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	495102	A. BUILDING _____ B. WING _____	C 08/06/2015

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MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD **REVISED** ARLINGTON, VA 22204

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 08/04/15 through 08/06/15. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Five complaints were investigated during this survey. The Life Safety Code survey/report will follow.

The census in this 161 certified bed facility was 130 at the time of the survey. The survey sample consisted of 23 current resident reviews (Residents #1 through 21 and Residents # 26 through 27) and 4 closed record reviews (Resident's #22 through 25).

F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221	

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure one of 27 residents in the survey sample was free from physical restraints, Resident # 17.

Past noncompliance: no plan of correction required.

The facility staff held Resident # 17's hands, physically restraining the resident during incontinence care, which resulted in bruising and skin tears to the resident's arms and hands.

Findings include:

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

Jane Rumidaye | Administrator | 8/28/15

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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Resident # 17 was admitted to the facility on 11/18/12. Diagnoses for Resident # 17 included, but were not limited to: Alzheimer's disease, PVD (peripheral vascular disease), HTN (high blood pressure), depression, and muscle weakness.

The most current MDS assessment was a quarterly assessment dated 05/19/15. This MDS assessed the resident with a cognitive score of "7" indicating the resident had severe impairment in daily decision making skills. This MDS also assessed the resident as requiring extensive assistance with toileting with at least one person physical assist. Additionally this MDS assessed the resident as 'not' having behavior symptoms and as 'not' resisting care.

The most current full MDS (minimum data set) with CAAS (care area assessment summary) was reviewed for comparison, dated 11/16/14. This MDS assessed the resident with a cognitive score of "4", again indicating the resident had severe impairment in daily decision making skills and as requiring extensive assistance from staff for toileting with at least one person physical assist. Additionally, the resident was assessed as 'not having behavior symptoms and as 'not' resisting care. The resident triggered in the CAAS area of this MDS for: cognition, communication, mood and urinary.

A review of a FRI (facility reported incident) alleged that on 06/06/15, Resident # 17 sustained three skin tears with bruising to the right wrist during incontinence care by two CNA (certified nursing assistants), CNA # 3 and CNA # 4.

During clinical record review on 08/05/15 and

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08/06/15 nursing notes were reviewed for Resident # 17.

A nursing note dated 06/06/15 and timed 8:32 a.m., documented: "Resident is alert and verbally responsive resident sustained skin tear on right arm, during incontinence care trying to scratch the CNA (certified nursing assistant), patent (sic) was very combative, kicking and scratching the CNA, refused for the writer to give skin care, slap (sic) the writer on the face, also refused the supervisor, son was put on the phone the patent (sic) refused to talk to him, MD (medical doctor) notified new order to apply triple antibiotic ointment and cover with gauze..."

A nursing note dated 06/06/15 and timed 11:32 p.m., documented: "...Pt (patient) has bruises on her Rt (right) arm due to pt kicking and resisting care this morning. Area is red but not bleeding noted (sic)...Investigation done to find out cause. Family requested incident report written by the nurse on duty that time but it was not granted..."

A nursing note dated 06/06/16 and timed 11:48 p.m. documented: "Head to toe assessment was completed, on assessment patient is noted with right lower arm skin tears, with bruising surrounding the skin tears that measures 14cm (centimeters) X (by) 4.5cm. Left lower arm and hand is noted with discoloration in several areas of the arm. First area measures 3cm X 2.5cm closed discolored area that is purplish in color that is on the left outer aspect of the arm. Second area measures 2cmX 2cmX closed that is red/purplish discoloration that is on the back of the left hand between the thumb and index finger. Third area measures 1cm X 0.5cm that is red/purplish...closed..."

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F 221	Continued From page 3	F 221		

A nursing noted dated 06/06/15 and timed 11:48 p.m. documented: "...skin tears that was sustained during ADL (activities of daily living) care...3 skin tears to the right arm...1.5 cm X 2 cm...1cm X 2cmX...0.3 cm X 1.2 cm..."

A nursing note dated 06/07/15 and timed 4:35 p.m., documented: "...Resident very combative refused ADL's during this shift...X-ray of right wrist...pending result..."

Resident'# 17's current CCP (comprehensive care plan) was then reviewed and documented the following: "...Assist with daily hygiene, grooming, dressing...break ADL tasks into sub-task for easier patient performance...Allow for flexibility in ADL routine to accommodate mood, preferences, and customary routine...Elicit family input for best approaches; ask physician to explain/reinforce need for treatment...If resident refuses contact son to speak with resident and explain care in Spanish...if resists care, leave (if safe to do so) and return later...Do not invade personal space...Elicit family input for best approaches...Talk with in a low pitch, calm voice to decrease/eliminate undesired behavior...Allow adequate time to respond. Do not rush or supply words...Approach/speak in calm, positive /reassuring manner...Explain each activity/care procedure prior to beginning it...Gain individual's attention before beginning...Provide assistance as needed...provide incontinence care as needed...psych consult as needed..."

On 08/06/15 at approximately 8:00 a.m., the assistant administrator was asked for the investigation, abuse policy, along with the x-ray reports and any psych consults regarding

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Resident # 17.

The investigation summary was presented and reviewed. The investigation was completed by the DON (director of nursing) on 06/12/15. The investigation summary documented: "On 06/06/15 at approximately 5:30 a.m. (Resident # 17) sustained 3 self inflicted skin tears to her right arm during care (incontinence). The two staff members held the patients hands while attempting to perform incontinence care...CNA # 3 attempted to provide incontinence care and Resident # 17 refused...CNA # 3 and CNA # 4 went to provide incontinence care for Resident # 17...Resident # 17 was yelling in another language, kicked her feet and attempted to scratch and bite CNA # 3, CNA # 4 tried to explain that they were trying to clean her...Resident # 17 continued to yell, kick and tried to scratch CNA # 3, CNA # 3 was holding her hands so that she could not hit them while CNA # 4 was changing her...Conclusion: Based on the investigation including resident (other residents in the facility) and staff interviews it was determined that abuse did not occur. The staff members used their best judgement in providing care for the resident and the self inflicted skin tears were accidental and the staff reacted to the resident's resistance to care. Their actions were not to intentionally cause harm."

Employee statements documented the following:

CNA # 3 (06/06/15) (via telephone)- "I went into the room at 4 am to change her. She did not let me...she was sitting in the chair and the bed was wet with urine and stool, so I changed the bed linens while she was in the chair...she had stool all over herself. I grabbed her depend and

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showed it to her and said let me change you. She grabbed the depend out of my hand and placed it under her arm and got back into the bed...covered herself up with the coat. When I kept asking her to let me change you she kept saying no, ...told the nurse...nurse on duty told me to go get the other CNA (CNA # 4) to help me...around 5 am we both entered the room...asked her to let us change her and she kept saying no...While I was in the room with CNA # 4 she told me to watch her lead, so CNA # 4 took a new depend and showed it to her and said your wet we are going to change you. So CNA # 4 started to get the wet clothes off of her and she started to kick, hit, and scratch. I was holding her hands so she could not hit us. So when I was holding her hand she went to scratch me on my hand that's when I moved...and she scratch (sic) herself...CNA # 4 and I kept cleaning her when we got the clothes and depends off her she had dried stool all over her buttocks and down to her legs...saturated with urine and stool, we gave her a bed bath and wiped her real good to clean her up...got her dressed and cleaned. When we were done she grabbed her walker and threw it at us and the shoes hit the bathroom door...I went to the nurse to tell her that the resident had a skin tear from changing her...."

