of Resident #26's worsening right heel DTI.

On 4/28/17 at 8:45 a.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to review Resident #26's weekly wound flow sheets to explain the timeline of the wound on the right heel. ASM #2 stated that the right heel wound was not documented and a separate wound evaluation sheet should have been implemented and completed by the wound nurse at the time that it was discovered. ASM #2 further stated, "I have no other documentation to support that this wound was properly assessed or monitored."

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

Complaint Deficiency

2. The facility staff failed to implement measures to promote healing of a suspected deep tissue injury for Resident #7 on admission which declined to an unstageable wound on Resident #7's heel. The facility staff also failed to initiate and implement interventions recommended by the facility wound care physician for a period of 13 days. The facility staff also failed to float the

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residents heels. Resident #7's heels were observed directly on the mattress during the survey.

Resident #7 was admitted to the facility on 8/16/16 with a readmission on 3/26/17 with diagnoses that included, but were not limited to; severe peripheral vascular disease (poor blood flow to the lower extremities [*Note the resident was evaluated in the hospital and found to have good blood flow to bilateral lower extremities. See physician note dated 4/9/17]), high blood pressure, coronary artery disease (a disease impacting the vessels of the heart), chronic obstructive pulmonary disease (affecting the lungs), dementia, bipolar disorder and amputations of the toes on the right foot.

Resident #7's most recent comprehensive MDS (minimum data set) a significant change assessment with an ARD (assessment reference date) of 4/2/17 documented that Resident #7 scored 10 out of a possible 15 on the BIMS (brief interview of mental status), indicating that Resident #7 was moderately cognitively impaired with decisions regarding daily living. In Section M, Skin Conditions, Resident #7 was documented as being at risk for developing pressure ulcers and as having 2 (two) unstageable * - slough / eschar, present on admission [*the 2nd toe and 3rd toe of the right foot] and an unstageable ulcer - suspected deep tissue injury* at the time of admission.

A review of Resident #7's clinical record revealed, a facility document titled, "Admission-Data Collection Form" that documented the following information; "Date of Admission 3/26/17. Time: 1700 (5:00 p.m.). Skin: Skin Conditions:

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Pressure Sore (Stage 1 - IV*). Skin Treatments: Pressure reduction (checked), For Chair (checked), Bed (checked), Turning/Repositioning (checked). Other: Heels offloading. *Right Heel Black. .*Small Red areas - Right heel * Scabs and areas on R Toe. Risk for Pressure Ulcers - Total Score (Braden Score Tool) 17 (15-18 at risk)"

A review of Resident #7's comprehensive care plan revealed, in part, the following documentation; "Focus: The resident has potential for impaired skin integrity/pressure ulcers due to: Occasional (sic) bladder incontinence, decrease (sic) mobility, PVD (peripheral vascular disease), actual pressure areas on right heel. Date Initiated: 3/17/2016. Interventions: Encourage and assist with turning and repositioning as needed. Date Initiated; 6/14/2016. Revision on: 1/16/2017. Provide pressure reduction/relieving mattress. Date Initiated: 3/31/2017. Treatments as ordered. Date Initiated: 3/31/2017. Skin assessment to be completed per Living Center Policy. Date Initiated: 3/17/2016.

A review of Resident #7's MAR (medication assessment record) and TAR (treatment assessment record) dated 3/1/2017 - 3/31/2017 did not reveal any documentation of treatments being applied to Resident #7's right foot, turning and repositioning or floating heals to alleviate pressure on Resident #7's heels.

A review of Resident #7's wound care specialist notes revealed, in part, the following notes:
- 3/29/2017. "Unstageable (Due to Necrosis) of the Right Heel. Focused Wound Exam. Etiology

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(quality): Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration: > (greater than) 1 days (sic). Objective: Healing. Wound Size (L (length) X W (width) X D (depth)): 3.5 x 4.6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adherent Black Necrotic Tissue (Eschar): 100%. Additional Information: Dry, hard, stable eschar. Dressing: Betadine- Twice Daily. Recommendation: Off-Load Wound. Reason for No Debridement: Non-infected heel necrosis. Assessment and Plan of Care Recommendations: Unstageable (Due to Necrosis) of the Right Heel - Initial Evaluation: -Add: Betadine - Twice Daily - Recommendation: Off-load wound." Signed by the wound care physician ASM (administrative staff member) #4.

- 4/12/17 Unstageable (Due to Necrosis) of the Right Heel. Etiology (quality): Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration: > (greater than) 1 days (sic). Objective: Healing. Wound Size (L (length) X W (width) X D (depth)): 3.5 x 4.6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adherent Black Necrotic Tissue (Eschar): 100%. Wound Progress: No Change. Dressing: Betadine - Twice Daily. Recommendation: Float Heels in Bed, Off-Load Wound, Reposition per facility protocol." Signed by ASM #4.

A review of Resident #7's physician orders revealed, in part, the following verbal orders signed by Resident #7's medical doctor: "Order Date: 4/13/2017 09:43 (a.m.) Communication Method: Verbal. Apply betadine to right foot, 2nd and 3rd toes BID every morning and at bedtime for wound care." There were no further orders provided.

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On 4/25/17 at 8:40 a.m. Resident #7 was observed sitting up in his bed with his breakfast tray in front of him eating his breakfast. A specialty air mattress was observed in place with the power on. Resident #7's feet were observed flat on the mattress and were not elevated.

On 4/25/17 at 1:50 p.m. Resident #7 was observed lying on his bed. Resident #7 was observed wearing "grippy" socks on his bilateral feet; there were no other types of heel protector devices observed on his bed or around his living space. A pillow was not observed under Resident #7's feet to offload his heels and his feet were observed flat on the mattress and not elevated.

On 4/26/17 at 7:50 a.m. Resident #7 was observed lying in his bed on his right side. CNA (certified nursing assistant) #1 was observed in Resident #7's room attending to his roommate. CNA #1 was asked if Resident #7's feet could be observed. CNA #1 asked Resident #7 if we could look at his feet and he agreed. CNA #1 then pulled the lower part of the blanket up to reveal Resident #7's feet and their position. A pillow was observed at the bottom of the bed, but it was flat and Resident #7's feet were not propped on the pillow to float the resident's heels. Resident #7's heels were in direct contact with the bed and Resident #7 was observed stretching his legs out and pushing against the wooden foot board of the bed with his right heel. There were no protective devices observed on Resident #7's heels and there was no device observed on the foot of his bed to protect Resident #7's heels from the hard surface of the foot board. CNA #1 was asked whether or not Resident #7 had protective devices in place to protect his heels. CNA #1

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stated that she thought that he had a heel lifter under his feet to enable his "feet to dangle." CNA #1 was asked whether or not there was a heel lifter under Resident #7's feet. CNA #1 stated she did not notice one but did see that there was a pillow which could be used in the same way. CNA #1 was asked whether or not Resident #7's feet were elevated and without pressure on his heels. CNA #1 stated they were not. CNA #1 further stated, "He (Resident #7) moves his feet and pushes up against the footboard, I don't think that there is anything else in place for him." CNA #1 was asked if she was aware that Resident #7 had a pressure sore on his right heel. CNA #1 stated, "Just on his toes, he had surgery to remove some toes and had some areas on his toes."

An interview was continued with CNA #1 at the nurse's station. CNA #1 was asked how she would be made aware of any special instructions or devices for residents that she cared for. CNA #1 stated that she would refer to the kardex (a medical information system used by nursing staff as a way to communicate important information on their patients). CNA #1 was asked if she had a kardex on her person at that time. CNA #1 stated that she did not and asked if she could retrieve the kardex. CNA #1 went to the nurse's station and attempted to locate a kardex for Resident #7. CNA #1 was unable to find the kardex. CNA #1 asked another staff member seated at the nurse's station and was directed to a book that contained individual "kardex" sheets for each resident. Resident #7's kardex sheet did not contain any information regarding pressure ulcers or that his heels were to be off-loaded while in bed. CNA #1 stated, "The kardex does not say anything about the pressure ulcer on his

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heel. I would not know that unless someone specifically told me. I would not know that his heels had to be floated."

A review of Resident #7's kardex found in a book at the nurse's station dated 4/3/17 documented, in part, the following information; "Please monitor my right foot for any discolor (sic) and notified (sic) nurse." There were no other updated kardex' in the reference book used by nursing and CNAs.

On 4/26/17 at 10:45 a.m. wound care was observed with LPN #1 and ASM #4, the wound care physician. Resident #7 was seated in his wheelchair with dressings removed from the right foot. ASM #4 explained that he had just completed his assessment and the nurse, LPN #1, would be reapplying the betadine and dressing. A clean chuck was placed on top of Resident #7's bed and Resident #7 placed his right foot on top of the chuck. The wound on was observed to be black and located on the lateral aspect of Resident #7's right heel. ASM #4 donned gloves and pressed the center of the black eschar and stated that the wound was stable and that the betadine was an important aspect of the treatment as it kept the wound area dry and hard, protecting the skin beneath and allowing the new skin to repair. ASM #4 further stated that without the eschar on the surface the wound would be a stage 3 or stage 4 and subject to infection. LPN #1 was asked who was doing the treatments on Resident #7's heel when she was not available. LPN #1 stated that the nurses caring for the resident were responsible for doing the treatments.

On 4/26/17 at 1:25 p.m., an interview was

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conducted with ASM (administrative staff member) #4 (the wound care physician). ASM #4 was asked the process for staff following his wound care recommendations. ASM #4 stated he couldn't speak to the policies and procedures in the building. ASM #4 stated his recommendations have to be "okayed" by the attending primary care physician but in general, the treatment he recommends is what he thinks will be implemented.

On 4/26/17 at 3:30 p.m. an interview was conducted with LPN (licensed practical nurse) #1, the wound nurse. LPN #1 was asked what was put into place, at the time of admission, to prevent the suspected deep tissue injury documented on Resident #7's heel from declining. LPN #1 stated "We had a treatment in place for skin prep on 3/27/17." LPN #1 was asked where the order was for the skin prep and where it was being signed off as being completed. LPN #1 stated, "I don't know about the order, I may have missed it, I did it though, we can do skin prep treatments without an order, the aides were doing it also." LPN #1 was asked to provide evidence that skin prep was being applied. LPN #1 further stated, "The wound doctor saw him (Resident #7) and gave recommendations for betadine application to the heel and to off load the heel wound." LPN #1 was asked why those recommendations were not put into place until 4/13/17. LPN #1 stated, "I was waiting on an okay from the vascular surgeon. He (the vascular surgeon) had requested that the area be kept clean and dry." When asked why it took two weeks to get approval from the vascular surgeon so as to implement the order, LPN #1 shrugged and stated that it shouldn't have.

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On 4/26/17 at 3:45 p.m. an interview was conducted with LPN #17, a floor nurse who had completed Resident #7's admission package and assessment on 3/26/17. LPN #17 was asked to describe what she remembered seeing on Resident #7's right heel when he was admitted to the facility on 3/26/17. LPN #17 reviewed her admission package and assessment, and stated: "I remember he (Resident #7) was admitted late that day, around 8:30 p.m. His skin looked pretty good except for the heel. It was on the outer aspect of his right heel, it was about the size of a quarter, very small. It was darkened like a bruise, I felt it and it was intact and not boggy. I remember it being firm." When asked why she documented the area as "black" LPN #17 stated that she just felt that it was dark, like a bruise. LPN #17 was asked if she contacted the physician to obtain a treatment order. LPN #17 stated, "I don't think that I did. I would have let the next shift know. I did not put any treatments in place because the heel was intact." LPN #17 was asked what she should do when she found an area of concern on the skin. LPN #17 stated, "We are instructed to refer to an RN, but I didn't because there was no RN around. I think I off loaded his heels by rolling up a pillow. I did not write it anywhere. We had been doing that for him, he could move his feet so it really was only beneficial when he was asleep." LPN #17 was asked if she updated the care plan to reflect the area on Resident #7's heel. LPN #17 stated, "No, I probably just got busy."

