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	495173	A. BUILDING _____ B. WING _____	C 03/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 3/22/16 through 3/24/16. An extended survey was conducted 3/25/16 through 3/29/16. Substandard Quality of Care was identified in the area of Quality of Care for Pressure Ulcers, F314. Fourteen complaints were investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements.

The Life Safety Code survey/report will follow.

The census in this 197 bed survey was 173 at the time of the survey. The Standard survey sample consisted of 28 residents: 25 current residents (Residents #1 through #23, #27 and #28) and 3 closed records (Residents #24 through #26). The Expanded survey sample consisted of 15 residents: 13 current residents (Residents #29 through #41) and 2 closed residents (Resident #42 and #43).

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F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224	F224

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 interviews, clinical record reviews,

1. Resident #28 is no longer in facility.

   Resident #19 was discharged to hospital on 4/8/16 and readmitted to facility on 4/13/16. Administrator and Social Worker met with resident on4/14/16 to discuss her concerns and apologize for any previous delays in response to call bell.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert E Bruce | TITLE: Administrator | (X6) DATE: 4-22-16

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 224	Continued From page 1 facility documentation and in the course of a complaint investigation, facility staff failed to ensure two residents (#28 and #19) from a survey sample of 40 were free from neglect. 1. The facility staff left Resident #28 on the toilet for over 40 minutes, did not answer the call bell within the specified response time and did not resolve grievances for Resident #28 regarding call bell concerns resulting in increased anxiety and inability to sleep. 2. The facility staff neglected to assure call bells were answered within the specific timeframes resulting in Resident #19's delay in receiving incontinence care and respiratory needs. The Findings Included: 1. In the course of a complaint investigation, Resident #28 was placed in the survey sample as a closed record as this resident is no longer at the facility. Resident #28 was admitted to the facility on 10/2/15 and chose to discharge home on 10/13/15. Diagnoses for Resident #28 included but not limited to CVA (Stroke), left side-weakness, atrial fibrillation, and obesity. Resident #28's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/09/2015 coded Resident #28 with a BIMS (Brief Interview Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident # 28 requiring extensive assistance with one person physical assistance for Activities of Daily Living, specifically toilet use (3 for extensive assistance defined as resident involved in activity, staff provide weight-bearing support and 2 for one person physical assist). Also Resident # 28 was	F 224	2. A review of 25% of the call bell response logs for one week will be completed to identify any other residents who may have experienced a delay in response to call bells. Social worker or designee will meet with those residents to apologize for the delay. Resident council meeting will be held and the Administrator will educate residents on facility process for communicating grievances/concerns to administrative staff.	

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F 224	Continued From page 2 coded as always continent of bowel and bladder. On 3/24/16 at 9:50 am a call was placed to the complainant and it was stated Resident #28 had pulled the call bell when on the toilet and had waited for assistance for 40 minutes until the resident placed a call to family using the cell phone to come help and as a result became very anxious and was unable to sleep. A clinical note documented on 10/2/15 at 10:31 pm that Resident #28, "was continent of bowel and bladder, was able to stand and reposition, was encouraged to ring for assistance prior to standing with noted left side weakness to upper extremity and was alert and oriented x 4 (no cognitive impairment). In a clinical note on 10/3/15 7:59 pm it was noted, "Continent of bowel and bladder and asks for assistance when needed by using call bell-within reach and asked to have the door closed at night due to noisy hallway/neighbors TV volume." Little is recorded on the clinical nursing notes until 10/11/15 at 7:00 pm where Resident #28 "requested to be D/C (discharged) informed no social worker available at this time and asked how can I help you be more comfortable? Stated, "I just want to go home", much 1:1 given. Family visited." The social worker wrote one note regarding the admission and the discharge on the same day 10/13/15, the actual discharge date at 5:43 pm. According to the call bell log presented by the facility Resident #28 was in Room 332 and on the day of admission 10/2/15 the cord was out at 8:39 and again out at 8:52 with a staff response time of 4 minutes 11 seconds. On 10/3/15 at 7:19 a voice response was given to Resident #28 at 4 minutes and 47 seconds but a staff responds was	F 224	3. In-service staff on purposeful rounding "4 P's" (pain, position, potty, possessions) Staff will be reeducated on need for timely response to call bell. Resident council meeting will be held for Administrator to educate residents on facility process for communicating grievances/concerns to administrative staff. Administrator will send letter to resident and families outlining the process of to file grievances/concerns to facility administration. Administrator will maintain a tracking log of all received grievances/concerns. Grievances/concerns will be addressed timely by social worker or designee and tracking log will reflect nature of concern, correction or/resolution Facility administrator will review policy on call bell response time.	