CNA # 4 (06/08/15)- "...I was not assigned to take care of Resident # 17...at approximately 5 a.m....I was asked by CNA # 3 to assist her with incontinence care for Resident # 17...CNA # 3 was already in the room when I came to assist her. Resident # 17 was yelling words I could not understand. I tried to explain to her that we needed to clean her. She was covered in bowel movement and was really dirty and needed to be changed. Resident # 17 continued to yell out and

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kicked her feet and was trying to scratch CNA # 3 and bite her hands...she continued to yell, kick and try to scratch...actually scratched herself. So CNA # 3 held her hands and I wiped her...when we were done changing her we say that her right hand was bleeding..."

The x-ray report for Resident # 17 was reviewed and documented negative for fracture or dislocation.

The psych consults were reviewed and revealed the following:

02/18/15 "Geriatric Psychiatry Progress Note: ...aggression, psychosis...combative with care, refusals, stable on exam...staff note that agitation is variable, episodic she was just started on remeron...states she is content, mood good...met with staff to discuss strategies for staff to manage agitation, ways to redirect and distract..."

The facility's abuse policy documented: "...it is important to be familiar...definitions of abuse, neglect...Abuse can occur in many forms and to varying degrees...physical abuse includes hitting, slapping, pinching, and kicking...employees are educated upon hire and annually on abuse prevention..."

The administrator, DON (director of nursing), and the assistant administrator were informed of concerns regarding Resident # 17 being physically restrained during incontinence care and sustaining multiple skin tears and bruising, in a meeting with the survey team on 08/06/15 at approximately 10:00 a.m.

The DON voiced that the staff used their best

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judgement. The DON was informed about the resident's CCP and that this was an identified issue with this resident and the CCP was not followed, the staff members did not leave the resident alone and did not attempt to contact the resident's family for any guidance prior to the resident being restrained, and as a result the resident incurred physical injury from being physically held down by the staff members. The DON was asked what are/were the 'strategies', documented in the psych consult. The DON voiced, it was pertaining to what was in the resident's CCP.

The DON further voiced that staff reacted based on the resident attempting to hit the staff. The DON was informed that according to the statements of the staff members, the resident repeatedly told the staff members no, prior to any physical resistance from the resident and the staff members continued, provoking the resident to the point of physical resistance. Again, the DON was informed that according to the evidence the facility staff did not follow the resident's CCP for care resistance for Resident # 17, and as result the resident incurred physical injury.

The facility submitted evidence for past non-compliance.

The facility ' s plan of correction was as follows:

1. The physician and responsible party were notified. Orders were obtained for the patient ' s skin tears and the treatment was administered. A head to toe skin assessment was completed as well as a pain evaluation and Braden Skin Risk assessment. The physician ordered lab work (UA/C&S), wrist x-ray, and a psyche consult. A

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Behavioral Evaluation was completed. The care plan was updated, and the involved employees were educated prior to returning from suspension, on Resident Rights related to restraints, right to refuse care, and behavioral interventions.

2. Residents resistive during care and /or with combative behaviors have the potential to be affected. An audit was completed to identify patients with known behavioral symptoms. The care plans were reviewed to ensure that appropriate care strategies were care planned to address behavioral episodes.

3. Staff education was completed on Resident Rights related to restraints, right to refuse care, and behavioral interventions. The ADNS and/or designee will complete random weekly audits for three months on patients with identified behaviors to ensure that appropriate care strategies are identified in the plan of care. Compliance with the facility Behavioral guidelines/systems is monitored through the daily QAA process.

4. Identified concerns will be reviewed by the facility ' s QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.

5. Corrective action was completed 7-6-15.

No further information or documentation was provided or presented prior to the exit conference, to evidence that Resident # 17 was not physically restrained by staff during incontinence care or that the resident's comprehensive plan of care was followed

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F 221	Continued From page 9 regarding the above issues and concerns.	F 221		
F 224 SS=D	Past Non- compliance 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure one of 27 residents in the survey sample was free from mistreatment, Resident # 17. The facility staff physically restrained Resident # 17's hands during incontinence care, which resulted in multiple bruises and skin tears to the resident's arms and hands. Findings include: Resident # 17 was admitted to the facility on 11/18/12. Diagnoses for Resident # 17 included, but were not limited to: Alzheimer's disease, PVD (peripheral vascular disease), HTN (high blood pressure), depression, and muscle weakness. The most current MDS assessment was a	F 224	Past noncompliance: no plan of correction required.	

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quarterly assessment dated 05/19/15. This MDS assessed the resident with a cognitive score of "7" indicating the resident was severe impairment in daily decision making skills. This MDS also assessed the resident as requiring extensive assistance with toileting with at least one person physical assist. Additionally this MDS assessed the resident as 'not' having behavior symptoms and as 'not' resisting care.

The most current full MDS (minimum data set) with CAAS (care area assessment summary) was reviewed for comparison, dated 11/16/14. This MDS assessed the resident with a cognitive score of "4", indicating the resident had severe impairment in daily decision making skills and as requiring extensive assistance from staff for toileting with at least one person physical assist. Additionally, the resident was assessed as 'not having behavior symptoms and as 'not' resisting care. The resident triggered in the CAAS area for: cognition, communication, mood and urinary.

A review of a FRI (facility reported incident) alleged that on 06/06/15, Resident # 17 sustained three skin tears with bruising to the right wrist during incontinence care by two CNA (certified nursing assistants), CNA # 3 and CNA # 4.

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wrist...pending result..."

Resident # 17's current CCP (comprehensive care plan) was then reviewed and documented the following: "...Assist with daily hygiene, grooming, dressing...break ADL tasks into sub-task for easier patient performance...Allow for flexibility in ADL routine to accommodate mood, preferences, and customary routine...Elicit family input for best approaches; ask physician to explain/reinforce need for treatment...If resident refuses contact son to speak with resident and explain care in Spanish...if resists care, leave (if safe to do so) and return later...Do not invade personal space...Elicit family input for best approaches...Talk with in a low pitch, calm voice to decrease/eliminate undesired behavior...Allow adequate time to respond. Do not rush or supply words...Approach/speak in calm, positive /reassuring manner...Explain each activity/care procedure prior to beginning it...Gain individual's attention before beginning...Provide assistance as needed...provide incontinence care as needed...psych consult as needed..."

On 08/06/15 at approximately 8:00 a.m., the assistant administrator was asked for the investigation, abuse policy, along with the x-ray reports and any psych consults regarding Resident # 17.

The investigation summary was presented and reviewed. The investigation was completed by the DON (director of nursing) on 06/12/15. The investigation summary documented: "On 06/06/15 at approximately 5:30 a.m. (Resident # 17) sustained 3 self inflicted skin tears to her right arm during care (incontinence). The two staff members held the patients hands while

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attempting to perform incontinence care...CNA # 3 attempted to provide incontinence care and Resident # 17 refused...CNA # 3 and CNA # 4 went to provide incontinence care for Resident # 17...Resident # 17 was yelling in another language, kicked her feet and attempted to scratch and bite CNA # 3, CNA # 4 tried to explain that they were trying to clean her...Resident # 17 continued to yell, kick and tried to scratch CNA # 3, CNA # 3 was holding her hands so that she could not hit them while CNA # 4 was changing her...Conclusion: Based on the investigation including resident and staff interviews it was determined that abuse did not occur. The staff members used their best judgement in providing care for the resident and the self inflicted skin tears were accidental and the staff reacted to the resident's resistance to care. Their actions were not to intentionally cause harm."