On 4/26/17 at 6:10 p.m., ASM (administrative staff member) #2 (the director of nursing) and ASM #3 (the regional director of clinical services)

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stated the facility did not have a policy for following the wound physician's recommendations.

On 4/26/17 at 6:37 p.m. a meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the interim regional director of clinical services. ASM #1, ASM #2 and ASM #3 were made aware of above concern and observations of Resident #7's feet not being floated and also the residents feet observed directly in contact with the foot board. At this time documentation was requested to evidence that interventions were initiated at the time of admission to prevent the suspected deep tissue injury on Resident #7's right heel from deteriorating.

On 4/27/17 at 4:55 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to describe the process staff follows when a resident is admitted to the facility. ASM #2 stated that a head to toe assessment is conducted and any wounds are captured on the admissions documentation. ASM #2 was asked what the nurse would do if she observed a pressure ulcer on admission. ASM #2 stated that the LPNs were not able to stage a wound and would have to have an RN (registered nurse) assess the wound within 48 hours to sign off on the admission and to stage the wound if necessary. ASM #2 was asked who would initiate orders for a wound found on admission. ASM #2 stated, "We would document what we see and then call and get an order from the facility doctor. A treatment should be put in place immediately." ASM #2 was asked what should be put in place for prevention of a pressure ulcer. ASM #2

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stated, "Weekly skin checks, the nursing on the units do this each week."

ASM #2 was asked if the wound care doctor made a recommendation how long it should take to be implemented. ASM #2 stated, "It should be done on the same day and no longer than 24 hours later." ASM #2 was asked to describe what was meant by "off load wounds." ASM #2 stated, "It means keep the heels up using either pillows are a "heels up" device. We also have specialty mattress, we can use skin prep, check the resident frequently, and we could also use multi podus boots to keep their heels protected." ASM #2 was made aware that the recommendations made by the wound care doctor for Resident #7 had not been put into place for a period of 14 days.

A review of the facility policy titled "Wound Prevention and Treatment Program Section Index" revealed, in part, the following documentation; "PREVENTION: Identify residents at risk for skin breakdown - Braden Scale. Residents identified at risk for skin breakdown will have interventions initiated on the Plan of Care (Suggested Interventions): i. Monitor for clinical changes ii. Weekly skin checks iii. Assess condition of mattress iv. Keep clean and dry v. Moisturize skin with lotion vi. Encourage ambulation and mobility vii. Position with pillows and support devices viii. Keep linen dry and wrinkly free ix. Protect skin. 5. Provide padding for elbows and heels. 6. Apply skin barrier. Skin Program: a. Identify residents at risk utilizing Branden (sic) Scale. b. Implement Plan of Care interventions for residents identified at risk for Pressure Ulcers. h. Resident(s) with wounds will

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have appropriate treatment. If there is deterioration or no change in a wound within 2 weeks, the treatment will be changed.

On 4/27/17 at 5:20 p.m. an end of day meeting was held with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim director of clinical services and ASM #5, an owner. The above area of concerns was discussed and no further information was provided prior to the end of the survey process.

*This information was obtained from the following website;
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.
Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

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Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

3.a. Resident #2 developed a pressure injury on the right calf on 3/9/17. The facility staff failed to implement treatment for the pressure injury until 3/17/17 (8days).

Resident #2 was admitted to the facility on 8/30/16 and readmitted to the facility on 1/23/17. Resident #2's diagnoses included but were not limited to: multiple sclerosis, diabetes and major depressive disorder. Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/30/17, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of two or more staff with bed mobility and as being totally dependent on two or more staff with transfers. Section M documented Resident #2 presented with two unstageable pressure injuries (1) present upon admission.

Resident #2's Braden scale for predicting pressure sore (injury) risk dated 8/30/16 documented the resident was at risk for pressure injuries.

Review of Resident #2's pressure ulcer (injury) records revealed the resident developed an unstageable pressure injury on the right calf on 3/9/17. (Note: review of the resident's clinical record revealed prevention interventions were previously implemented and the resident's physician deemed pressure injuries was unavoidable. Also, clinical record review and

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interviews with staff and Resident #2 revealed the resident was non-compliant with turning and repositioning). Further review of Resident #2's clinical record (including March 2017 physician's orders, March 2017 physician's notes and the March 2017 TAR [treatment administration record]) revealed treatment was not implemented for the right calf pressure injury until 3/17/17 when Santyl (2) and a foam dressing every day was ordered by the physician. (Note: further review of the pressure ulcer record revealed the pressure injury did not decline from 3/9/17 through 3/17/17).

Resident #2's comprehensive care plan initiated on 1/23/17 documented, "Pressure ulcer actual and at risk due to... DTI (deep tissue injury)/unstageable to right calf...Interventions: wound MD (medical doctor) as ordered. Date Initiated 03/17/2017..."

On 4/26/17 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the wound care nurse). LPN #1 was made aware of the above findings. LPN #1 stated during the time period of 3/9/17 through 3/17/17 staff offloaded (positioned to relieve pressure) Resident #2 and applied skin prep (3) to the resident's right calf pressure injury. LPN #1 stated the resident favors his right side because of right leg pain. LPN #1 confirmed there was no documentation that treatment was provided to Resident #2's right calf pressure injury from 3/9/17 until 3/17/17. LPN #1 was asked how often skin prep should have been applied to the resident's right calf. LPN #1 stated although the wound care physician did not follow the resident at that time, the protocol was to apply skin prep every day. LPN #1 confirmed she provided

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wound care Monday through Friday each week except for the days she was "pulled" to work as a floor nurse. LPN #1 stated the nurse providing care to Resident #2 was responsible for wound care when she (LPN #1) didn't provide wound care. LPN #1 was asked how she could evidence wound care was provided to Resident #2 on the days she didn't provide wound care since there was no physician's orders documented on the TAR. LPN #1 stated the two CNAs (certified nursing assistants) who care for Resident #2 are good CNAs so she could tell this surveyor that they offloaded the resident's right calf although she didn't witness them do so. LPN #1 stated she could not tell this surveyor that other nurses applied skin prep to the resident's right calf.

On 4/26/17 at 4:52 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated when nurses identify a new wound and LPN #1 is not available then the nurses call the physician to get a treatment order. ASM #2 stated if LPN #1 is available then she looks at the wound to determine if it is a pressure ulcer or a non-pressure wound and obtains an order to treat the wound. ASM #2 stated LPN #1 observes residents' pressure ulcers each day except for weekends and when LPN #1 is "pulled to the medication cart." ASM #2 was asked how staff ensures treatments are initiated. ASM #2 stated the manager's print out order listings then staff ensures the treatments are implemented and the responsible party is notified.

On 4/26/17 at 6:35 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above findings.

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No further information was presented prior to exit.

(1) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve

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without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

(2) Santyl is an ointment that removes dead tissue from wounds to aid in wound healing. This information was obtained from the website: http://www.santyl.com/

(3) "SKIN-PREP is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films..." This information was obtained from the website: http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/

3.b. The facility staff failed to implement the wound care physician's recommendations for treatment of Resident #2's sacral (1) pressure injury from 3/15/17 through 4/25/17.

Resident #2 was readmitted to the facility on 1/23/17. Review of Resident #2's pressure ulcer (injury) records revealed the resident presented with an unstageable pressure injury (2) on the sacrum on 1/23/17. A physician's order dated 1/24/17 documented an order for Santyl (3) to be applied to the sacrum once daily. The former wound care physician's initial evaluation of Resident #2's sacral pressure injury dated

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1/30/17 documented the area as a stage four pressure wound (4) and recommended Santyl once daily. Review of Resident #2's February 2017 and March 2017 TARs (treatment administration records) revealed Santyl was applied to Resident #2's sacral pressure injury per the wound care physician's recommendations until 3/3/17 when the wound care physician's note documented to discontinue Santyl and add silver alginate (5) with foam once daily. A physician's order dated 3/3/17 documented an order for silver alginate and a foam dressing daily. Review of Resident #2's March 2017 TAR revealed silver alginate with foam was applied to Resident #2's sacral pressure injury from 3/3/17 through 3/15/17 per the wound care physician's recommendations.

A wound care physician's note dated 3/15/17 documented to discontinue silver alginate, continue foam and add Santyl and calcium alginate (6) once daily. A wound care physician's note dated 3/22/17 documented to continue foam, Santyl and calcium alginate once daily. A wound care physician's note dated 3/29/17 documented to continue foam, Santyl and calcium alginate once daily. A physician's order dated 3/31/17 documented an order for calcium alginate and a foam dressing once daily. The order did not include Santyl.

Review of Resident #2's March 2017 TAR revealed the facility staff continued to apply silver alginate and foam to Resident #2's sacral pressure injury from 3/15/17 until 3/31/17 although the wound care physician recommended foam, Santyl and calcium alginate until 3/31/17 at which time the order was changed to calcium alginate and a foam dressing once daily. A

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wound care physician's note dated 4/5/17 documented to continue foam, Santyl and calcium alginate once daily. A wound care physician's note dated 4/19/17 documented to continue foam, Santyl and calcium alginate once daily.

Resident #2's April 2017 TAR documented to cleanse the sacral wound and apply calcium alginate and a foam dressing daily. The TAR failed to document the use of Santyl as recommended in the wound care physician's 4/5/17 and 4/19/17 notes.

(Note: further review of wound care physician notes revealed the pressure injury did not decline from 3/15/17 through 4/19/17.)

There was no March 2017 or April 2017 attending physician's notes in Resident #2's clinical record. A nurse practitioner's note dated 3/7/17 documented, "Sacral wound." A nurse practitioner's note dated 3/22/17 documented, "healing wound RLE (right lower extremity)." The nurse practitioner notes failed to document any discussion regarding the wound physician's recommendations or any reason the recommendations should not be followed. There were no April 2017 nurse practitioner's notes in Resident #2's clinical record.

Resident #2's comprehensive care plan initiated on 1/23/17 documented, "Pressure ulcer actual and at risk due to: Pressure Ulcer Present to Sacrum...Interventions: Treatments as ordered. wound MD (medical doctor) as ordered..."

On 4/26/17 at 1:25 p.m., an interview was conducted with ASM (administrative staff

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member) #4 (the wound care physician). ASM #4 was asked if it was possible for Resident #2 to suddenly develop unstageable pressure injuries. ASM #4 stated the resident had so many co-morbidities, was exceeding thin, was non-compliant with treatment and had poor intake; ASM #4 stated these factor drastically increased the risk of the resident developing unstageable pressure injuries. ASM #4 was asked the process for staff following his wound care recommendations. ASM #4 stated he couldn't speak to the policies and procedures in the building. ASM #4 stated his recommendations have to be "Okayed" by the attending primary care physician but in general, the treatment he recommends is what he thinks will be implemented.

On 4/26/17 at 1:45 p.m. LPN #1 was observed providing wound care to Resident #2. Foam, Santyl and calcium alginate was applied to the resident's sacral pressure injury.

On 4/26/17 at 4:05 p.m., an interview was conducted with LPN #1 (the wound care nurse). LPN #1 was asked why the wound physician's recommendations were not followed regarding Resident #2's sacral pressure injury. LPN #1 was also asked if she had held a discussion with the attending physician or nurse practitioner regarding the wound recommendations. LPN #1 stated she didn't recall a discussion with the attending physician or the nurse practitioner. LPN #1 was asked if the wound care physician's recommendations should have been followed. LPN #1 stated she didn't remember what the wound looked like and if there was any drainage. LPN #1 was asked if she typically follows the wound care physician's recommendations and

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stated, "Yes."

