DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	R-C 09/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204

(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 revisit to the standard survey conducted 08/04/2015 through 08/06/2015, was conducted 09/09/2015 through 09/10/2015. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. One complaint was investigated during the survey. The census in this 161 bed facility was 126 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Resident #101 - 114).	{F 000}	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.	
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to provide physician ordered treatment for pressure ulcers for one of 14 residents, Resident #109.	{F 314}	**F 314 Treatment/Services to Prevent/ heal pressure sores.** **The facility will continue to provide treatments and services to prevent or heal pressure sores.** 1. Resident #109 wound was evaluated by the physician and wound team, and the treatments were completed. MD and RP were notified. 2. Treatment administration records of current residents were reviewed to ensure that treatments were completed as ordered. Skin sweeps were completed on current residents. Prevention interventions were reviewed for residents with pressure ulcers and those at high risk. 3. Nurses received education regarding the completion of treatments as ordered by the physician. The Administrative Director of Nursing Services or designee will complete random weekly audits of residents with pressure ulcers to ensure compliance with treatment administration, documentation, and prevention, for the next 90 days.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jane M. Armitage	NHA	9/24/15

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

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{F 314}	Continued From page 1 Treatments for pressure ulcers that were ordered every three days were not completed on 09/04/2015 or 09/08/2015. Findings were: Resident #109 was originally admitted to the facility on 08/27/2015. His diagnoses included but were not limited to: Right hip fracture, adult failure to thrive, muscle weakness and cognitive communication deficit. Due to his recent admission there was no MDS (minimum data set) information available. During entrance conference with the DON (director of nursing) and the administrator, a list of all residents with current pressure ulcer areas and the date of the next scheduled dressing change was requested. Resident #109 was on the list with the next dressing change scheduled for 09/12/2015. Resident #109's clinical record was reviewed beginning on 09/09/2015 at approximately 2:00 p.m. Observed on the physician order sheet for the month of September were the following orders for wound/pressure ulcer care: "Coccyx wound every day shift every three days for wound healing clean with cleansing lotion, skin prep and apply tegaderm hydrocolloid; Left posterior thigh every day shift every three days for wound healing clean with cleanser, skin prep and apply Duoderm until resolved; Mid back wound every day shift every three days for wound healing clean with wound cleanser, pat dry, skin prep, and apply tegaderm hydrocolloid; right hip surgical wound every day shift every other day for wound healing clean with wound cleanser, skin	{F 314}	4. Identified concerns will be submitted to the facility Quality Assurance committee. Recommendations for further corrective action will be discussed and implemented as needed. 5. October 8, 2015	

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{F 314}	Continued From page 2	{F 314}		

prep to periwound, apply Melgisorb to wound bed and covered (sic) with bordered gauze."

The progress note section was then reviewed. A note dated 09/01/2015 contained the following: "Wound team follow up today...SDTI (suspected deep tissue injury to mid spine measures 6 cm (centimeters) X 1 cm, scattered granulation and epithelial tissue with scant serous drainage, periwound intact with non-blanchable redness present...Coccyx measures 8 cm X 8 cm non blanchable redness SDTI stage 1...left posterior thigh measures 3 cm X 2 cm 100% epithelial tissue present..." An additional note on 09/04/2015 contained the following: "Correction to the wound team note: the mid spine wound is a healing stage 3 pressure ulcer not a SDTI and the coccyx wound is a Stage 1 pressure ulcer not an SDTI."

On 09/04/2015 the nurse's notes contained the following entries: "16:37 Coccyx every day shift every 3 days for wound healing clean with cleansing lotion, skin prep and apply tegaderm hydrocolloid nurse manager will do tx (treatment); 16:37 Mid Back every day shift every three days for wound healing clean with wound cleanser, pat dry, skin prep, and apply tegaderm hydrocolloid. nurse manager will do tx. 16:37 Left posterior thigh every day shift every three days for wound healing clean with cleanser, skin prep and apply Duoderm until resolved. Nurse manager will do tx. 16:38 Right hip surgical wound every day shift every other day for wound healing clean with wound cleanser, skin prep to periwound, apply Melgisorb to wound bed and covered (sic) with bordered gauze. Nurse manager will do tx."