Employee statements documented the following:

CNA # 3 (06/06/15) (via telephone)- "I went into the room at 4 am to change her. She did not let me...she was sitting in the chair and the bed was wet with urine and stool, so I changed the bed linens while she was in the chair...she had stool all over herself. I grabbed her depend and showed it to her and said let me change you. She grabbed the depend out of my hand and placed it under arm and got back into the bed...covered herself up with the coat. When I kept asking her to let me change you she kept saying no, ...told the nurse...nurse on duty told me to go get the other CNA (CNA # 4) to help me...around 5 am we both entered the room...asked her to let us change her and she kept saying no...While I was in the room with CNA

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4 she told me to watch her lead, so CNA # 4 took a new depend and showed it to her and said your wet we are going to change you. So CNA # 4 started to get the wet clothes off of her and she started to kick, hit, and scratch. I was holding her hands so she could not hit us. So when I was holding her hand she went to scratch me on my hand that's when I moved...and she scratch herself...CNA # 4 and I kept cleaning her when we got the clothes and depends off her she had dried stool all over her buttocks and down to her legs...saturated with urine and stool, we gave her a bed bath and wiped her real good to clean her up...got her dressed and cleaned. When we were done she grabbed her walker and threw it at us and the shoes hit the bathroom door...I went to the nurse to tell her that the resident had a skin tear from changing her...."

CNA # 4 (06/08/15)- "...I was not assigned to take care of Resident # 17...at approximately 5 a.m....I was asked by CNA # 3 to assist her with incontinence care for Resident # 17...CNA # 3 was already in the room when I came to assist her. Resident # 17 was yelling words I could not understand. I tried to explain to her that we needed to clean her. She was covered in bowel movement and was really dirty and needed to be changed. Resident # 17 continued to yell out and kicked her feet and was trying to scratch CNA # 3 and bite her hands...she continued to yell, kick and try to scratch...actually scratched herself. So CNA # 3 held her hands and I wiped her...when we were done changing her we say that her right hand was bleeding..."

The x-ray report for Resident # 17 was reviewed and documented negative for fracture or dislocation.

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The psych consults were reviewed and revealed the following:

02/18/15 "Geriatric Psychiatry Progress Note: ...aggression, psychosis...combative with care, refusals, stable on exam...staff note that agitation is variable, episodic she was just started on remeron...states she is content, mood good...met with staff to discuss strategies for staff to manage agitation, ways to redirect and distract..."

The facility's abuse policy documented: "...it is important to be familiar...definitions of abuse, neglect...Abuse can occur in many forms and to varying degrees...physical abuse includes hitting, slapping, pinching, and kicking...employees are educated upon hire and annually on abuse prevention..."

The administrator, DON (director of nursing), and the assistant administrator were informed of concerns regarding Resident # 17 being physically restrained during incontinence care and sustaining multiple skin tears and bruising, in a meeting with the survey team on 08/06/15 at approximately 10:00 a.m.

The DON voiced that the staff used their best judgement and that the resident was not intentionally hurt. The DON was informed about the resident's CCP addressing an already identified issue (2012) with this resident regarding combativeness and resistance to care at times. The DON was also made aware that the CCP was not followed, the staff members did not leave the resident alone and did not attempt to contact the resident's family for any guidance prior to physically restraining the resident and as a result

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the resident incurred physical injury by the staff members. The DON was asked what should the staff members have done. The DON voiced, they should have followed the care plan.

The DON further voiced that staff reacted based on the resident attempting to hit the staff. The DON was informed that according to the statements of the staff members, the resident repeatedly told the staff members "No", prior to any physical resistance from the resident and the staff members continued for their convenience or task completion, which provoked the resident to physically resist. The DON and administrator were made aware that the word, "no" means "no" and obviously, that was a word that both the resident and staff members know and understand, but refused to listen to the resident. The DON was informed that if staff had not continued and followed the resident's CCP (as documented) after the resident told them "No" repeatedly, that the resident may have not incurred injury.

The facility submitted evidence for past non-compliance.

The facility ' s plan of correction was as follows:

1. The physician and responsible party were notified. Orders were obtained for the patient ' s skin tears and the treatment was administered. A head to toe skin assessment was completed as well as a pain evaluation and Braden Skin Risk assessment. The physician ordered lab work (UA/C&S), wrist x-ray, and a psyche consult. A Behavioral Evaluation was completed. The care plan was updated, and the involved employees were educated prior to returning from

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F 224	Continued From page 17 suspension, on Abuse Policy. 2. All residents have the potential to be affected. Head to toe body audits on residents in the involved employees assignments and resident interviews. 3. Staff education was completed on the facility Abuse policy . The ADNS and/or designee will complete random weekly audits for three months on like patients to ensure that appropriate care strategies are identified in the plan of care. 4. Identified concerns will be reviewed by the facility ' s QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. 5. Corrective action was completed 7-6-15 No further information or documentation was provided or presented prior to the exit conference, to evidence that Resident # 17 was not abused, as a result of being physically restrained by staff during incontinence care after the resident repeatedly told the staff members, "No." The resident's comprehensive plan of care was not followed regarding the above issues and concerns.	F 224		
F 279 SS=D	Past non-compliance 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	Continued From page 18 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a Comprehensive Care Plan (CCP) for one of 27 residents in the survey sample: Resident's #9 . Resident #9 did not have a care plan to address pressure ulcers or incontinence. Findings include: Resident #9 was admitted to the facility 12/15/11 with readmission on 6/9/15 with diagnoses including but not limited to: Glaucoma, muscle weakness, dementia, chronic obstructive pulmonary disease, and hypertension. The most recent MDS (minimum data set) was a	F 279	**F 279 Develop Comprehensive Care Plans** **The facility will continue to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.** 1. Resident # 9 the Care Area Summary Sheet was reviewed to ensure that all areas that were triggered and coded to proceed to care plan did in fact have a care plan developed. 2. Comprehensive MDS assessments of current residents were reviewed to ensure that Care Areas that were triggered to care plan had a care plan in place. Care plans were initiated as appropriate. 3. The Interdisciplinary Team received education by the ADNS or designee regarding the necessity of ensuring that a care plan is developed based on the assessment and Care Areas that are triggered to proceed to care plan. The MDS coordinator and/or designee will complete random weekly audits of Care Area Assessment Summaries to ensure that all areas coded to proceed to care plan are addressed in the plan of care, for 90 days. 4. Identified concerns will be reviewed by the facility's QAA Committee.	

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quarterly assessment dated 6/2/15. Resident #9 was assessed as being cognitively intact with a score of 15 of 15.

The electronic medical record was reviewed on 8/5/15 and revealed a full MDS dated 2/8/15 with care area assessment section "V" (CAA's). In the care area's of "pressure ulcers and incontinence", column "A Care Area Triggered" was checked. Under column "B Addressed in Care Plan" was also checked, indicating a care plan was put in place for Resident #9.

Review of Resident #9's care plan did not show evidence that a care plan was created in the above area's.

The above information was brought to the attention of the MDS coordinator (registered nurse, RN #2) on 8/5/15 at 10:45 a.m. At this time RN #2 also reviewed the MDS care area's triggers and the care plan and verbalized that the two area's in question should have a care plan due to assessments evidencing incontinence "leakage" that could cause skin break down.