On 4/26/17 at 4:52 p.m., an interview was conducted with ASM #2 (the director of nursing) regarding the facility process for following the wound care physician's recommendations. ASM #2 stated when the wound care physician gives a recommendation, the wound care nurse is supposed to write the recommendation as an order on the order form and have the order approved by the attending physician. ASM #2 stated the wound nurse "dropped the ball" if the wound physician gave a recommendation and the recommendation was not implemented. ASM #2 stated recommendations from the wound physician are usually implemented the same day the recommendations are given or within 24 hours. ASM #2 stated she checks to ensures orders for wounds are implemented and care plans are updated at the weekly wound meetings. ASM #2 stated she wasn't saying she didn't miss "stuff" but there was a process and all pressure injuries are discussed in the weekly wound meetings. ASM #2 stated she has a wound round sheet that documents the wounds and treatments. ASM #2 stated the information documented on her wound round sheets is obtained from the wound care nurse's documentation and the wound physician's notes.

On 4/26/17 at 6:10 p.m., ASM #2 and ASM #3 (the regional director of clinical services) stated the facility did not have a policy for following the wound physician's recommendations.

On 4/26/17 at 6:35 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the concern that the facility staff were not

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following the wound physician's recommendations.

No further information was presented prior to exit.

(1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis..." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

(2) "Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon,

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

(3) Santyl is an ointment that removes dead tissue from wounds to aid in wound healing. This information was obtained from the website: http://www.santyl.com/

(4) "Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

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(5) Silver alginate is a wound dressing. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/

(6) Calcium alginate is a wound dressing. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/2610818

3.c. Resident #2 developed a pressure injury on the right heel on 4/19/17. The facility staff failed to implement treatment until 4/25/17 (six (6) days).

A physician's order dated 1/23/17 documented an order to offload Resident #2's heels while in bed every shift. Resident #2's April 2017 TAR (treatment administration record) documented the resident's heels were offloaded each shift during April 2017.

Review of Resident #2's clinical record revealed a physician's order dated 4/6/17 for skin prep (1) to be applied to the resident's heels every day shift. The order was discontinued on 4/19/17.

Review of Resident #2's pressure ulcer (injury) records revealed the resident developed an unstageable pressure injury (2) on the left lateral heel on 4/19/17 and an unstageable pressure injury on the right medial heel on 4/19/17. (Note: review of the resident's clinical record revealed prevention interventions were previously implemented and the resident's physician deemed pressure injuries was unavoidable. Also, clinical record review and interviews with staff and Resident #2 revealed the resident was non-compliant with turning and repositioning).

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The wound care physician's initial evaluation of the right heel wound and left heel wound dated 4/19/17 documented the areas as unstageable deep tissue injuries and the wound care physician recommended skin prep to each heel every shift. A physician's order dated 4/19/17 documented an order for skin prep to the left heel every day shift. There was no treatment order for Resident #2's right heel.

Resident #2's April 2017 TAR documented skin prep was applied to the resident's left heel once a day each day from 4/19/17 through 4/25/17. There was no skin prep treatment documented for the resident's right heel from 4/19/17 through 4/25/17.

Resident #2's comprehensive care plan initiated on 1/23/17 failed to document information regarding a right heel pressure injury.

On 4/25/17 at 5:23 p.m., ASM (administrative staff member) #2 (the director of nursing) and LPN (licensed practical nurse) #1 (the wound care nurse) were asked to provide evidence that treatment for Resident #2's right heel pressure injury was implemented on 4/19/17 when the wound was identified.

A physician's order dated 4/25/17 documented to apply skin prep to Resident #2's right heel every day shift.

On 4/26/17 at 4:05 p.m., an interview was conducted with LPN #1. LPN #1 stated she only documented skin prep to Resident #2's left heel instead of skin prep to both heels when she transcribed the 4/19/17 physician's order that was documented on the April 2017 TAR. LPN #1 was

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asked if she could verify that nurses applied skin prep to both heels since the order on the TAR only documented to apply skin prep to the left heel and there was no directive to apply skin prep to the right heel. LPN #1 stated the nurses follow the TAR to complete treatments when she isn't at the facility so she could not confirm skin prep was applied to both of Resident #2's heels. LPN #1 stated she meant to document to apply skin prep to both heels on the 4/19/17 order that was transcribed to the April 2017 TAR but she made a transcription error.

On 4/26/17 at 6:35 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above findings.

No further information was presented prior to exit.

(1) "SKIN-PREP is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films..." This information was obtained from the website: http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/

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

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of the soft tissue...
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

(3) Santyl is an ointment that removes dead tissue from wounds to aid in wound healing. This information was obtained from the website:

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http://www.santyl.com/

4. For Resident #19, facility staff failed to maintain infection control practices during a dressing change to promote healing and prevent infection of an unstageable [1] sacral pressure wound [2].

Resident #19 was admitted to the facility on 3/27/17 with diagnoses that included but were not limited to high blood pressure, failure to thrive, hallucinations, major depressive disorder, liver cancer, and anxiety disorder. Resident #19's most recent MDS (minimum data set) was an admission MDS with an ARD (Assessment Reference Date) of 4/3/17. Resident #19 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #19 was coded as requiring extensive assistance with one person physical assist with transfers, ambulation, dressing and limited assistance from one staff member with locomotion on and off the unit.

Review of Resident #19's most recent wound care evaluation by the wound care physician dated 4/26/17 documented the following: "Unstageable (Due to necrosis): Wound Size: 1 x 0.4 cm x 0.2 cm. Wound progress: Improved. Dressing: Santyl [3] -Once daily, dry protective dressing- once daily."

Review of Resident #19's most recent POS (Physician Order Sheet) revealed the following current order: "Santyl Ointment 250 UNIT/GM (gram) (Collagenase) Apply to Sacrum topically every day shift for Wound Care Cleanse wound with normal saline, apply santyl ointment and a

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foam dressing."

On 4/27/17 at 3:50 p.m., observation of wound care was conducted with RN (registered nurse) #6. RN #6 walked to the treatment cart, pulled out a package of gauze and saline bullets and placed them on top of the treatment cart. RN #6 then pulled out Santyl and squeezed the medication into a medicine cup and placed the cup on top of the treatment cart. RN #6 was not observed washing her hands prior to preparing the treatment supplies.

Next, RN #6 took her bare hands and pulled a stack of gauze out of the package and placed the gauze on top of the treatment cart. Nothing was underneath the stack of gauze. The gauze was flat touching the surface of the treatment cart. RN #6 then placed the stack of gauze in her scrub pocket and carried the saline bullets and medicine cup of Santyl with her bare hands. RN #6 walked into Resident #19's room, explained the procedure and walked out of his room. RN #6 was observed walking back to the treatment cart.

RN #6 was then observed taking the stack of gauze from the scrub pocket and placing it on top of a foam dressing package. RN #6 then gathered supplies again and walked to Resident #19's room. The supplies were placed on top of Resident #19's bedside table while his belongings were still on the table. The table was not wiped down, and a drape was not used. RN #6 was then observed placing the stack of gauze on the bedside table without a drape underneath the gauze. The gauze was flat against the bedside table.

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RN #6 washed her hands, donned gloves and took the old dressing off Resident #19's sacral wound. She then took gauze from the top of the stack and wiped off Resident #19's wound. She was no observed removing her gloves or washing her hands prior to cleaning the wound.

Resident #19's wound was a tiny open area with slough. The area around the wound was reddened non-blanchable skin. RN #6 measured the wound as 3 x 2 x 0 cm (centimeters). RN #6 measured the wound from one side of the reddened non-blanchable skin to the other side. RN #6 then changed her gloves and cleaned the wound with normal saline from the saline bullets. She was not observed to wash her hands when she changed her gloves.

RN #6 then took some gauze from the top of the stack and wiped the wound dry. RN #6 placed Santyl on the wound and then covered the wound with a foam dressing. RN #6 then threw away the rest of the gauze that was not used during the procedure. The last few pieces of gauze that were lying against the bedside table were not used during the dressing change. RN #6 was then observed washing her hands.

On 4/27/17 at approximately 4:15 p.m., an interview was conducted with RN #6. When asked if she could identify anything that she might have done differently during the dressing change, RN #6 stated, "Well I usually use a drape underneath the supplies but I don't have a drape because central supply is locked. Or I will use a napkin." When asked if it is good practice to put gauze pads directly on the treatment cart surface or on the resident's bedside table surface, RN #6 stated, "Well I never use the bottom of the gauze

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and I usually place it on top of a package like I did earlier when I put the gauze on the foam package." When asked if it was ever ok to place gauze pads in a scrub pocket, RN #6 stated, "No that would be kind of gross. I don't ever put gauze in my pocket. I am very big about what touches the wound." When RN #6 was informed of the wound care observations, RN #6 stated, "That wasn't gauze. That was a piece of paper the hospice nurse handed me. I never put gauze in my pocket."

On 4/27/17 at 4:23 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the wound care nurse. When asked the process of maintaining infection control during a dressing change, LPN #1 stated that she would wash her hands before she gathered supplies, gather supplies and place them into a Ziploc bags, and use gauze that are in individual packages. LPN #1 stated that she would use the Ziploc bags as a clean surface to put her supplies on. When asked if it was ever ok to place treatment supplies directly on the resident's bedside table, LPN #1 stated, "No. It is never ok. You don't know what is on the table." When asked if it was ok for a stack of gauze to be placed on the bedside table if the nurse plans to throw away the bottom stack after a dressing change, LPN #1 stated, "Well that is not good practice at all and it is wasteful." When asked if it was ever ok to place treatment items in her scrub pocket, LPN #1 stated, "No. That is never ok. The supplies are not clean anymore. That's the reason why I place them in Ziploc bags." LPN #1 stated that she would wash her hands right before she provides the treatment. LPN #1 stated that she would also change her gloves and wash her hands after she takes the dirty dressing off the resident. LPN #1

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stated, "If I am taking my gloves off, I am washing my hands."

On 4/27/17 at 4:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.

The facility's policy titled, "General Rules for Dressing Changes," documents in part, the following: "Purpose: Proper cleaning and proper changing of dressing on a wound can aid healing and prevent infection. What to do: 1. Wash your hands 2. Explain procedure to the patient what you are going to do even if you do not think they can hear you. 3. Position patient so they are comfortable. 4. Estimate what dressing supplies will be needed and place on a clean work area. 5. Open the dressing materials. 6. Place protective pads under the body part where the wound is located. 7. Place garbage bag nearby for soiled dressings. To remove old dressings: 1. Put on clean gloves (not sterile). 2. Loosen all tape... 3. Remove old dressings. One layer at a time and place in garbage bag. 4. If dressings stick to the wound, moisten with normal saline to ease removal. 5. Remove and throw away old gloves. 6. Wash your hands. To clean the wound: Open sterile supplies by peeling apart the edges and leave each dressing inside the open package. 2. Put on sterile gloves. 3. Using swabs dipped in normal saline, clean along the wound edges using small circular motions from one end of the wound to the other. 4. Clean each side of wound separately. 5. Do not scrub back and forth across wound. 6. Pat the area dry with sterile gauze. 7. Throw away cleaning materials. Dress the wound: After the wound is dry, apply dressing as instructed by the nurse or a medical provider. 2. Tape the dressing in place."

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[1] Unstageable Pressure-Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

[2] A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

[3] SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

5. The facility staff failed to assess and appropriately treat Resident #30's pressure injury from her admission on 4/5/17 until 4/12/17, when she was seen by the wound specialist.

Resident #30 was admitted to the facility on 4/5/17 with diagnoses including, but not limited to: history of a stroke with paralysis, left leg amputation, heart disease, diabetes and major

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depression. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 4/12/17, Resident #30 was coded as being moderately impaired for making daily decisions. She was coded as having one unstageable pressure ulcer on admission to the facility.