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F 224	Continued From page 3 logged at 17 minutes and 36 seconds. On 10/4/15 at 3:27:23, Resident #28 rang the call bell and waited for a verbal response for 24 minute and 44 seconds while the staff response time was 42 minutes and 35 seconds. Later that same day at 20:04:54 (9:04:54 pm) Resident #28 waited 13 minutes and 40 seconds for staff to respond. The final recorded call bell logged was on 10/08/15 at 7:32:55 with a voice response time of 3 minutes and 52 seconds and a wait time of 8 minutes and 39 seconds. In an interview on 3/24/16 at 12:25 pm with Administration #1, the staff responsible for keeping a grievance log, it was stated that "no formal grievance was placed in regards to Resident #28. If a family member made a grievance to a unit manager I would expect that manager to report this to me immediately. That did not happen with Resident #28, there should have been a follow-up to the resident's and family grievance." In an interview on 3/25/16 at 2:00 pm with RN #2 Unit Manager on the unit where Resident #28 resided, she/he could recall a grievance from Resident #28 in regards to a bedside commode and that the resident needed a two person assist. It was noted in this interview that staff had talked to family regarding Resident's #28's complaint to go to restroom with assistance and that several attempts were made to help the resident as it was difficult to self transfer. According to RN #2, a bedside commode was given to assist Resident (#28) as it was too difficult to make it to the bathroom. The only other complaint RN #2 remembered regarding Resident #28 was about the loud noises in the hallway and the door was closed.	F 224	4. QA/Designee will audit 10% of the automated call bell logs weekly X 6 weeks for timely response time. Significant variances will be investigated and staff will be educated and/or counseled as appropriate. QA/Designee will complete Call Bell Observation/Resident Interview form for 10% of resident's weekly X 6 weeks. The administrator will complete an analysis of grievance/concerns and will submit a report of findings to QAPI committee for discussion and further recommendations. DON or designee will analyze the call bell response and will submit a report of findings and trends to the QAPI committee for discussion and recommendations. 5. Completion: 5/13/16	

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According to the Director of Nursing in an interview on 3/25/16 at approximately 2:30 pm it was stated in a meeting with several surveyors that the expected call bell time response is 3 minutes but with the staffing difficulties it is hard to meet that expectation. According to the 'Procedure for Answering Call Light' (revision 4/09/2013), "Resident's call lights will be answered timely to respond to resident's requests and needs."

Resident #28 had to call a family member to come assist while on the toilet waiting for 42 minutes for staff to respond to the call bell resulting in anxiety, lack of sleep, and a decrease in using the call bell. This grievance was not followed nor resolved and as a result, Resident #28 made the decision to discharge from the building.

2. The facility staff neglected to assure call bells were answered within the specified timeframes resulting in Resident 19's delay in receiving incontinence care and respiratory needs.

Resident #19 was admitted to the nursing facility on 5/23/14 with diagnoses that included acute and chronic respiratory failure with tracheostomy, obstructive sleep apnea, asthma, bronchitis, obesity and dependence on a *respirator/ventilator.

*A ventilator blows air into your airways through a breathing tube. One end of the tube is inserted into your windpipe and the other end is attached to the ventilator. The breathing tube serves as an airway by letting air and oxygen from the

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ventilator flow into the lungs.

The process of inserting the tube into your windpipe is called intubation (in-too-BA-shun). Usually, the breathing tube is put into your windpipe through your nose or mouth. The tube is then moved down into your throat. A tube placed like this is called an endotracheal (en-do-TRA-ke-al) tube.

Sometimes the breathing tube is placed through a surgically made hole called a tracheostomy (TRA-ke-OS-to-me). The hole goes through the front of your neck and into your windpipe. The tube put into the hole sometimes is called a "trach" tube.

Both types of breathing tubes pass through your vocal cords and affect your ability to talk.

For the most part, endotracheal tubes are used for people who are on ventilators for shorter periods. The advantage of this tube is that it can be placed in an airway without surgery.

Trach tubes are used for people who need ventilators for longer periods. For people who are awake, this tube is more comfortable than the endotracheal tube. Under certain conditions, a person who has a trach tube may be able to talk.