On 8/5/15 at 3:10 p.m. RN #2 approached this surveyor and verbalized after investigating the care plans in question, the care plans were canceled when Resident #9 was discharged to the hospital and did not get added to the care plan, as they should have been, when Resident #9 was re-admitted to the facility.

The above finding was brought to the attention of the administrator and director of nursing on 8/5/15 at 4:30 p.m. No further information was presented prior to the exit conference 8/6/15.

Recommendations for further corrective action will be discussed and implemented as needed.

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F 281 SS=D	Continued From page 20 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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, the facility staff failed follow professional standards of nursing by using an improper CPR (cardiopulmonary resuscitation) technique for 1 of 27 residents in the survey sample (Resident #24). LPN #4 failed to properly position her hands upon Resident #24 ' s chest. LPN # 4 performed CPR with her hands over the xyphoid process (the cartilaginous section at the lower end of the sternum) instead of the middle of sternum. By placing her hands over the xyphoid process, LPN #4 caused the compressions to be ineffective. Findings included: Resident #24 was admitted to the facility on 07/17/2015 with diagnoses including, but not limited to: Right below knee amputation, wound infection, peripheral vascular disease and diabetes mellitus. No MDS (minimum data set) had been completed for this resident, but he was assessed in the clinical record as alert and oriented x 4. On 08/05/2015 at approximately 2:20 p.m. Resident #24's clinical record was reviewed. A	F 281 F 281	**F 281 Professional Standards** **The facility will continue to provide services that meet professional standards.** 1. Resident #24 no longer resides in the facility. LPN #4 has received a CPR skills review via a certified CPR instructor. 2. An audit of licensed nurses was completed by Human Resources to ensure that their CPR certification is current. 3. Nurses will receive Cardio Pulmonary Resuscitation (CPR) certification by a certified CPR instructor. HR will obtain current CPR credentials for all new hires and maintain a log/spreadsheet to track the certifications. HR will inform the Administrative Director of Nursing Services of certifications that are soon to be due for re-certification. Mock Codes will be held weekly on each shift for 30 days and then 3 times monthly for 60 days. 4. Identified concerns will be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. 5. September 4, 2015	

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progress note written by LPN #4 (licensed practical nurse) stated, "...pt (patient) noted unresponsive at 3.10 am (3:10 a.m.)... 911 was call cpr (cardiopulmonary resuscitation) initiated..." (sic)

The DON (director of nursing) was interviewed on 08/06/2015 at approximately 7:55 a.m. regarding the "Code Blue" incident with Resident #24 on 07/18/2015. An investigation of the incident was requested. The DON stated, "There was no investigation. We didn't know anything about improper CPR being done. The police didn't say anything to us about this." The DON was asked if licensed personnel are required to have CPR certification prior to working at the facility. The DON stated, "Yes." Nurses and CNA's (certified nursing assistants), "No, just nurses." Are nurses required to complete a skills checkoff on employment? The DON stated, "Nurses are checked off on skills during orientation. Let me look into this further and I will get back with you"

At approximately 9:40 a.m. the DON stated, "(Name) LPN #4 did start CPR. He was up on the bedside commode and didn't look well. He had a pulse. They assisted him to bed and reassessed. No pulse found. CPR was initiated."

The "Emergency Management" policy, Revised 11/2013, was reviewed. At approximately 10:05 a.m., the DON was asked if "Mock Drills" are performed in the facility as stated in the policy. The DON stated, "No."

The HR (human resources) Director was interviewed at approximately 11:20 a.m. regarding if current CPR certifications are kept in the employee files. The HR Director stated, "If they

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have one we make a copy. If there isn't one in there, it doesn't mean they don't have one. We ask them to bring us copies when they get a new card." No copy of any CPR certification was located in LPN #4's employee file. "I guess my predecessor didn't get copies either. I have been here two years, since 2013. I need to use another system to keep track of CPR certifications so I can stay on them."

On 08/06/2015 at approximately 1:25 p.m., LPN #4 was interviewed by the survey team regarding the night of 07/17/15 and early morning of 07/18/15. LPN #4 stated, "I came in, made rounds. (Name) Resident #24 was sitting on the side of his bed. I normally work on the second floor, but tonight I was on three. I went back to him (Resident #24) after rounds to check and see if he was okay. I introduced myself and gave him his call light and to call if he needed anything. (Name) Resident #24 stated I am fine and okay.

After I did my twelve o'clock meds (medications) and treatments I checked on (Name) Resident #24 again. I took his vital signs and blood sugar, everything was normal. He was laying in bed. He (Resident #24) called out on his call bell about 30 minutes later requesting something for pain. I gave him Percocet. He (Resident #24) called out again about 30 minutes later wanting his pillow adjusted. About an hour later he (Resident #24) called and the tech went to his room and I came in a minute later. He needed to use the commode. I offered him a bedpan and he said no, I need a commode. We went and got a bedside commode. The tech and myself helped him up to the commode because he was a below the knee amputee. I told the tech to stay with the resident while he was up.

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The tech left the room to answer another call light and I went into the room. (Name) Resident #24 said I need to have a BM (bowel movement) and I don't want anyone watching me. I placed the call light in reach, told him to call if he needed anything and I went to the nurse's station to get a drink of water. A few minutes later I checked on the resident and he was not done. He said I will call when I am finished. I went back to the nurse's station. A few minutes later the tech went to check on the resident and yelled out for the nurse standing in the hall. I also went to the resident's room. (Name) Resident #24 had pulled his table closer to him, crossed his arms on the table and laid his forehead down on his arms. I lifted up his head and arm and called out his name. He was unresponsive.

We (the other nurse, tech and I) moved him to his bed. I ran to the nurse's station to get the crash cart and called a code while they were arranging him. He had been tilted on his side and they were laying him flat. I returned to the room with the cart and I started compressions. Other nurse's were there by then placing the board under his back, putting on an oxygen mask and taking a blood pressure. He was not breathing, had no pulse or B/P (blood pressure). Someone took the oxygen mask off and started using a mask with ambu bag (a handheld device used to provide ventilation to people who are unable to breath). I was doing compressions when the policeman arrived. He (policeman) said, Let me help and took over compressions. I went to the desk to talk to 911 on the phone and get the paperwork ready. The other nurse stayed in the room. The policeman was here fast, within about five minutes."

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This surveyor asked LPN #4 where she placed her hands on the resident while doing compressions. She demonstrated on herself, traced the ribcage, found the xyphoid process, placed her hands on top of the xyphoid process, partially on the upper abdomen and partially on the lower part of the sternum, then started mimicking compressions. For clarification I had LPN #4 demonstrate on me her hand placement during compressions. She repeated the above process identically. This surveyor drew a picture of a rib cage with xyphoid process and sternum and asked LPN #4 to show exactly where she would place her hands to do chest compressions. She traced out the ribcage with a pen and put a mark directly on the end of the xyphoid process (1). LPN #4 showed this surveyor her current CPR (BLS - basic life support) card. The card was issued on 08/30/13 and expires on 08/2015. The card had been issued from an American Heart Association course.