On 4/27/17 at 8:20 a.m., observation was made of Resident #30's pressure ulcer. The wound measured 0.3 X 0.1 X 0.1 cms (centimeters), and had a pink wound bed. The wound had no drainage.

A review of Resident #30's progress notes revealed the following:
- 4/5/17 at 4:10 p.m. by LPN (licensed practical nurse) #1, the wound nurse: "Wound Note: Resident was assessed by wound nurse. Resident had dressing on sacrum. Nurse removed dressing to reveal a wound measuring 5 X 0.5 X 0.2 with light serous exudate (drainage). Awaiting an RN to stage wound. Resident has an old amputation scar on the left leg. Dry skin noted behind left ear. Some moisture noted in the skin of right hand and between the fingers of the right hand. Resident is currently resting in bed, bed in lowest position and call light within reach."
- 4/14/17 at 6:10 p.m. by LPN #1: "Wound Note: Resident was seen by wound Dr. (doctor) on 4/12/17 for sacral wound measuring 0.5 X 0.3 X 0.2. No exudate, 40% necrotic tissue, 60% granulation tissue. Current tx (treatment) is Santyl (3) and foam dressing daily."

A review of Resident #30's discharge notes from the outside hospital dated 4/4/17 revealed, in part, the following:

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- Discharge Summary dated 4/5/17, containing the following paragraph: "Coccygeal wound - This has been evaluated and managed per wound care on a regular basis. Wound has mixed pressure and intertriginous moisture/shear component. Wound appears unchanged and has been treated with saline, cover with Mepilex (foam dressing) and change every 3 days or more frequently if soiled."
- Medication orders: "Bacitracin-Polymyxin B Ointment (4) Apply 500 g (grams) topically 2 times a day....Clotrimazole 1% cream For surgical wound breakdown, sequela. Apply to groin creases two times daily."

A review of Resident #30's orders dated 4/5/17, signed by the physician on 4/9/17 revealed, in part, the following: "Polysporin Ointment Apply topically two times a day related to pressure ulcer of sacral region, stage 3 (6)...Clotrimazole Cream 1% Apply to groin topically two times a day related to pressure ulcer of the sacral region, stage 2." A review of the TARs (treatment administration records) for Resident #30 revealed that these treatments were administered as ordered.

A review of the comprehensive care plan for Resident #30 dated 4/12/17 revealed, in part, the following: "Resident has an unstageable sacral pressure ulcer and is at risk for further breakdown due to impaired mobility, incontinence, right sided [paralysis] and DM (diabetes mellitus)...Treatments as ordered."

On 4/26/17 at 4:50 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed about the process for assessing pressure injuries of newly admitted residents.

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She stated that if the wound nurse does an initial assessment, an RN (registered nurse) follows up on that assessment within 48 hours for the purposes of staging the wound. She stated LPN #1 implements a treatment for the wound even before an RN assessment of the wound. When asked where LPN #1 gets information for the proper treatment for the pressure injury, ASM #2 stated: "She gets that from the admitting orders or from our physician." At this time, ASM #2 was made aware of concerns regarding Resident #30's admission orders for wound care.

On 4/26/17 at 4:55 p.m., LPN #1 was interviewed regarding the treatment for Resident #30's sacral pressure injury implemented at the time of admission. LPN #1 stated: "An RN was not with me when I went in to see it the first time. I can't remember who followed up to assess it." At this point, LPN #1 needed to leave for the day. She stated she would review the admission orders and meet again with the surveyor in the morning on 4/27/17.

On 4/27/17 at 11:20 a.m., LPN #1 was again interviewed. She was shown the above-referenced discharge information from the outside hospital. When she read the paragraph about the "coccygeal wound," LPN #1 stated: "I do not remember ever seeing this. I did not know this was in there." When informed that the discharge information was in the front of Resident #30's chart, LPN #1 stated: "I didn't ever see it." She stated the outside hospital discharge information did not indicate a stage for the pressure injury. She stated when she assessed the wound on 4/5/17; it was unstageable due to the presence of slough. She stated she thought ASM #2 had gone with her to stage it, but could

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not find any information about this in the clinical record. She stated she could not remember any conversations about the wound with either ASM #2 or with LPN (licensed practical nurse) #11, the unit manager. When asked to review the discharge medication orders for Polysporin and for Clotrimazole, LPN #1 stated: "Oh, it looks like they (Polysporin and Clotrimazole) were for something else. I didn't realize that they weren't for the pressure ulcer." When asked what the hospital orders for the wound treatment were, LPN #1 stated: "It looks like the saline and the foam dressing. But I need to check and get back to you."

On 4/27/17 at 11:30 a.m., LPN #11 was interviewed. She stated the creams on the facility admission orders were not appropriate treatments for a Stage 3 or an unstageable pressure ulcer. She stated the same treatment as the outside hospital had been providing should have been ordered for the resident (saline and foam dressing). When asked if she could locate any staging of the wound by an RN prior to 4/12/17, she stated that she could not. She stated the process for wound assessment begins with the admitting charge nurse. She stated if a resident has a pressure injury, the admitting nurse informs the wound nurse. The wound nurse assesses the pressure injury within 24 hours of admission. This is followed by an RN assessment and staging within the next 24 hours. She stated the wound nurse is responsible for obtaining treatment orders for the wound. LPN #11 stated: "I never looked at [Resident #30]. I didn't know she even had a wound until right now."

No further information was provided prior to exit.

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(1) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.

(3) Santyl - "Collagenase Santyl® Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. The enzyme collagenase is derived from the fermentation by Clostridium histolyticum. It possesses the unique ability to digest collagen in necrotic tissue." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d .

(4) "Bacitracin is used to help prevent minor skin injuries such as cuts, scrapes, and burns from becoming infected. Bacitracin is in a class of medications called antibiotics. Bacitracin works by stopping the growth of bacteria." This information is taken from the website https://medlineplus.gov/druginfo/meds/a614052.html.

(5) "Clotrimazole is used to treat yeast infections of the vagina, mouth, and skin such as athlete's

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F 314	Continued From page 229 foot, jock itch, and body ringworm. It can also be used to prevent oral thrush in certain patients." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682753.html (6) Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. This information was obtained from the website http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.	F 314		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the	F 328	F328 1. Resident #13 and Resident #8 nebulizer mask and equipment were put in protective storage. 2. Current residents with nebulizer masks and equipment were placed in proper storage. 3. The Director of Nursing/designee will re-educate nursing staff on proper treatment care for special needs and proper storage of nebulizer equipment. The Director of Nursing/designee will randomly audit residents with nebulizer equipment to ensure proper storage three times a week times four weeks and then monthly times two months. 4. The Director of Nursing/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	6-5-17

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comprehensive person-centered care plan, and the resident's goals and preferences.

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

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

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility

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staff failed to provide proper treatment and services for respiratory care for two of 32 residents in the survey sample, Resident #8 and Resident #13.

1. The facility staff failed to store Resident #8's nebulizer mask in a sannitary manner. Resident #8's nebuizer mask was observed uncovered sitting ontop of a plastic bag on seprate ocassions during the survey.

2. The facility staff failed to store Resident #13's nebulizer equipment in a protective cover. Resident #13's nebulizer equipment was observed lying unprotected on top of, and in contact with, her bedside table.

The findings include:

1. Resident #8 was admitted to the facility on 3/25/17 and readmitted on 4/6/17 with diagnoses that included but were not limited to: stroke, indigestion, weakness, respiratory failure, difficulty swallowing and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 4/13/17 coded the resident as usually being able to make self-understood and sometimes understand others. The resident's brief interview for mental status was coded "00" indicating the resident was unable to answer any questions correctly. The resident was coded as requiring assistance from staff for all activities of daily living.

An observation was made of Resident #8 on 2/25/17 at 12:55 p.m. The resident was getting ready to get out of bed into the wheelchair. The

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nebulizer mask was observed sitting on top of a plastic bag on the bedside table.

An observation was made of Resident #8 on 2/25/17 at 1:30 p.m. The resident was up in the wheelchair. The nebulizer bag was observed sitting on top of a plastic bag on the bedside table.

An observation was made of Resident #8 on 2/25/17 at 4:08 p.m. The resident was up in the wheelchair. The nebulizer mask was observed sitting on top of the plastic bag.

Review of the care plan initiated on 3/23/17 did not evidence documentation regarding proper storage of the residents nebulizer mask.

Review of the physician's orders for April 2017 documented, "Ipratropium-Albuterol Solution (1) 0.5-2.5 MG (milligrams)/3ML (milliliters) 1 vial inhale orally every 6 hours...."

Review of the April 2017 MAR (medication administration record documented, "Ipratropium-Albuterol Solution (1) 0.5-2.5 MG (milligrams)/3ML (milliliters) 1 vial inhale orally every 6 hours...." The medication was documented as being given four times a day in April 2017.

An interview was conducted on 4/26/17 at 8:07 a.m. with RN (registered nurse) #6, the resident's nurse. When asked what process the staff follows after a nebulizer treatment is completed, RN #6 stated, "We put it (nebulizer mask) in the bag." When the observations above were reviewed with RN #6, she stated, "I gave her it (the nebulizer treatment) around noon. I don't remember that, I

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usually put it (nebulizer mask) in a bag." When asked if the resident was capable of taking the mask off and placing it on the bedside table, RN #6 stated, "No." When asked why staff put the nebulizer mask in a plastic bag, RN #6 stated, "Well it's for infection control."

An interview was conducted on 4/26/17 at 1:15 p.m. with LPN #4. When asked the process staff followed after a nebulizer treatment was completed, LPN #4 stated, "You wash it (nebulizer mask) out. Take it apart, dry it and put in in the bag." When asked why staff did this, LPN #4 stated, "To avoid infection."

An interview was conducted on 4/27/17 at 11:07 a.m. with LPN #11, the unit manager. When asked the process staff followed after a nebulizer treatment, LPN #11 stated, "After it's done take the mask and rinse it with warm water. Air dry it and put it in the bag."

On 4/27/17 at 6:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled "OXYGEN ADMINISTRATION" did not evidence any documentation regarding the care of the nebulizer mask.

No further information was provided prior to exit.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory

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therapy equipment."

(1) DuoNeb Inhalation Solution is a combination of the ß2-adrenergic bronchodilator, albuterol sulfate, and the anticholinergic bronchodilator, ipratropium bromide. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=8337

2. The facility staff failed to store Resident #13's nebulizer equipment in a protective cover.

Resident #13 was admitted to the facility on 6/5/15 and readmitted on 3/31/17 with diagnoses including, but not limited to: Diabetes, bipolar disorder (1), congestive heart failure, and schizoaffective disorder (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 2/6/17, she was coded as having no cognitive impairment for making daily decisions.

On the following dates and times, Resident #13's room was observed. At each of these observations, Resident #13's nebulizer tubing and mouthpiece were observed lying unprotected on top of, and in contact with, her bedside table: 4/25/17 at 12:00 noon and 3:40 p.m.; 4/26/17 at 8:25 a.m. and 12:00 noon; 4/27/17 at 10:32 a.m.

A review of Resident #13's physician's orders

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revealed the following order written 2/9/17: "DuoNeb Solution (3) 0.5 - 2.5 MG/3ML (milligrams per three milliliters). 1 applicatorful (sic) inhale orally at bedtime for SOB (shortness of breath)."

A review of Resident #13's MARs (medication administration records) revealed that she had received this medication as ordered in February, March, and April 2017.

On 4/26/17 at 12:50 p.m., Resident #13 was asked if she ever touched the nebulizer equipment between administrations of the medication. She stated that she did not.