A ventilator uses pressure to blow air or a mixture of gases (like oxygen and air) into the lungs. This pressure is known as positive pressure. You usually exhale (breathe out) the air on your own, but sometimes the ventilator does this for you too.

A ventilator can be set to "breathe" a set number of times a minute. Sometimes it's set so that you

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can trigger the machine to blow air into your lungs. But, if you fail to trigger it within a certain amount of time, the machine automatically blows air to keep you breath(http://www.nhlbi.nih.gov/health/health-topics/topics/vent/howdoes).

The most recent minimum Data Set (MDS) assessment was an Annual dated 2/9/16 and coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills needed for daily decision making. The resident had a tracheostomy and was ventilator dependent, thus non-verbal. She was not assessed to have mood problems. She was coded totally dependent on two staff for bed mobility, on one staff for toilet use and personal hygiene. She was not able to steady herself without physical assistance for surface-to-surface transfers. She was not able to walk, turn around, move from a seated position or move on and off the toilet. The resident was assessed impaired on both side of lower extremities. She used no mobility devices. She was coded occasionally incontinent of bowel and bladder. The resident was assessed with arthritis, asthma, shortness of breath, respiratory failure and pain. The resident was assessed to have Moisture Associated Skin Damage (MASD) from incontinence. She was on a pressure relief mattress, nutrition and hydration plan to manage skin problems and provided topical medications for skin condition. Out of 7 days, she received a diuretic 5 days and an antianxiety 2 days. The resident required oxygen therapy, suctioning and ventilator treatments/support.

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The care plan dated 2/17/16 identified the resident was at risk for ineffective airway clearance related to chronic tracheostomy as a result of respiratory failure and was an asthmatic. The goal the staff set for the resident was that her airway would be maintained through trach use, oxygen and suctioning, as well as nocturnal (night time) ventilator dependence. Some of the approaches the staff would use to accomplish this goal included assess and report signs and symptoms of altered respirations (short, slow, shallow or irregular respirations), maintain humidified oxygen, assess for changes in mental status (restlessness, lethargy, irritability) consult with other respiratory therapist and follow pulmonary orders and ventilator protocol. The resident was identified as receiving a diuretic and the staff was to respond promptly to calls for assist to the toilet. The staff identified a skin rash on thighs related to MASD. The goal set for the resident was that she would be free of the rash. Some of the approaches to accomplish this goal included to report changes/complications and treat per physician's orders and to keep clean and dry at all times.

The care plan indicated the resident was on the ventilator at night, but the physician progress notes dated 3/23/16 indicated humidified *FiO2 at 28% via tracheostomy mask and currently no ventilator at night.

*FiO2 is an index of arterial oxygenation efficiency that corresponds to ratio of partial pressure of arterial O2 to the fraction of inspired O2(http://medical-dictionary.thefreedictionary.com

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Resident #19 was observed on 3/23/16 at 1:30 p.m. in a specialty pressure relieving bariatric bed that allowed her to maintain complete uprightness as though she was sitting in a chair. She could be fully understood through lip reading and writing. She initiated and responded appropriately to conversation. She stated one of her concerns was that she has to wait to either use the bedpan, be suctioned or have the water released that collected in the blue oxygen tubing. She said when too much water collects in the tubing, she feels like she is choking and it makes her anxious. She stated in regard to the need for the bedpan, she can hold her urine up to about 15 minutes, but will wet on herself after that.

According to the resident, if she sat long periods in the urine, she started to scratch her inner and outer thighs and knew she had dug a few places to break the skin because she sat too long in urine. She stated she did not wear briefs at all and was fully able to assist the staff to get on and off the bedpan by rolling on her side and they placing her on it. She said she did not use Chux because they were an irritant, but used a regular sheet as a draw sheet under her buttocks. She stated her Lasix (Diuretic) had been reduced to 20 milligrams a day and she was on Mybetriq for over active bladder, but felt the staff still ignored her.