According to the American Heart Association, hand placement on an adult for chest compressions should be in the middle of the sternum. "...Imagine a line between the nipples and put your hands on the center of the chest right below that line. Push hard and fast--about two every second..." (1)

This surveyor received a copy of a blank "Personnel Folder Checklist Revised April 2014" from the DON at approximately 2:15 p.m. The checklist included an entry for "Job Specific Orientation Checklist (...Licensed Nurses...). The DON stated, "This is used by HR to check off for new employees." No such list was included in LPN #4's employee file. A copy of LPN #4's

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F 281	Continued From page 25 inservice transcript was received by this surveyor. The transcript included a notation, "Annual Mandatory: 2011 Emergency Response Online Class Completed 1/9/2012." Training details for this course stated, "Description: Procedures for responding to emergency situations are presented. Resident emergency situations, weather emergencies, utility system failures and evacuation procedures are addressed. 21 minutes Status: Completed." The DON was asked if nurses are expected to have a current license and CPR card in order to work in the facility. The DON stated, "Yes, there is an expectation that nurses will be licensed and have a current, valid CPR card before working with residents. There is not a policy stating this and it is not written anywhere. It is just our expectation." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 08/06/2015 at approximately 2:15 p.m. No further information was received by the survey team prior to the exit conference on 08/06/2015. (1) American Heart Association website: http://www.heart.org, "Steps of CPR" (cardiopulmonary resuscitation), 2014. This is a complaint deficiency.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	**F 282** **Services by Qualified Persons/per care plan.** **The facility will continue to provide or arrange services that are provided by qualified person in accordance with each resident's written plan of care.**	

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review, the facility staff failed to implement the care plan for Resident # 17. The facility staff to follow the care plan and physically restrained the resident during incontinence care, which resulted in bruising and skin tears to the resident's arms and hands.

Findings included:

Resident # 17 was admitted to the facility on 11/18/12. Diagnoses for Resident # 17 included, but were not limited to: Alzheimer's disease, PVD (peripheral vascular disease), HTN (high blood pressure), depression, and muscle weakness.

The most current MDS assessment was a quarterly assessment dated 05/19/15. This MDS assessed the resident with a cognitive score of "7" indicating the resident had severe impairment in daily decision making skills. This MDS also assessed the resident as requiring extensive assistance with toileting with at least one person physical assist. Additionally this MDS assessed the resident as 'not' having behavior symptoms and as 'not' resisting care.

The most current full MDS (minimum data set) with CAAS (care area assessment summary) was reviewed for comparison, dated 11/16/14. This MDS assessed the resident with a cognitive score of "4", again indicating the resident had severe impairment in daily decision making skills and as requiring extensive assistance from staff for

1. Resident #17 care plan was reviewed to ensure that it included appropriate care strategies for the staff in the event that resistive behaviors occurred.
Staff members #3 and #4 received education on how to locate and initiate appropriate care strategies for handling behaviors.

2. Patients with a behavior of refusing and/or resisting care have the potential to be affected.
Review of current residents who have a history of resisting or refusing care to ensure that their plan of care includes appropriate care strategies to guide the staff should the behavior occur.

3. Nursing staff will be educated by the staff development nurse on where to find the care strategies that should be used if the behavior occurs, to provide safety to patients as well as staff.

Current residents that have been identified as having a behavioral episode will be tracked on a behavior tracking log.
The behavior tracking logs will be reviewed weekly in the morning clinical meeting by the Interdisciplinary team for 90 days
DCD/ADNS will do random weekly audits of staff members on different shifts to confirm staff knowledge of where to find care strategies to deal with behavioral episodes.

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toileting with at least one person physical assist. Additionally, the resident was assessed as 'not having behavior symptoms and as 'not' resisting care. The resident triggered in the CAAS area of this MDS for: cognition, communication, mood and urinary.

A review of a FRI (facility reported incident) alleged that on 06/06/15, Resident # 17 sustained three skin tears with bruising to the right wrist during incontinence care by two CNA (certified nursing assistants), CNA # 3 and CNA # 4.

During clinical record review on 08/05/15 and 08/06/15 nursing notes were reviewed for Resident # 17.

A nursing note dated 06/06/15 and timed 8:32 a.m., documented: "Resident is alert and verbally responsive resident sustained skin tear on right arm, during incontinence care trying to scratch the CNA (certified nursing assistant), patent (sic) was very combative, kicking and scratching the CNA, refused for the writer to give skin care, slap (sic) the writer on the face, also refused the supervisor, son was put on the phone the patent (sic) refused to talk to him, MD (medical doctor) notified new order to apply triple antibiotic ointment and cover with gauze..."

A nursing note dated 06/06/15 and timed 11:32 p.m., documented: "...Pt (patient) has bruises on her Rt (right) arm due to pt kicking and resisting care this morning. Area is red but not bleeding noted (sic)...Investigation done to find out cause. Family requested incident report written by the nurse on duty that time but it was not granted..."

A nursing note dated 06/06/16 and timed 11:48

4. Identified concerns will be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.

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p.m. documented: "Head to toe assessment was completed, on assessment patient is noted with right lower arm skin tears, with bruising surrounding the skin tears that measures 14cm (centimeters) X (by) 4.5cm. Left lower arm and hand is noted with discoloration in several areas of the arm. First area measures 3cm X 2.5cm closed discolored area that is purplish in color that is on the left outer aspect of the arm. Second area measures 2cmX 2cmX closed that is red/purplish discoloration that is on the back of the left hand between the thumb and index finger. Third area measures 1cm X 0.5cm that is red/purplish...closed..."

A nursing noted dated 06/06/15 and timed 11:48 p.m. documented: "...skin tears that was sustained during ADL (activities of daily living) care...3 skin tears to the right arm...1.5 cm X 2 cm...1cm X 2cmX...0.3 cm X 1.2 cm..."

A nursing note dated 06/07/15 and timed 4:35 p.m., documented: "...Resident very combative refused ADL's during this shift...X-ray of right wrist...pending result..."

Resident # 17's current CCP (comprehensive care plan) was then reviewed and documented the following: "...Assist with daily hygiene, grooming, dressing...break ADL tasks into sub-task for easier patient performance...Allow for flexibility in ADL routine to accommodate mood, preferences, and customary routine...Elicit family input for best approaches; ask physician to explain/reinforce need for treatment...If resident refuses contact son to speak with resident and explain care in Spanish...if resists care, leave (if safe to do so) and return later...Do not invade personal space...Elicit family input for best

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approaches...Talk with in a low pitch, calm voice to decrease/eliminate undesired behavior...Allow adequate time to respond. Do not rush or supply words...Approach/speak in calm, positive /reassuring manner...Explain each activity/care procedure prior to beginning it...Gain individual's attention before beginning...Provide assistance as needed...provide incontinence care as needed...psych consult as needed..."

On 08/06/15 at approximately 8:00 a.m., the assistant administrator was asked for the investigation, abuse policy, along with the x-ray reports and any psych consults regarding Resident # 17.

The investigation summary was presented and reviewed. The investigation was completed by the DON (director of nursing) on 06/12/15. The investigation summary documented: "On 06/06/15 at approximately 5:30 a.m. (Resident # 17) sustained 3 self inflicted skin tears to her right arm during care (incontinence). The two staff members held the patients hands while attempting to perform incontinence care...CNA # 3 attempted to provide incontinence care and Resident # 17 refused...CNA # 3 and CNA # 4 went to provide incontinence care for Resident # 17...Resident # 17 was yelling in another language, kicked her feet and attempted to scratch and bite CNA # 3, CNA # 4 tried to explain that they were trying to clean her...Resident # 17 continued to yell, kick and tried to scratch CNA # 3, CNA # 3 was holding her hands so that she could not hit them while CNA # 4 was changing her...Conclusion: Based on the investigation including resident (other residents in the facility) and staff interviews it was determined that abuse did not occur. The staff

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members used their best judgement in providing care for the resident and the self inflicted skin tears were accidental and the staff reacted to the resident's resistance to care. Their actions were not to intentionally cause harm."