On 4/27/17 at 10:32 a.m., LPN (licensed practical nurse) #12 was asked how nebulizer tubing and mouthpieces should be stored between administrations. She stated this equipment should be stored in plastic bags with drawstrings. When asked why, LPN #12 stated: "So [the equipment] does not get dirty. It's an infection control thing." LPN #12 accompanied the surveyor to Resident #13's bedside and was shown Resident #13's nebulizer equipment. When asked if the equipment was properly stored, LPN #12 said it was not. LPN #12 stated: "There should be a bag to store it in."

On 4/27/17 at 11:15 a.m., ASM (administrative staff member) #2, the director of nursing was informed of this concern.

No further information was provided prior to exit.

(1) "Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity

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levels, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.

(3) "The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601063.html.

F 329 SS=D 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS — F 329

483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

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F 329	Continued From page 237 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to ensure the drug regimen for one of 32	F 329	F329 1. Resident #14 was interviewed and care plan updated. 2. Current residents on psychotropic drugs will be reviewed for gradual dose reductions. 3. The Director of Nursing/designee will re-educate nursing staff on unnecessary medications. The Director of Nursing/ designee will randomly audit residents on psychotropic to ensure gradually dose reductions and behavioral interventions are identified as indicated weekly times four weeks and then monthly times two months. 4. The Director of Nursing/designee will report the audit results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	6-5-17

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residents in the survey sample, (Resident #14), was free from unnecessary medications.

The facility staff failed to attempt non-pharmacological interventions prior to the administration of prn (as needed) Ativan (antianxiety medication [1]) to Resident #14 on several occasions in the month of April 2017.

The findings include:

Resident #14 was admitted to the facility on 3/4/13 and readmitted on 7/5/15 with diagnoses that included but were not limited to: gastroparesis [2], generalized anxiety disorder, history of mental and behavioral disorders, high blood pressure, and type two diabetes. Resident #14's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #14 was coded as being cognitively intact in the ability to make daily decisions, scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded as being independent with transfers, and ambulation; and independent with supervision only for dressing, eating, toileting, and bathing.

Review of Resident #14's most recent POS (Physician Order Sheet) documented the following order: "Ativan Tablet 0.5 MG (milligrams) (Lorazepam) Give 0.5 mg by mouth every 6 hours as needed for anxiety. Do not give from 7 pm to 7 am per Psych (psychiatric) NP (Nurse Practitioner)."

Review of Resident #14's April 2017 MAR (Medication Administration Record) revealed that Resident #14 received prn Ativan on the following

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dates and times:

"4/1/17 at 9:02 a.m., 6:35 p.m.
4/2/17 at 8:16 a.m., and 4:47 p.m.
4/3/17 at 8:37 a.m., and 4:08 p.m.
4/4/17 at 9:51 a.m., and 5:50 p.m.
4/5/17 at 8:34 a.m., and 4:05 p.m.
4/6/17 at 8:16 a.m., and 6:24 p.m.
4/7/17 at 11:10 a.m., and 6:30 p.m.
4/8/17 at 8:46 a.m., and 6:17 p.m.,
4/9/17 at 8:16 a.m., and 6:15 p.m.,
4/10/17 at 9:10 a.m., and 5:55 p.m.
4/11/17 at 4:45 p.m.
4/12/17 at 8:56 a.m. and 4:15 p.m.
4/13/17 at 8:30 a.m., and 4:30 p.m.
4/14/17 at 8:40 a.m., and 3:57 p.m.
4/16/17 at 7:50 a.m., and 3:28 p.m.
4/17/17 at 8:11 a.m., and 4:16 p.m.
4/18/17 at 8:34 a.m.
4/19/17 at 10:08 a.m., and 4:00 p.m.
4/20/17 at 8:42 a.m., and 4:25 p.m.
4/21/17 at 4:15 a.m.
4/22/17 at 8:42 a.m.
4/23/17 at 8:12 a.m., and 5:00 p.m.
4/24/17 at 3:55 p.m.
4/25/17 at 8:27 a.m., and 4:46 p.m.
4/26/17 at 7:49 p.m."

Notes on the April 2017 MAR and April 2017 nursing notes failed to reveal that non-pharmacological interventions were attempted prior to the administration of prn Ativan.

On 4/26/17 at 1:25 p.m., an interview was conducted with Resident #14. Resident #14 stated that facility staff did not attempt other interventions prior to administering her prn anti-anxiety medication. Resident #14 stated,

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"They just give it to me."

On 4/26/17 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who administered Ativan on some occasions to Resident #14. When asked about the process staff follows prior to administering a prn anti-anxiety agent, LPN #4 stated that she would try to attempt non-pharmacological interventions such as diverting the resident's attention before giving the prn medication. When asked if she attempts non-pharmacological interventions every time prior to administering prn anti-anxiety medications, LPN #4 stated, "It depends on why the resident is anxious. Sometimes I do, sometimes I don't."

On 4/26/17 at 4:33 p.m., an interview was conducted with LPN #1, a nurse who administered Ativan to Resident #14 on some of the dates listed above. LPN #1 stated that non-pharmacological interventions should be attempted prior to administering prn anti-anxiety medications. LPN #1 stated that Resident #14 will refuse non-pharmacological interventions prior to administering her Ativan. LPN #1 stated that the resident will say that she already attempted interventions when she requests her Ativan. When asked if this was documented in the clinical record, LPN #1 stated that this information was not documented. LPN #1 stated that she works with Resident #14 on daily basis and that she does not document the non-pharmacological interventions the resident attempted. LPN #1 stated, "It's so routine with her that I don't document."

On 4/26/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2,

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the DON (Director or Nursing) were made aware of the above concerns.

The facility policy titled, "Chemical Restraint" documents in part, the following: "It is the policy of the facility to comply with OBRA regulations stating that the resident has the right to be free of chemical restraints imposed for the purpose of discipline or staff convenience, and which are not required to treat the resident's medical condition. PROCEDURE: Interventions to be used to avoid using psycho-pharmacologic drugs may include: exercise, all departments may be involved, verbal instructions, speak clearly, diversion activities such as TV/Videos, Music therapy, Bingo, Picture Books. etc., frequent visits, Massage/Therapeutic touch/warm hands, Pillows and other positioning aids, Food/Warm beverages, Toileting."

References:
[1] Ativan - Used to treat anxiety disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.

[2] Gastroparesis - Delayed gastric emptying, disorder that slows or stops the movement of food from the stomach to the small intestine. This information was obtained from The National Institutes of Health.

F 329

F 360 SS=D 483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT

F 360

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the

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preferences of each resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that facility staff failed to serve food at the appropriate nutritive value.

The facility staff failed to ensure that the appropriate amount of meat was mixed into the second batch of meat sauce and failed to ensure that 14 residents were served the appropriate amount of protein for lunch on 4/25/17.

The findings include:

On 4/25/17 at 11:45 a.m., tray line was observed. The following food items were being served:

Spaghetti
Meat Sauce
Green Peas
Mashed Potatoes
Pureed Spaghetti
Chicken Patty
Meat/Hamburger Steak
Fries
Chicken noodle soup

The meat sauce was observed being served in a 6 ounce ladle. The meat sauce was observed to be very chunky with meat.

On 4/25/17 at 12:33 p.m., the first batch of meat sauce was empty.

On 4/25/17 at approximately 12:35 p.m., OSM (other staff member) #10, the Dietary manager, was observed giving a can of red sauce to OSM

1. Residents were offered substitutes and refused.
2. The Certified Dietary Manager re-educated dietary staff on following menu recipes. 6-5-17
3. The Certified Dietary Manager/ designee will conduct random audits to ensure food is served at the appropriate nutritive value three times a week times four weeks and then monthly times two months.
4. The Certified Dietary Manager/ designee will report the audits results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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#11, the cook.

On 4/25/17 at approximately 12:35 p.m., OSM #11, the cook was observed putting the sauce from the can into a pot onto the stove. No additional meat was observed being added to the pot of sauce.

At approximately 12:40 p.m. the second batch of meat sauce was placed on the tray line. The second batch of meat sauce appeared to have very little meat in the sauce. The sauce appeared very thin (not chunky). 14 trays for 14 residents were prepared with the second batch of meat sauce.

On 4/25/17 at 12:59 p.m., an interview was conducted with OSM #11. When asked how much meat was used in the first batch of meat sauce, OSM #11 stated, "The recipe called for 20 pounds of meat." When asked how much meat was used in the second batch of sauce, OSM #11 stated, "I didn't add meat. I only had sauce left." OSM #11 stated that some remnants of meat from the first batch were mixed into the second batch.

On 4/26/16 at 9:50 a.m., further interview was conducted with OSM #11. OSM #11 stated that when she ran out of the meat for the meat sauce she had told the dietary manager. OSM #11 stated that the dietary manager had given OSM #11 a can of red sauce to use for the second batch. OSM #11 stated that it was not common for the kitchen to run out of food items. OSM #11 stated that it was up to the Dietary Manager to order enough food for each meal.

On 4/26/17 at 10:19 a.m., an interview was

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conducted with OSM 10, the Dietary Manager. When asked how much meat was supposed to be used for the meat sauce, OSM #10 stated that the recipe called for 22 lbs (pounds) of ground meat. When asked if the kitchen ran out of meat for the sauce on 4/25/17, OSM #10 stated, "We didn't run out of meat for the sauce. I pulled the second pan of meat out of the oven for the cook. It was there." When asked if she saw the cook add the meat to the second batch of sauce, OSM #10 stated, "No I didn't see her add it." OSM #10 stated that the cook had a second pan of meat and that it might have all been added to the first batch of meat sauce.

On 4/26/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings.

Review of the meat sauce recipe documented the following: "Portion Size 6 Oz (ounces), Servings: 95 Ingredient Beef, Ground Lean, 80/20, Amount 22 3/4 LB (pounds)."

A policy could not be provided. No further information was provided prior to exit.

F 364 SS=B 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP F 364

(d) Food and drink

Each resident receives and the facility provides-

(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(d)(2) Food and drink that is palatable, attractive,

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and at a safe and appetizing temperature;
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and facility document review, it was determined that facility staff failed to serve food at a palatable temperature during the lunch meal on 4/25/17.

The findings include:

On 4/25/17 at 11:30 a.m., temperatures of the lunch food items were conducted with OSM (Other Staff Member) #24, the Regional District Dietary Manager. The following food items and temperatures were recorded in degrees Fahrenheit.

Chicken Patty: 162.8
Hamburger Steak: 160.1
Green Peas: 191.3
Mashed Potatoes: 189.7
Pureed Spaghetti: 161.8
Pureed Peas: 163.1
Meat Sauce (Regular): 155.3
Regular Spaghetti: 180.0

On 4/25/17 at 12:58 p.m., the last food cart was taken to the West 1 unit. At 1:27 p.m. temperatures were taken of food items on the test tray by OSM #10, the Dietary Manager. The following food items and temperatures were recorded in degrees Fahrenheit:

Chicken Patty: 104.5
Hamburger Steak: 97.3

On 4/25/17 at 1:27 p.m., OSM #10 stated that the

1. New thermometers were purchased for the dietary department.
2. The Certified Dietary Manager re-educated the dietary staff on serving food at a palatable temperature. 6-5-17
3. The Certified Dietary Manager will conduct random audits of food temperatures three times a week times four weeks and then monthly times two months.
4. The Certified Dietary Manager/ designee will report the audits results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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thermometer must have been broken because she was getting low recordings. OSM #10 then left to get a new thermometer from the kitchen. The chicken patty and hamburger steak tasted cold by this writer and another surveyor. The hamburger steak also tasted bland.

On 4/25/17 at 1:28 p.m., OSM #10 took temperatures of the following food items with the second thermometer in degrees Fahrenheit:

Green Peas: 39.5
Mashed Potatoes: 46.5

On 4/25/17 at 1:28 p.m., OSM #10 stated that the second thermometer must have been broken. This writer and a second surveyor tasted the Green Peas and Mashed Potatoes. The food tasted cold. The second surveyor offered to grab another thermometer from kitchen staff.