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{F 314}	Continued From page 3 On 09/08/2015 the following notes were observed: "16:34 Coccyx every day shift every 3 days for wound healing clean with cleansing lotion, skin prep and apply tegaderm hydrocolloid. Will be done by wound team; 16:35 Mid Back every day shift every three days for wound healing clean with wound cleanser, pat dry, skin prep, and apply tegaderm hydrocolloid. Will be done by wound team.; 16:42 Right hip surgical wound every day shift every other day for wound healing clean with wound cleanser, skin prep to periwound, apply Melgisorb to wound bed and covered (sic) with bordered gauze. Will be done by wound team." There was no documentation regarding the Left Posterior thigh wound. The TAR (treatment administration record) was reviewed. Each wound treatment for 09/04/2015 was marked with a nurse's initials and the number "9", indicating "other/See Nurse's Notes" for information. The physician ordered treatments were completed on 09/05/2015 per the TAR. The were no notes in the clinical record to indicate why the nurse manager had not done the treatments on 09/04 or orders to change the treatment to 09/05/2015. The TAR also indicated with a nurse's initials and the number 9 that the left posterior thigh wound care had not been done on 09/04/2015 as ordered. The wound care to the left posterior thigh, every day shift every three days for wound healing clean with cleanser, skin prep and apply Duodern until resolved, was not done until 09/07/2015. There was no documentation in the progress notes to indicate why the wound care was not done on 09/04/2015 as scheduled and ordered or if the doctor had ordered the change to 09/07/2015.	{F 314}		

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{F 314}	Continued From page 4	{F 314}		

Also on the TAR for 09/08/2015 the entries for the coccyx wound dressing, the mid back wound dressing and the surgical wound dressing were all marked with a nurse's initials and the number "9", again indicating "other/See Nurse's notes" for information.

On 09/10/2015 at approximately 8:15 a.m., the DON came to the conference room to speak with this surveyor regarding Resident #109. She presented documentation titled, "Quality Assurance and Performance Improvement Committee." She stated, "We missed the dressing changes scheduled on 09/08/2015. The nurse documented that the wound team would do them, but the wound team did not do them until yesterday (09/09/2015). We notified the physician and the RP (responsible party...we did a 100% audit of everyone getting wound care to make sure the other dressings were done...

The unit manager, LPN (licensed practical nurse) #1 was interviewed on 09/09/2015 at approximately 8:30 a.m., regarding the wound care that was documented in the nurse's notes as being done by the unit manager on 09/04/2015. He was asked if he had done the dressing changes on that date. He stated, "No, I did the dressings on 09/01/2015...No one told me that I needed to do them on 09/04/2015."

This surveyor attempted to contact the nurse who had done the dressing changes on 09/05/2015 to ascertain why the dressings were done on that day instead of the scheduled day of 09/04/2015 and to determine if an order had been obtained from the physician to change the dressing schedule or to let the physician know that the

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{F 314}	Continued From page 5 dressings were not done on 09/04/2015 as ordered. There was no answer to the surveyors call. No further information was obtained prior to the exit conference on 09/10/2015. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to maintain a complete and accurate clinical record for one of 14 residents, Resident #109. Throughout Resident #109's clinical record the facility staff documented that the resident was on contact isolation, Resident #109 was not on isolation. Findings were:	F 514 SS=D		
{F 314}	**F 514 Records-Complete/Accurate/Accessible** **The facility will continue to maintain clinical records on each resident in accordance with accepted professional standards and practices.** 1. Resident # 109 medical record was reviewed by his physician and the need for contact isolation was clarified as not clinically indicated. 2. Charts were reviewed of those residents admitted after 8/26/15 to identify any clinical documentation for isolation precautions 3. Nursing received education regarding the need to obtain a physician order for isolation precautions if clinically indicated as well as accurate documentation in progress notes regarding the isolation precautions. The Administrative Director of Nursing Services or designee will complete random weekly audits of progress notes for 90 days to ensure that documentation is accurate as it pertains to isolation precautions. 4. Identified concerns will be submitted to the facility Quality Assurance committee. Recommendations for further corrective	F 514		

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F 514	Continued From page 6	F 514		

Resident #109 was originally admitted to the facility on 08/27/2015. His diagnoses included but were not limited to: Right hip fracture, adult failure to thrive, muscle weakness and cognitive communication deficit.

Due to his recent admission there was no MDS (minimum data set) information available.

On 09/09/2015 at approximately 12:45 p.m., initial tour of the facility was completed. Resident #109 was not observed to be on isolation during the tour.

Review of the progress note section of the clinical record showed continued documentation from 08/29/2015 through 09/08/2015 that Resident #109 was on contact precautions. A note dated 09/08/2015 contained the following information: "...contact isolation for MRSA (methicillin resistant staphylococcus areus) in nares..."

The physician order sheet nor the list of diagnoses in the clinical record included orders for Resident #109 to be on isolation or that he was positive for MRSA in his nares.

On 09/10/2015 at approximately 8:45 a.m., LPN (licensed practical nurse) #1 was interviewed regarding Resident #109. LPN #1 was asked if Resident #109 was positive for MRSA and if he was ordered to be on isolation. He stated, "No, he is not on isolation."

The DON (director of nursing) and the administrator were notified of the above information during a meeting on 09/10/2015 at approximately 9:45 a.m.

action will be discussed and implemented as needed.

5. October 8, 2015

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F 514	Continued From page 7 No further information was obtained prior to the exit conference on 09/10/2015.	F 514		