Employee statements documented the following:

CNA # 3 (06/06/15) (via telephone)- "I went into the room at 4 am to change her. She did not let me...she was sitting in the chair and the bed was wet with urine and stool, so I changed the bed linens while she was in the chair...she had stool all over herself. I grabbed her depend and showed it to her and said let me change you. She grabbed the depend out of my hand and placed it under her arm and got back into the bed...covered herself up with the coat. When I kept asking her to let me change you she kept saying no, ...told the nurse...nurse on duty told me to go get the other CNA (CNA # 4) to help me...around 5 am we both entered the room...asked her to let us change her and she kept saying no...While I was in the room with CNA # 4 she told me to watch her lead, so CNA # 4 took a new depend and showed it to her and said your wet we are going to change you. So CNA # 4 started to get the wet clothes off of her and she started to kick, hit, and scratch. I was holding her hands so she could not hit us. So when I was holding her hand she went to scratch me on my hand that's when I moved...and she scratch (sic) herself...CNA # 4 and I kept cleaning her when we got the clothes and depends off her she had dried stool all over her buttocks and down to her legs...saturated with urine and stool, we gave her a bed bath and wiped her real good to clean her up...got her dressed and cleaned. When we were done she grabbed her walker and threw it at

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us and the shoes hit the bathroom door...I went to the nurse to tell her that the resident had a skin tear from changing her...."

CNA # 4 (06/08/15)- "...I was not assigned to take care of Resident # 17...at approximately 5 a.m....I was asked by CNA # 3 to assist her with incontinence care for Resident # 17...CNA # 3 was already in the room when I came to assist her. Resident # 17 was yelling words I could not understand. I tried to explain to her that we needed to clean her. She was covered in bowel movement and was really dirty and needed to be changed. Resident # 17 continued to yell out and kicked her feet and was trying to scratch CNA # 3 and bite her hands...she continued to yell, kick and try to scratch...actually scratched herself. So CNA # 3 held her hands and I wiped her...when we were done changing her we say that her right hand was bleeding..."

The x-ray report for Resident # 17 was reviewed and documented negative for fracture or dislocation.

The psych consults were reviewed and revealed the following:

02/18/15 "Geriatric Psychiatry Progress Note: ...aggression, psychosis...combative with care, refusals, stable on exam...staff note that agitation is variable, episodic she was just started on remeron...states she is content, mood good...met with staff to discuss strategies for staff to manage agitation, ways to redirect and distract..."

The facility's abuse policy documented: "...it is important to be familiar...definitions of abuse, neglect...Abuse can occur in many forms and to

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varying degrees...physical abuse includes hitting, slapping, pinching, and kicking...employees are educated upon hire and annually on abuse prevention..."

The administrator, DON (director of nursing), and the assistant administrator were informed of concerns regarding Resident # 17 being physically restrained during incontinence care and sustaining multiple skin tears and bruising, in a meeting with the survey team on 08/06/15 at approximately 10:00 a.m.

The DON voiced that the staff used their best judgement. The DON was informed about the resident's CCP and that this was an identified issue with this resident and the CCP was not followed, the staff members did not leave the resident alone and did not attempt to contact the resident's family for any guidance prior to the resident being restrained, and as a result the resident incurred physical injury from being physically held down by the staff members. The DON was asked what are/were the 'strategies', documented in the psych consult. The DON voiced, it was pertaining to what was in the resident's CCP.

The DON further voiced that staff reacted based on the resident attempting to hit the staff. The DON was informed that according to the statements of the staff members, the resident repeatedly told the staff members no, prior to any physical resistance from the resident and the staff members continued, provoking the resident to the point of physical resistance. Again, the DON was informed that according to the evidence the facility staff did not follow the resident's CCP for care resistance for Resident # 17, and as result

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F 282	Continued From page 33 the resident incurred physical injury. No further information or documentation was provided or presented prior to the exit conference, to evidence that Resident # 17 was not physically restrained by staff during incontinence care or that the resident's comprehensive plan of care was followed regarding the above issues and concerns.	F 282		
F 314 SS=G	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 and complaint investigation the facility staff failed to perform skin assessments for the prevention of a pressure sore for one of 27 residents in the survey sample. Facility staff failed to provide documented skin assessments for Resident #22 for twelve days following a re-admission to the facility. The resident was then found with a stage III pressure ulcer on her coccyx (harm). The pressure sore developed necrotic tissue, a foul odor and was assessed as a stage IV pressure sore prior to the resident's discharge from the facility.	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 #22 no longer resides in the facility. 2. All residents at risk for pressure ulcers have the potential to be affected. The facility will complete a skin sweep on all residents. New identified pressure ulcers will be addressed. Comprehensive pressure ulcer assessments, PUSH tools, and Braden's will be completed accordingly; additionally care plans will be updated to include prevention strategies and individualized interventions and goals. Physician/family will be notified, and treatment orders obtained. Prevention interventions will be validated.	

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F 314	Continued From page 34 The findings include: The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure ulcer as "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear." The NPUAP defines a stage III pressure ulcer as, "Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. Bone/tendon is not visible or directly palpable." The NPUAP defines a stage IV pressure ulcer as, "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling...Exposed bone/muscle is visible or directly palpable." The NPUAP defines an unstageable pressure ulcer as, "Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined, but it will be either a Category/Stage III or IV." (1) Resident #22 was admitted to the facility on 2/2/15, readmitted on 2/23/15 and was discharged on 3/29/15. Diagnoses for Resident #22 included metastatic endometrial cancer, hematuria, urinary obstruction, hyperpotassemia, thrombocytopenia, anemia, hypertension, diabetes, bronchopneumonia and urinary tract	F 314	3. New admissions or readmissions will have a skin check documented on admission and a second skin check documented within 24 hours of admission. The ADNS/Designee will complete record reviews to validate compliance, in the daily clinical QAA meeting. Skin checks will be completed by licensed nurses as ordered. The ADNS/Designee will complete random reviews of skin sheets to validate compliance, in the daily QAA meeting. 4. Identified concerns will be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed. 5. September 4, 2015	

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infection. The minimum data set (MDS) dated 3/7/15 assessed Resident #22 as cognitively intact. This MDS assessed Resident #22 to require the extensive assistance of one person for transfers and bed mobility.

Resident #22's closed clinical record was reviewed on 8/5/15. The record documented no skin assessments for Resident #22 from 2/24/15 until 3/9/15 when the resident was assessed with a stage III pressure sore on her coccyx. Resident #22's treatment record indicated a body audit was completed on 3/2/15 but the record documented no assessment associated with this audit. The resident was at the hospital for almost nine hours on 3/4/15 for a blood transfusion. No skin assessment was conducted upon the resident's return to the facility. Five days later (3/9/15) the resident was assessed with the stage III pressure sore to her coccyx. The record initially assessed the resident's coccyx wound as a stage III pressure sore. Additional assessments described the wound as unstageable due to the presence of slough. The wound developed necrotic tissue, a foul odor and was later assessed by a physician as a stage IV pressure sore.