On 4/25/17 at 1:29 p.m., the following food items and temperatures were recorded with the third thermometer in degrees Fahrenheit:

Spaghetti with meat sauce: 44.2
Pureed peas: 41.2
Pureed Spaghetti: 40.5

On 4/25/17 at 1:29 p.m., this writer and a second surveyor tasted the spaghetti with meat sauce, pureed peas and pureed spaghetti. The food tasted cold. The Dietary manager was asked to test all food items. The dietary manager stated that all three thermometers must have been broken because of the low temperature recordings.

On 4/25/17 at 1:30 p.m., an interview was

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conducted with OSM #10. When asked what she thought of the food, OSM #10 stated, "It tastes good." When asked what she thought of the temperature of the food, OSM #10 stated, "I am not going to say it was cold, the thermometers were broken." When asked how the temperature of the food felt to her, OSM#10 stated, "I thought it was luke warm." When asked if she would eat luke warm food, OSM #10 stated, "Yes."

On 4/26/17 at 10:10 a.m., further interview was conducted with OSM #10. OSM #10 stated that the reason why she was recording low temperatures was because all three thermometers were set to degrees Celsius not degrees Fahrenheit. OSM #10 stated that dietary staff usually record temperatures in degrees Fahrenheit.

The food temperatures that were recorded would have been the following in degrees Fahrenheit if the thermometer was set to degrees Celsius.

Chicken Patty: 104.5 degrees Celsius would convert to 220 degrees Fahrenheit. (The chicken patty was initially at a temperature of 162.8 degrees Fahrenheit on the steam table).

Hamburger Steak: 97.3 degrees Celsius would convert to 207.1 degrees Fahrenheit. (The hamburger steak was initially at a temperature of 160.1 degrees Fahrenheit on the steam table).

Green Peas: 39.5 degrees Celsius would convert to 103.1 degrees Fahrenheit.
Mashed Potatoes: 46.5 degrees Celsius would convert to 115.7 degrees Fahrenheit.
Spaghetti with meat sauce: 44.2 degrees Celsius would convert to 111.5 degrees Fahrenheit.

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Pureed Peas: 41.2 degrees Celsius would convert to 106.1 degrees Fahrenheit.
Pureed Spaghetti: 40.5 degrees Celsius would convert to 104.9 degrees Celsius.

Individual interviews conducted with two cognitively intact residents revealed concerns that the food was always cold and not palatable.

On 4/26/17 at 2:30 p.m. a group interview was conducted with seven residents. Four residents stated that the food was cold.

On 4/26/17 at 5:00 p.m. at the end of day meeting, ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Food: Quality and Palatability" documents in part, the following: "It is the center policy that, food is prepared by methods that conserve nutritive value, flavor and appearance. Food is palatable, attractive and served at the proper temperature."

No further information was presented prior to exit.

F 371 SS=E — 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY — F 371

(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

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(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review it was determined that facility staff failed to store, prepare, and serve food in a sanitary manner.

1. The facility staff failed to ensure the facility's mixer was free from debris.

2. The facility staff failed to wear hair restraints while in the facility kitchen.

3. The facility staff failed to ensure clean dishware was free from debris by a dusty fan.

4. The facility staff failed to label the open date of a plastic bag of opened meatballs; and facility staff failed to label the prepare date or use by date of seven bowls of applesauce, one bowl of cottage cheese, and 5 cups of fruit that were sitting on a rack in the refrigerator.

F 371 F371

1. The Certified Dietary Manager cleaned the debris from the mixer. The cook applied a beard guard. The Plant Ops Director cleaned the fan. The Certified Dietary Manager disposed of the unlabeled food and labeled the prepared servings accordingly.
2. The Certified Dietary Manager re-educated the dietary staff on storing, preparing, and serving food in a sanitary manner. 6-5-17
3. The Certified Dietary Manager will conduct random audits of the kitchen to ensure equipment is free from debris, hair restraints are used, stored dish-ware is clean, and foods labeled three times a week times four weeks and then monthly times two months.
4. The Certified Dietary Manager/ designee will report the audits results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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The findings include:

1. The facility staff failed to ensure the facility's mixer was free from debris.

On 4/25/17 at 6:47 a.m., inspection of the kitchen was conducted. At 6:50 a.m., the mixer was observed to have the plastic cover over the top of it. When the cover was removed, dried up debris was observed on the outside of the bowl of the mixer, and in the inside of the mixer.

On 4/25/17 at 7:05 a.m., an interview was conducted with OSM (other staff member) # 9, a dietary aide. When asked if the mixer was clean and ready to be used, OSM #9 stated that it should be. OSM #9 walked over to the mixer and lifted the cover. OSM #9 stated, "No it's not clean." When asked who was responsible for ensuring the mixer was clean, OSM #9 stated, "The cook cleans it. After we are done using the mixer it is supposed to be cleaned right away." OSM #9 stated, "I am going to take the cover off for now because it is not clean."

On 4/26/17 at 11:03 a.m., an interview was conducted with OSM #10, the Dietary Manager. When asked when the facility mixer was cleaned, OSM #10 stated, "After each use." OSM #10 stated the staff that use the mixer, are responsible for cleaning the mixer when they are done. OSM #10 stated, "It has been taken care of."

On 4/26/17 at 5:00 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

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The facility policy titled, "Equipment," documents in part the following: "It is the center policy that all foodservice equipment is clean, sanitary, and in proper working order. Action Steps: 1. The Food Service Director will ensure that all equipment is routinely cleaned and maintained in accordance to manufacturer directions and training materials. 2. The Food Service Director will ensure that all staff members are properly trained in the cleaning and maintenance of all equipment. 3. The Food Services Director ensures that all food contact equipment is cleaned and sanitized after every use. 4. The Food Services Director ensures that all non-food contact equipment is clean..."

No further information was presented prior to exit.

2. The facility staff failed to wear hair restraints while in the facility kitchen.

On 4/25/17 at 11:45 a.m., tray line was observed. OSM (other staff member) # 15, the cook, was observed in the kitchen preparing brownie mix. OSM #15 was observed with a short beard. He was not wearing a beard restraint. On 4/25/17 at 12:58 p.m., at the end of tray line, OSM # 15 was observed carrying the tray of brownie batter. He was not wearing a beard restraint.

On 4/25/17 at 1:37 p.m., an interview was conducted with OSM # 15. When asked what he should be wearing while preparing food, OSM #15 stated, "A beard net." When asked why a beard net or other hair restraints should be worn while preparing food, OSM # 15 stated, "So hair won't get into the food." OSM #15 confirmed that

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he was not wearing a beard net while preparing the brownies in the kitchen.

On 4/26/17 at 10:19 a.m., an interview was conducted with OSM #10, the dietary manager. When asked what staff should be wearing while in the kitchen, OSM #10 stated that hair and facial hair must be restrained by a hair restraint or beard net. When asked why staff should wear hair restraints, OSM #10 stated, "So hair won't fall into the food."

On 4/26/17 at 5:00 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Staff Attire," documents in part the following, "It is the center policy that all employees wear approved attire for the performance of their duties. Action Steps: 1. The Food Services Director insures that all staff members have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. 2. All staff will exhibit appropriate personal hygiene. 3. The Food Services Director insures all staff members wear clean approved attire including appropriate footwear (closed toe, full shoe, with non-slip sole) for safety, daily..."

No further information was presented prior to exit.

3. The facility staff failed to ensure clean dishware was free from debris by a dusty fan.

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On 4/25/17 at 9:25 a.m., an observation of the dishwasher area was conducted. At 9:45 a.m., a wall mounted fan covered in black dirt was observed blowing on clean dishes, utensils, trays, and cups as they came out of the dish machine.

On 4/25/17 at 12:58 p.m., an observation of the dishwasher area was conducted. The wall mounted fan covered in black dirt was observed blowing on clean cups that were sitting in crates underneath the fan.

On 4/26/17 at 10:40 a.m., an observation of the dishwasher area was conducted with OSM (Other Staff Member) #9, the dietary aide. OSM #9 was observed putting dishes into the dishwasher. The fan was blowing debris onto the dishes as they came out of the dishwasher.

On 4/26/17 at 10:40 a.m., an interview was conducted with OSM #9. When asked what she observed about the wall mounted fan, OSM #9 stated, "The fan is dirty." When asked why this was a problem, OSM #9 stated, "There is a 100 percent chance it is blowing on the dishes." OSM #9 stated, "I will call maintenance so they can disconnect and clean it." OSM #9 stated that maintenance was responsible for cleaning the fan.

On 4/26/17 at 11:03 a.m., an interview was conducted with OSM #10, the Dietary Manager. When asked who was responsible for cleaning the fans in the dish washer area, OSM #10 stated, "Maintenance."

On 4/27/17 at approximately 3:20 p.m., an interview was conducted with OSM #1, the Director of Maintenance. When asked who was

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responsible for cleaning the fans in the kitchen, OSM #1 stated that maintenance was responsible, but dietary staff needed to alert maintenance when the fans are dirty. OSM #1 stated, "They work in that area everyday. I am not trying to put blame on someone else but we do not go into the kitchen every day." OSM #1 stated that they cleaned the fans as needed.

On 4/26/17 at 5:00 p.m., at the end of day meeting, ASM (administrative staff member) #1, the Administrator, ASM #2 the DON (Director of Nursing) were made aware of the above concerns.

A policy could not be provided regarding the cleaning of fans in the facility kitchen.

No further information was presented prior to exit.

4. The facility staff failed to label the open date on a plastic bag of opened meatballs; and failed to label a prepare date or use by date for seven bowls of applesauce, one bowl of cottage cheese, and 5 cups of fruit that were sitting on a rack in the refrigerator.

On 4/25/17 at 6:47 a.m., inspection of the kitchen was conducted. At 6:51 a.m., the facility refrigerator was observed to contain an opened bag of meatballs in a plastic unlabeled bag. No open date or use by date could be found on the bag.

At 6:52 a.m., a rack of prepared food items were observed in the facility's refrigerator. A date could not be found on seven bowls of applesauce, one

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bowl of cottage cheese, and 5 cups of fruit.

On 4/25/17 at 6:52 p.m., an interview was conducted with OSM (other staff member) # 21, a dietary aide. When asked when the bowls of applesauce, cottage cheese and fruit cups were prepared, OSM #21 stated, "I think yesterday." When asked if he prepared the food items, OSM #21 stated, "These weren't here when I left yesterday." When asked if food items should be labeled when prepared, OSM #21 stated, "They should be."

On 4/25/17 at 7:06 a.m., OSM # 21 and OSM # 22, a dietary aide were observed with the tray of unlabeled food items from the refrigerator and a marker. When asked if they were labeling the food items, OSM #22 stated, "Yes, they should be labeled." When asked when the food items were prepared, OSM # 22 stated, "They weren't here yesterday when I left at 2 p.m., so it must of have been yesterday."

On 4/25/17 at 7:10 a.m., an observation was made of OSM # 21 and OSM # 22 discarding the unlabeled food items from the refrigerator. When asked if they were throwing away the unlabeled food items from the refrigerator, OSM #21 stated, "I thought we could label them but (Name of a cook, OSM # 11) said it should be discarded because we don't know when it was made."

On 4/25/17 at 8:10 a.m., an interview was conducted with OSM # 10, the Dietary Manager. When asked when the bag of meatballs was opened, OSM # 10 stated, "Yesterday, but it should have been labeled." OSM #10 stated that she discarded the opened bag of meatballs.

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F 371	Continued From page 256 On 4/26/17 at 5:00 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings. The facility policy titled, "Food Storage" did not address labeling of opened or prepared food. No further information was presented prior to exit.	F 371		
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to maintain the dumpster in a sanitary manner. The findings include: On 4/25/17 at 7:18 a.m., observation of the facility's dumpsters was conducted. Three gloves were observed on the ground in front of the first dumpster. The first dumpster was also observed to be half way open. A cardboard box filled with additional trash was observed behind the second (middle) dumpster. On 4/25/17 at 8:10 a.m., an interview was conducted with OSM (other staff member) #10, the dietary manager. OSM #10 stated that maintenance was responsible for ensuring the dumpsters were free from debris. On 4/25/17 at 4:24 p.m., an interview was conducted with OSM (other staff member) #1, the maintenance director. When asked who was responsible for ensuring the dumpster was closed	F 372	F372 1. On April 25, 2017 the Housekeeping Director removed the debris around the dumpster and ensured the door was closed completely. 2. On April 27, 2017, the Maintenance and Housekeeping Director re-educated staff regarding disposing of garbage and refuse properly. 3. The Housekeeping Director/ designee will randomly inspect the dumpster to ensure it's free from debris and the doors are closed properly weekly times four weeks and then monthly times two months. 4. The Housekeeping Director/ designee will report the inspection results monthly to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	6-5-17

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and free from debris, OSM #1 stated, "It's a joint effort between me, housekeeping, and dietary." OSM #1 stated that he did not check the dumpster that day but thought housekeeping was making rounds on the dumpster that morning.

On 4/26/17 at 5:00 p.m., at the end of day meeting, ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. A policy could not be provided. No further information was presented prior to exit.

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

(a) Infection prevention and control program.

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

(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

F 441

F441
1. Resident #19 is discharged.
2. The Director of Nursing educated the staff RN on the infection control program. The Wound RN/designee re-educated the licensed staff on infection control practices during wound care.
3. The Director of Nursing/Wound care RN/ designee will audit nurse competencies for wound care and the infection control log for accuracy and completion weekly times four weeks and then monthly times two months.
4. The Director of Nursing/designee will report the audits results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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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 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

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program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an infection control program, as evidenced by incomplete infection control tracking logs; and failed to maintain infection control practices during a wound care observation for one of 32 residents in the survey sample, Resident #19.

1. The facility staff failed to maintain complete Infection Control Logs. The facility staff failed to document the date, site and results of cultures obtained on the Infection Control Logs for June, July, August, September, October 2016 and January, March and April 2017.

2. For Resident #19, facility staff failed to maintain infection control practices while providing wound care to his sacral pressure ulcer [1].

The findings include:

1. The facility Infection Control Logs since the previous survey, were reviewed.

The June 2016 logs contained 48 entries for infections, resident names and dates. The column titled, "Cultures: date/site/results" was empty for all 48 entries of infections.

The July 2016 logs contained 24 entries for infections, resident names and dates. The column titled, "Cultures: date/site/results" was empty for all 24 entries of infections.

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The August 2016 logs contained seven entries for infections, resident names and dates. The column titled, "Cultures: date/site/results" was empty for all seven entries of infections.

The September 2016 logs contained 17 entries for infections, resident names and dates. The column titled, "Cultures: date/site/results" was empty for all 17 entries of infections.

The October 2016 logs contained 33 entries for infections, resident names and dates. The column titled, "Cultures: date/site/results" was empty for all 33 entries of infections.

The November and December 2016 logs were complete.

The January 2017 logs contained 30 entries for infections, resident names and dates. The column titled, "Cultures: date/site/ results was not complete for 14 of these entries, missing either date of culture, site of culture or results of culture.

The February 2017 logs were complete.

The March 2017 logs contained 13 entries for infections, resident names and dates. The column titled, "Organism Cultured" was documented only three times when there were three other opportunities for documentation.

The April 2017 logs contained 21 entries for infections, resident names and dates. The column titled, "Culture: dates/site/results" was not complete. There were no dates in this column and only three culture results. There were five other opportunities for documentation.

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An interview was conducted with RN (registered nurse) #1, the assistant director of nursing who is responsible for the infection control tracking, on 4/26/17 at 10:44 a.m. When asked how long she has been responsible for the infection control logs, RN #1 stated, "Since November (2016)." When asked why infections were tracked, RN #1 stated, "We have to make sure we are practicing good infection control and identify the spread of infections to other residents." When asked why organisms were tracked on the infection control logs, RN #1 stated, "I track for trends and cluster of infections and then do education with the staff accordingly."

The facility policy, "Infection Control" documented, "The facility will monitor and investigate the cause and spread of infection. Continuous surveillance will be provided by staff. Any infection will be reported using the Infection Report Form. Procedure: 1. Obtain Infection Report Form. 2. Complete Resident Name, Age, Sex, Unit and Room Number. 3. Document date infection was first noted and Date of Admission/Readmission if less than one month prior. 4. Document if evidence of infection was present at time of admission. 5. Document risk factors. 6. Check appropriate boxes as it applies to the resident. 7. Document if resident was hospitalized due to this infection. 8. Document if culture was done, date of culture, site and results. 9. Turn completed form in to Infection Control Nurse. 10. Infection Control Nurse will investigate all Infection Control Reports."

The administrator, director of nursing and administrative staff member (ASM) #3, the interim regional director of clinical services, were made aware of the above concern on 4/26/17 at 6:37

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p.m.

No further information was provided prior to exit.
2. The facility staff failed to maintain infection control practices while providing wound care to Resident #19's sacral pressure ulcer [1].

Resident #19 was admitted to the facility on 3/27/17 with diagnoses that included but were not limited to high blood pressure, failure to thrive, hallucinations, major depressive disorder, liver cancer, and anxiety disorder. Resident #19's most recent MDS (minimum data set) was an admission MDS with an ARD (Assessment Reference Date) of 4/3/17. Resident #19 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #19 was coded as requiring extensive assistance with one person physical assist with transfers, ambulation, dressing and limited assistance from one staff member with locomotion on and off the unit.

Review of Resident #19's most recent POS (Physician Order Sheet) revealed the following current order: "Santyl [2] Ointment 250 UNIT/GM (gram) (Collagenase) Apply to Sacrum topically every day shift for Wound Care Cleanse wound with normal saline, apply Santyl ointment and a foam dressing."

On 4/27/17 at 3:50 p.m., observation of wound care was conducted with RN (registered nurse) #6. RN #6 walked to the treatment cart, pulled out a package of gauze and saline bullets and placed them on top of the treatment cart. RN #6 then pulled out Santyl and squeezed the medication into a medicine cup and placed the

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cup on top of the treatment cart. RN #6 was not observed washing her hands prior to preparing the treatment supplies.

Next, RN #6 took her bare hands and pulled a stack of gauze out of the package and placed the gauze on top of the treatment cart. Nothing was underneath the stack of gauze. The gauze was flat touching the surface of the treatment cart. RN #6 then placed the stack of gauze in her scrub pocket and carried the saline bullets and medicine cup of Santyl with her bare hands. RN #6 walked into Resident #19's room, explained the procedure and walked out of his room. RN #6 was observed walking back to the treatment cart.

RN #6 was then observed taking the stack of gauze from the scrub pocket and placing it on top of a foam dressing package. RN #6 then gathered supplies again and walked to Resident #19's room. The supplies were placed on top of Resident #19's bedside table while his belongings were still on the table. The table was not wiped down, and a drape was not used. RN #6 was then observed placing the stack of gauze on the bedside table without a drape underneath the gauze. The gauze was flat against the bedside table.

RN #6 washed her hands, donned gloves and took the old dressing off Resident #19's sacral wound. She was not observed removing her gloves or washing her hands. She then took gauze from the top of the stack and wiped off Resident #19's wound.

Resident #19's wound was a tiny open area with slough. The area around the wound was

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reddened non-blanchable skin. RN #6 measured the wound to be 3 x 2 x 0 cm (centimeters). RN #6 measured the wound from one side of the reddened non-blanchable skin to the other side. RN #6 then changed her gloves and cleaned the wound with normal saline from the saline bullets. She was not observed to wash her hands when she changed her gloves.

RN #6 then changed her gloves and cleaned the wound with normal saline from the saline bullets. She was not observed to wash her hands when she changed her gloves.

RN #6 then took some gauze from the top of the stack and wiped the wound dry. RN #6 placed Santyl on the wound and then covered the wound with a foam dressing. RN #6 then threw away the rest of the gauze that was not used during the procedure. The last few pieces of gauze that were against the bedside table were not used during the dressing change. RN #6 was then observed to wash her hands.

On 4/27/17 at approximately 4:15 p.m., an interview was conducted with RN #6. When asked if she could identify anything that she might have done differently during the dressing change, RN #6 stated, "Well I usually use a drape underneath the supplies but I don't have a drape because central supply is locked. Or I will use a napkin." When asked if it is good practice to put gauze pads directly on the treatment cart surface or on the resident's bedside table surface, RN #6 stated, "Well I never use the bottom of the gauze and I usually place it on top of a package like I did earlier when I put the gauze on the foam package." When asked if it was ever ok to place gauze pads in a scrub pocket, RN #6 stated, "No

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that would be kind of gross. I don't ever put gauze in my pocket. I am very big about what touches the wound." When told RN #6 about the wound care observations, RN #6 stated, "That wasn't gauze. That was a piece of paper the hospice nurse handed me. I never put gauze in my pocket."

On 4/27/17 at 4:23 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the wound care nurse. When asked the process of maintaining infection control during a dressing change, LPN #1 stated that she would wash her hands before she gathered supplies, gather supplies and place them into a Ziploc bags, and use gauze that are in individual packages. LPN #1 stated that she would use the Ziploc bags as a clean surface to put her supplies on. When asked if it was ever ok to place treatment supplies directly on the resident's bedside table, LPN #1 stated, "No. It is never ok. You don't know what is on the table." When asked if it was ok for a stack of gauze to be placed on the bedside table if the nurse plans to throw away the bottom stack after a dressing change, LPN #1 stated, "Well that is not good practice at all and it is wasteful." When asked if it was ever ok to place treatment items in her scrub pocket, LPN #1 stated, "No. That is never ok. The supplies are not clean anymore. That's the reason why I place them in Ziploc bags." LPN #1 stated that she would wash her hands right before she provides the treatment. LPN #1 stated that she would also change her gloves and wash her hands after she takes the dirty dressing off the resident. LPN #1 stated, "If I am taking my gloves off, I am washing my hands."

On 4/27/17 at 4:30 p.m., ASM (administrative

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staff member) #1, the administrator was made aware of the above concerns.

The facility's policy titled, "General Rules for Dressing Changes," documents in part, the following: "Purpose: Proper cleaning and proper changing of dressing on a wound can aid healing and prevent infection. What to do: 1. Wash your hands 2. Explain procedure to the patient what you are going to do even if you do not think they can hear you. 3. Position patient so they are comfortable. 4. Estimate what dressing supplies will be needed and place on a clean work area. 5. Open the dressing materials. 6. Place protective pads under the body part where the wound is located. 7. Place garbage bag nearby for soiled dressings.

To remove old dressings: 1. Put on clean gloves (not sterile). 2. Loosen all tape... 3. Remove old dressings. One layer at a time and place in garbage bag. 4. If dressings stick to the wound, moisten with normal saline to ease removal. 5. Remove and throw away old gloves. 6. Wash your hands. To clean the wound: Open sterile supplies by peeling apart the edges and leave each dressing inside the open package. 2. Put on sterile gloves. 3. Using swabs dipped in normal saline, clean along the wound edges using small circular motions from one end of the wound to the other. 4. Clean each side of wound separately. 5. Do not scrub back and forth across wound. 6. Pat the area dry with sterile gauze. 7. Throw away cleaning materials. Dress the wound: After the wound is dry, apply dressing as instructed by the nurse or a medical provider. 2. Tape the dressing in place."