Resident #22's closed clinical record documented the resident was admitted on 2/2/15 with "non blanchable redness" to both of her heels but no other pressure areas. Nursing notes documented the redness to the left heel was resolved on 2/7/15. A readmission nursing assessment dated 2/23/15 listed the resident had nephrostomy tubes on her right/left side, a suprapubic pubic catheter but no other areas of skin breakdown. A nursing note dated 2/24/15 stated, "...patient noted with her skin to be intact, no areas of

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impaired skin noted...she is on a pressure reducing mattress." Resident #22 was assessed by the facility as a low risk for pressure sore development with use of the Braden Scale for Predicting Pressure Sore Risk form.

Resident #22's Braden assessments prior to 3/9/15 documented the following.

2/24/15 - Score of 17 (low risk) - Resident assessed with no sensory impairment, occasional skin moisture, walks occasionally, slightly limited mobility, adequate nutrition with a friction/shear problem listed as "Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance..."

3/3/15 - Score of 17 (low risk) - Resident assessed with no sensory impairment, occasionally moist skin, chairfast (must be assisted into chair or wheelchair), slightly limited mobility, adequate nutrition with a friction/shear problem listed as "Potential problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair...occasionally slides down."

The resident's plan of care (print date 8/5/15) listed the resident was assessed upon admission to be at risk for skin breakdown. The care plan entry dated 2/3/15 stated, "At risk for alteration in skin integrity related to impaired mobility. Interventions listed were, "Encourage to reposition as needed; use assistive devices as needed...Observe skin condition with ADL care daily; report abnormalities...Provide preventative

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skin care routinely and prn (as needed)." Other than resolved entries related to the resident's red heels upon admission, there were no updates/revisions regarding pressure sore prevention until the development of the coccyx pressure sore on 3/9/15.

The record documented the resident was assessed on 3/9/15 with a stage III pressure sore on her coccyx approximately 2 inches long and 2 inches width with no depth listed. A nursing note dated 3/9/15 stated, "Writer was notified by nursing assistant that patient had skin impairment noted during ADL (activities of daily living) care this AM. Upon assessment with RN (registered nurse) manager of 3rd floor patient with stage 3 (III) wound to her coccyx that measures 5 cm (centimeters) x 5 cm with 80% slough present with scant amount of serous drainage present and 20% of epithelial tissue present. Wound was cleaned with normal saline, pat dry, with Santyl applied to wound bed, skin prep to periwound with Allevyn sacrum dressing applied to wound. M.D...informed of wound with treatment plan in place. Order will be for Santyl twice per day for wound healing...She was changed to a Roho wheelchair cushion from a regular foam cushion...Head to toe assessment completed she is noted with bilateral nephrostomy tubes, suprapubic cath (catheter), coccyx wound, and bilateral lower extremity pitting edema. No other impairments noted during the assessment...She spends most of the time in her wheelchair during the day, uses a walker for ambulation transfers..."

A pressure ulcer record dated 3/9/15 documented, "Coccyx wound measure 5 cm x 5 cm with 80% slough present with scant amount of serous drainage with 20% epithelial tissue

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present. Periwound skin is intact with blanchable redness present." This record documented Resident #22's risk factors as resident required staff assistance to move, narcotic use, cancer/terminal illness, decreased sensory perception, newly admitted/readmitted and head of bed elevated most of the time. A note documented on this form stated, "Patient had appointment...for recent blood transfusion on 3/4/15 she was picked up...at 7:10 a.m. to be transported to hospital via stretcher. She arrived at hospital...at 8:06 am. She returned to facility at 4 pm on 3/4/15 via stretcher."

Additional nursing notes listed Resident #22's pressure sore as "unstageable" and with a foul odor. Pressure ulcer tracking records listed the wound developed necrotic tissue with heavy exudate and was later assessed by a physician as a stage IV pressure sore. The clinical record documented the following regarding the progress of Resident's coccyx pressure sore after 3/9/15.

3/10/15 - "Late entry for 3/9/15 for clarification. Wound is unstageable. Wound bed is 80% slough."
3/12/15 - Body audit done no new skin alteration noted continue with treatment on coccyx done as ordered..."
3/12/15 - "...Body audit done no new skin alteration, continue with treatment on coccyx done as ordered well tolerated Pain management in progress..."
3/17/15 - "Patient followed up by wound team today, wound to her coccyx measures 3.5 cm x 6 cm with 80% slough present with moderate amount of serosanguineous drainage present and 20% of epithelial tissue present with edges macerated...braden score is a 17... Head to toe

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assessment completed she is noted with bilateral nephrostomy tubes, suprapubic cath, and bilateral lower extremity pitting edema. No other impairments noted during the assessment..."
3/20/15 - "...wound care done it have drainage but no blood noted, it is very hard to touch...no new skin alteration noted." (sic)
3/21/15 - "...Body audit done no new skin alteration noted continues with treatment order..."
3/24/15 - "patient followed up by wound team today, wound to her coccyx measures 7 cm x 10.5 cm x 2 cm depth with 3.5 cm tunnelling (tunneling) at 6 o'clock with 100% slough present with heavy amount of serosanguineous drainage present edges macerated, wound noted with foul odor present. Wound was cleaned with Dakins saline, pat dry, with Santyl applied to wound bed, skin prep to periwound with Allevyn Sacrum dressing applied to wound. Head to toe assessment completed during wound round with increased edema noted to her bilateral lower extremities..." (sic)

Resident #22's pressure ulcer healing chart for the coccyx wound documented the following assessments according to the pressure ulcer scale for healing (PUSH) scoring system.

3/9/14 - slough present with light amount of exudate, length x width > 24.0 square cm
3/17/15 - necrotic tissue with moderate amount of exudate, length x width > 24.0 square cm
3/24/15 - slough present with heavy amount of exudate, length x width > 24.0 square cm

A physician's progress note dated 3/17/15 documented the resident had an unstageable wound to the coccyx area with instructions to apply a Santyl wet to dry dressing daily. A

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physician's progress note dated 3/25/15 stated, "Internal Medicine Follow-up...Stage IV large coccyx ulcer: Patient is wheelchair bound with extensive medical hx (history) with advanced Endometrial CA (cancer) - now has a large sacral pressure wound of difficult management due to lack of mobility and nutritional deficits..." An undated addendum to this note stated, "Pt (patient) very weak at extreme risk for breakdown at any site. Her coccygeal area decubiti was preempted by poor muscle condition...and nine hours of being on a stretcher/gurney while at (hospital) ED (emergency department)..."

The record documented the resident was out of the facility at a hospital on 3/4/15 from 7:10 a.m. until 4:00 p.m. getting a blood transfusion. There was no record of a skin assessment upon the resident's return from the blood transfusion on 3/4/15. A note dated 3/4/15 at 7:26 p.m. listed an assessment of the resident's vital signs and general condition but included no assessment of her skin. The note documented, "Patient as alert and oriented x 3, returned from blood transfusion this pm in stable condition, no reaction noted at this time. All pm and pain medication administered as ordered well tolerated. One staff assist with ADL care and transferred to bed..."

Five days later on 3/9/15 the resident was assessed with the stage III pressure sore to her coccyx.

The record documented a physician's order dated 2/23/15 for a body audit to be conducted every Monday for "skin observation." After the readmission assessment dated 2/23/15 there was no further mention of the resident's skin until 3/9/15 when the resident was assessed with

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stage III pressure ulcer on her coccyx. A nurse signed off the resident's treatment record on 3/2/15 indicating a body audit was completed but there was no documentation of this assessment in the record. Skin worksheets completed by the certified nurses' aides during ADL care dated 3/2/15 and 3/5/15 identified the resident's skin was "Abnormal." Two areas were marked on the sheet's body diagram on the resident's right/left lower back area. The form stated, "Check Abnormal if: broken, bruised or reddened areas." There were no nursing assessments regarding either of these skin worksheets identifying or describing the abnormal skin areas.

On 8/6/15 at 8:25 a.m. the licensed practical nurse (LPN #4) that cared for Resident #22 during her stay was interviewed about skin assessments. LPN #4 stated she did not remember Resident #22. Concerning skin assessments, LPN #4 stated weekly skin assessments were supposed to be done on all residents. LPN #4 stated, "If you see anything wrong you report to wound team and make a note." Concerning skin assessments not showing any impairment, LPN #4 stated, "You make a note everything is ok." LPN #4 stated certified nurses' aide (CNAs) filled out "shower sheets" for each resident on shower days indicating if there were any problem skin areas and these sheets were reviewed by the nurses.

On 8/6/15 at 8:30 a.m. CNA #2 that worked on Resident #22's nursing unit during the resident's stay was interviewed. CNA #2 stated she did not remember anything about Resident #22 or her skin. CNA #2 stated, "Too many residents. I don't remember."

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On 8/6/15 at 9:50 a.m. the director of nursing (DON) was interviewed about any skin assessments in the days prior to Resident #22's coccyx pressure sore. When asked if she had any skin assessments for Resident #22 between 2/24/15 until 3/9/15, the DON stated, "No. We do not." The DON stated they conducted an investigation after the pressure sore was found on 3/9/15. The DON stated the outcome of their investigation was the resident had lots of co-morbidities and spent a long time on a stretcher when in the hospital on 3/4/15 for the blood transfusion. The DON stated nurses did not conduct a skin assessment when the resident returned from the hospital on 3/4/15 until the report of the pressure ulcer on 3/9/15. The DON stated skin assessments were routinely done on readmissions to the facility but they did not consider Resident #22's day at the hospital for the blood transfusion a readmission. The DON stated marked areas of skin impairment on the CNA skin sheets dated 3/2/15 and 3/5/15 were probably the resident's nephrostomy tubes. The DON did not present any nursing assessments related to the CNA shower sheets showing an assessment identifying these areas as the nephrostomy tubes. When asked what could have been done in attempt to prevent/minimize Resident #22's pressure sore, the DON stated, "Assessment before and after she (Resident #22) went out."

On 8/6/15 at 10:55 a.m. the licensed practical nurse (LPN #3) unit manager was interviewed about Resident #22. LPN #3 stated if skin impairments were found an incident sheet was completed, the physician was contacted for treatment orders and the wound was then tracked weekly by the wound team. When asked if

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routine skin assessments included a description/assessment of the skin (color, appearance, presence of pain or moisture), LPN #3 stated, "We are not doing that." LPN #3 stated nurses initialed the treatment records indicating a skin assessment was done but did not make notes regarding the assessments unless there was impairment. Other than the treatment record initialed by a nurse on 3/2/15, LPN #3 did not present any evidence of a documented skin assessment from 2/24/15 until 3/9/15 when the pressure sore was found.

The Prevention and Treatment of Pressure Ulcers: Quick Reference Guide on pages 15 and 16 states, "Skin and tissue assessment is important in pressure ulcer prevention, classification, diagnosis, and treatment...Educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration...In individuals at risk of pressure ulcers, conduct a comprehensive skin assessment: as soon as possible but within eight hours of admission, as part of every risk assessment, ongoing based on the clinical setting and the individual's degree of risk and prior to the individual's discharge...Increase the frequency of skin assessment in response to any deterioration in overall condition...Document the findings of all comprehensive skin assessments...Ongoing assessment of the skin is necessary in order to detect early signs of pressure damage, especially over bony prominences...Include the following factors in every skin assessment: skin temperature; edema; and change in tissue consistency in relation to surrounding tissue...Assess localized pain as part of every

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F 314	Continued From page 44 skin assessment. When the individual is able to respond reliably, ask him or her to identify any areas of discomfort or pain that could be attributed to pressure damage..." (2) These findings were reviewed with the administrator, director of nursing and assistant administrator during a review meeting on 8/6/15 at 9:50 a.m. This was a complaint deficiency. (1) NPUAP Pressure Ulcer Stages/Categories. National Pressure Ulcer Advisory Panel. 8/8/15. <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/> (2) National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview and clinical record review the facility staff failed to ensure a medication error	F 332	**F 332** **Free of medication error rates of 5% or more.** **The facility will continue to ensure that it is free of medication error rates of five percent or greater.** 1. Resident #16 was assessed for adverse effects, medication error report completed, and her physician and responsible party was notified. LPN #2 completed medication pass training. Additional training was provided to the LPN that failed to transcribe the order.	

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rate of less than five (5) percent. There were two errors out of twenty-six opportunities resulting in an error rate of 7.69%.

Findings include:

A medication pass and pour observation was conducted 8/5/15 beginning at 8:15 a.m. with LPN (licensed practical nurse) # 2. LPN # 2 prepared medications for Resident # 16 as this surveyor recorded medication name and dose from the label on the medication card. Included in Resident # 16's medications was "Abilify 2 mg tablet Give 7 mg orally one time a day for depression GIVE WITH 5 MG = 7 MG." and "Abilify 5 mg tablet Give 5 mg orally one time a day for depression GIVE WITH 2 MG = 7 MG." The resident's medications also included "Vitamin B-12 Tablet 1000 mcg Give one sublingually (under the tongue) one time a day." LPN # 2 then administered Resident # 16's medications. Resident # 16 took all medications whole, by mouth, with a glass of water. The resident was not instructed to place the Vitamin B-12 tablet under her tongue.

The clinical record was reviewed 8/5/15 at 8:35 a.m. for reconciliation of medications administered. A physician order dated 8/4/15 directed "Decrease Abilify to 5 mg p.o. (by mouth) every day." The order was signed by the physician, and had "Noted" with staff initials written on the order.

On 8/5/15 at 8:50 a.m. LPN # 2 was interviewed about the two medications. LPN # 2 stated "The staff member who 'noted' the order was supposed to follow through and put the new order in the computer; that wasn't done because I still

2. All residents have the potential to be affected.
Orders for currents were reviewed to ensure that medications ordered were noted and entered into the system correctly

3. Nurses completed medication pass training.
New orders will be reviewed by the Administrative Director of Nursing/Director of Care Delivery to ensure that orders are transcribed correctly into the electronic system for 90 days.
Nurses will receive medication pass training on hire, annually, and as appropriate, should there issues be noted.

4. Identified concerns will be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented as needed.

5. September 4, 2015

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show she was getting the two tablets to equal the 7 mg dose." LPN # 2 was then asked about the administration of the Vitamin B-12 tablet. LPN # 2 stated "Maybe I was just carried away.....I usually give it to her under the tongue."

The administrator, assistant administrator, and DON (director of nursing) were informed of the above findings during a meeting with facility staff 8/5/15 at 3:30 p.m.

No further information was provided prior to the exit conference.