[1] A pressure ulcer is an inflammation or sore on

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the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

[2] SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

F 514 SS=D 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

(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

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(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, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure access to clinical records in a timely manner and failed to maintain a complete and accurate clinical record for three of 32 residents in the survey sample, Residents #2, and #1.

1. The facility staff failed to ensure the closed clinical records were accessible to the survey team in a timely manner.

2. The facility staff failed to date three of Resident #2's weekly skin integrity checks

3. The facility staff failed to accurately document Resident #1's behaviors on the April 2017 medication administration record (MAR).

1. Closed records request were obtained from previous company. Resident #2 records have been corrected. Resident #1 medical records were corrected.
2. The Director of Nursing/designee will re-educate licensed staff on accuracy and completeness of medical records. 6-5-17
3. The Director of Nursing/designee will audit behavior monitoring sheets and skin sheets for completion and accuracy three times a week times four weeks and then monthly times two months.
4. The Director of Nursing/designee will report the audits results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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The findings include:

1. The survey team entered the facility on 4/25/17 at 6:30 a.m. The entrance conference was conducted with the director of nursing, administrative staff member (ASM) #2 at approximately 7:30 a.m. During the entrance conference the closed records of Residents #21, #26, #27, and the last six months of Resident #31's records were requested. The facility has both electronic records and paper records. They are not completely electronic.

Residents #21 and #26's closed paper records were received 4/25/17 at approximately 11:00 a.m.

During an interview on 4/25/17 at 1:50 p.m. with ASM #1, the administrator, ASM #2, and ASM #3, the interim regional director of clinical services, items were requested for Resident #27. Originally the request was for items dated July and August 2016 but at the end of the interview that was changed to a request for items dated May to August 2016. ASM #1 stated that the whole clinical record would be provided. The following items were requested: Face sheet, diagnoses list, MARs (medication administration records) and TARs (treatment administration records), physician orders, laboratory test results and any wound cultures, physician and nurse practitioner progress notes, the MDS (minimum data set) assessments, care plan, interdisciplinary progress notes to include any SBARS (Situation Background Assessment Recommendation), Wound doctor notes and any consults.

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Access to the electronic medical records, from the previous owner's records, prior to November 2016, was given to the survey team on 4/25/17 at approximately 2:30 p.m.

At the end of the day meeting on 4/25/17 at 5:10 p.m., the closed records for Resident #27 were again requested. The administrator, ASM #1 informed the survey team that she had requested the medical records from the previous owners.

On 4/26/17 at approximately 9:00 a.m. ASM #1 informed the survey team that the closed medical records requested should be at the building at 11:00 a.m.

On 4/26/17 at 4:14 p.m. ASM #1, ASM #2 and ASM #, the interim regional director of clinical services, were informed that the lack of access to Resident #27's closed clinical record was impeding the survey process. They were informed that it had been over 24 hours since the records were requested.

On 4/26/17 at 4:58 p.m. ASM #1 presented a small file containing medical records for Resident #27. Once reviewed the file contained records dating back to 2014 through 2015. No 2016 records were presented. When asked where this file came from, ASM #1 stated, "I asked medical records to double check for any of (Resident #27)'s clinical record. This is was she presented. ASM #1 stated, "I completed the form and submitted it to the (name of person at former owners)." ASM#1 was asked to provide all emails and the times for when she contacted the previous owners for the records. ASM #1 stated, "We were told they (previous owners) would

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provide records in 24 hours after we requested them.

On 4/26/17 at 5:00 p.m. ASM #1 was asked to provide the closed clinical record for Resident #27. Specifically asked for were wound consults, physician orders and physician progress notes for the time period of Mary to August 2016.

During the end of the day meeting with ASM #1, ASM #2, ASM #3, the closed record for Resident #27 was again requested. ASM #1 stated that the whole record would be available at 9:00 a.m. on 4/27/17.

On 4/27/17 at 9:10 a.m. ASM #1 informed the survey team that they (the facility) had the record. When the survey team reviewed the record it was missing the following items: physician orders, physician progress notes, wound consults and wound tracking. ASM #1 assured the survey team that she was calling (name of former owners) to get the record.

On 4/27/17 at 9:25 a.m. ASM #1 showed this surveyor that the file was received and it documented, "Hardcopy."

On 4/27/17 at 10:05 a.m. other staff member (OSM) #5, the social worker, presented papers to the surveyor investigating Resident #27.

On 4/27/17 at 10:10 a.m. the papers just received were returned to ASM #2 as the papers presented were from 2014 and 2015. ASM #2 gave the surveyor more papers. They were again 2015.

On 4/27/17 at 10:20 a.m. ASM #2 informed this

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surveyor and the other surveyor that they had located the 2016 files and are printing them now.

On 4/27/17 at 10:42 a.m. OSM #6, payroll/human resources, presented a stack of papers that contained the 2016 MARs. At 10:58 a.m. an interview was conducted with ASM #1, ASM #2, ASM #3 and ASM#5, the owner. The requested information was again asked for. At this time ASM #5 stated that (name of former owner) had come in and picked up all the records and had taken them. This surveyor and the long term care supervisor were also present during this interview. The administrative team was informed of the concern that the survey process was being impeded due to lack of cooperation in getting the closed record requested on 4/25/17 for Resident #27.

On 4/27/17 at 11:55 a.m. ASM #1 gave another stack of papers to the surveyor. They were all nurse progress notes and the wound physician consults.

On 4/27/17 at 12:05 p.m. ASM #1 was informed since no further records had been received as requested, there would be a citation related to impeding the survey process.

During decision making on 4/28/17 at approximately 11:30 a.m. a paper was slid under the door of the conference room. The paper documented, "Physician Orders: in date order - discharge to admission (each month grouped as set); monthly physician order sheet (recaps); physician order & signature form, and telephone orders." Handwritten on this papers documented, "(Resident #27) have all these 5/1/16 to 8/31/16."

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The facility policy, "Electronic Signature for Clinical Record Documentation" documented in part, "Access to a hard copy of the clinical record is available to surveyors and others who are authorized access to clinical records by law. All state licensure and practice regulations continue to apply. If the state law is more restrictive that federal requirements, the facility will adhere to the state law."

No further information was provided prior to exit.

2. The facility staff failed to date three of Resident #2's weekly skin integrity checks.

Resident #2 was admitted to the facility on 8/30/16 and readmitted to the facility on 1/23/17. Resident #2's diagnoses included but were not limited to: multiple sclerosis, diabetes and major depressive disorder. Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/30/17, coded the resident as being cognitively intact.

Review of Resident #2's weekly skin integrity checks (not present in the resident's chart) revealed LPN (licensed practical nurse) #2 signed and failed to date three skin checks. The form documented, "Signature Date." Each weekly skin integrity check form contained six places for separate weekly skin checks to be completed.

On 4/26/17 at 3:25 p.m., an interview was conducted with LPN #2. LPN #2 stated, "I guess I forgot to date because the form doesn't say to date." LPN #2 was made aware the form documented "signature date." LPN #2 stated she must have just forgotten to date the form.

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On 4/26/17 at 4:40 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the wound care nurse). LPN #1 confirmed weekly skin checks should be dated. When asked if the weekly skin checks were a part of the clinical record, LPN #1 stated she would have to refer that question to the director of nursing but could find out.

On 4/26/17 at 4:52 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the weekly skin integrity checks were contained in a separate book on the unit because the form allowed spaces for multiple weeks' worth of checks. ASM #2 stated nurses were supposed to date the form when they completed a skin check and the form becomes a part of the clinical record when it becomes full.

On 4/26/17 at 6:35 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2, and ASM #3 (the regional director of clinical services) were made aware of the above findings.

The facility weekly skin assessment policy documented, "2. The evaluating nurse must date and sign each assessment..."

No further information was presented prior to exit.

3. The facility staff failed to accurately document Resident #1's behaviors on the April 2017 medication administration record (MAR).

Resident #1 was admitted to the facility on 10/22/16 with diagnoses that included:

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Parkinson's disease (1), movement disorder, difficulty swallowing, dementia and urinary retention.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/18/17 coded the resident as having scored an 11 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance for all activities of daily living.

Review of the resident's care plan initiated on 10/24/16 did not evidence documentation regarding documenting behaviors.

Review of the physician's orders dated April 2017 documented, "Monitor for BEHAVIORS r/t (related to) psychotropic medications: there must be a nursing note for all behaviors with documentation for non-pharmacological interventions, medications administered and follow up...Order date 10/23/17."

Review of the April 2017 MAR documented, "Monitor for BEHAVIORS r/t (related to) psychotropic medications: there must be a nursing note for all behaviors with documentation for non-pharmacological interventions, medications administered and follow up...Order date 10/23/17." In the left hand column there was a "Y/N (yes or no)" On the following dates Resident #1's behaviors were documented with a "Y":
4/2/17 on the 7:00 a.m. to 3:00 p.m. shift;
4/3/17 on the 11:00 p.m. to 7:00 a.m. shift;
4/4/17 on the 11:00 p.m. to 7:00 a.m. shift;
4/6/17 on the 11:00 p.m. to 7:00 a.m. shift;

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4/8/17 on the 11:00 p.m. to 7:00 a.m. shift;
4/9/17 on the 7:00 a.m. to 3:00 p.m. shift and the 11:00 to 7:00 p.m. shift;
4/11/17 on the 11:00 p.m. to 7:00 a.m. shift;
4/13/17 on the 11:00 p.m. to 7:00 a.m. shift;
4/18/17 on the 11:00 p.m. to 7:00 a.m. shift and
4/24/17 on the 3:00 p.m. to 11:00 p.m. shift.

Review of the nurse's notes for those dates did not evidence documentation regarding the resident's behaviors.

An interview was conducted on 4/25/17 at 1:05 p.m. with LPN (licensed practical nurse) #18, the nurse who documented a "Y" on the resident's behavior flow sheet eight out of 11 times. When asked what the "Y" means on the behavior MAR, LPN #18, stated, "On the MAR it pops up yes or no. for me I don't put in no because it means I'm not monitoring (the behavior). When I check yes it means I'm monitoring the behavior and if there is a behavior I would write a note." When asked if she had observed Resident #1 having any behaviors, LPN #18 stated, "No." If I'm doing it wrong I need someone to orient me, I'm pretty new here."

An interview was conducted on 4/26/17 at 1:15 p.m. with LPN #4, the resident's nurse. When asked what the "Y" on the behavior flow sheet meant, LPN #14 stated, "It means yes they have behaviors." When asked if Resident #1 ever had behaviors, LPN #14 stated, "No." When asked what staff did if there were behaviors being displayed, LPN #4 stated, "We would have to document it."

On 4/26/17 at 6:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 277 director of nursing were made aware of the findings. No further information was provided prior to exit.	F 514		

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING _____ B. WING _____	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 4/25/17 through 4/28/17. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 177 certified bed facility was 111 at the time of the survey. The survey sample consisted of 24 current Resident reviews (Residents # 1 through # 20, #28 through #30 and #32) and eight closed record reviews (Residents # 21 through #27 and #31).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12VAC5-371-110. Management and administration
Cross reference to F167, F226

12VAC5-371-140. Policies and procedures
Cross reference to F153, F165, F226, F240, F244, F250, F252, F279, F280, F281, F282, F309, F311, F312, F314, F328, F329, F360, F364, F371, F372, F441, F514

12VAC5-371-150. Resident rights
Cross reference to F153, F165, F240, F250

12VAC5-371-180. Infection control
Cross reference to F328, F371, F372, F441

12VAC5-371-200. Director of nursing
Cross reference to F281

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tanya Rocquemore NHA — TITLE: Administrator — (X6) DATE: 5/25/17