During the above interview, the resident stated she had addressed the aforementioned issues several times with the Director of Nursing (DON)

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and the Unit 4 Manager Registered Nurse (RN), but the care would get better and then go back to the same thing. She stated, "At the beginning of the month, she and her daughter took the issues to the DON that included not answering calls bells until the staff get ready or the light is cut off, it is hours before I know who my her nurse is. I told them, I pee on myself and have to sit in it, waiting on the nurse to give me the bedpan that I a fully able to use. As far as the blue tubing is concerned, I informed them at times water is bubbling in it for long periods of time and it gets hot and dries out my trach and makes it feel like I am choking. I recently went to the emergency room with breathing problems, it can happen to me quickly. I have put on my light for assistance and see the nurse walk right by my room like they don't see the light. If they need more staff or better staff, they should get it."

Further during the interview, the resident wrote to this surveyor the following information: "Will you change my nurse to someone that will help me and not make me wait forever and know how to help me, please. It is so unfair to me because when I call for help, it takes forever and a day for them to come. I see them go right by the door and still don't come in. I don't understand that. This is how they have been treating me and it's been going on for a while. One time I called for the nurse to use the bed pan and she said I just used the bed pan and made me sit in pee for a while and another one changed my bed. They say I am on a routine toileting schedule, but that is not true, they do not come every two hours only if I ring for the bed pan with a delay in responding to me."

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On 3/23/16 at approximately 2:10 p.m., the resident stated she had to use the bed pan and pressed the call bell. A voice response was almost immediate (resident not able to speak back to tell the nurse what she needed), but the actual staff response time was 10 minutes. The resident was getting anxious as she waited for the nurse. The resident was dry when the nurse arrived to place her on the bed pan. The resident's head was lowered, she rolled to her right side, the bed pan was placed under her, padded with a brief. After she was finished, the nurse provided peri-care, the resident positioned herself high in the bed, after which the bed was returned to an upright position.

Review of the incident the resident spoke about during the interview, the nurse's notes entry dated 3/11/16 at 6:28 a.m. indicated the resident was sent out via 911 to the local Emergency Department (ED) with signs and symptoms of difficulty breathing, with low saturation (sat) levels 85/88 and lethargy. Attempts to increase sats were unsuccessful.

The ED (emergency department) notes indicated the resident was evaluated in the ED on 3/10/16 at 10:37 p.m. and presented on arrival with shortness of breath and respiratory distress. EMS reported to the ED staff that upon their arrival the resident was coming in and out of consciousness and her oxygen (O2) sat levels were 80-90 % and they had to bag her with a BVM (bag to valve mask) with improved O2 sats to 100 %. EMS reported they suctioned the resident and along with bagging, she became more alert. The

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resident was stabilized in the ED and discharged back to the nursing facility, according to the facility's nurse's notes, arriving on 3/11/16 at 6:32 a.m.

On 3/23/16 at 4:46 p.m., a skin assessment was conducted with the assistance of Licensed Practical Nurse (LPN) #5. Before the skin assessment the resident used the bed pan in the same process as previously observed. After which the skin assessment revealed that the back of the resident's upper thighs were scarred and dark in color from MASD. Four open areas were observed: one on each outer thigh and one on each inner thigh. The LPN stated that the resident scratched those areas that came from urine irritation. The resident then nodded her hear in confirmation and mouthed that she did scratch those places on her legs because they were the spots she could reach sitting up. The LPN stated the resident was usually wet when they come to give her the bed pan. The resident waved her finger and mouthed "That is not true. You come too late after I call." The LPN stated they use a sheet instead on Chux or any other type of pad because of the resident's skin problems. The resident stated because she sat up all the time, when wets on herself, the urine it collects at the back of her thighs. She stated she is able to reach and scratch the two places between her thighs and the two places on the outside of her thighs.

The resident's daughter entered the room on 3/24/16 at approximately 5:15 p.m. She stated she did not know the resident had "dug out places" on her thighs because of her scratching,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING _____ B. WING _____	C 03/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

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but knew her scratching was rooted in the nursing staff taking too long to answering the resident's call bells and she having to sit in urine. She stated, " I am concerned because I constantly address this issue, along with anything she needs when she presses the call bell for a nurse. It gets better and then it gets worse. I have spoken to the Administrator, the DON and the Unit Manager. I just don't want anything to happen to her (resident). The staff can be rude. Usually it was the night shift (7 p.m. to 7 a.m.), but now it is spilling over into the day shift." She stated about two weeks ago, she called the Administrator and got his voice mail to tell him about the call bell issue. She stated when he did not return her call, she called back and spoke to the DON about the issue.

On 3/23/16 at 12:15 p.m., the local Ombudsman approached the survey team with a concern from Resident #19 and family about staff not responding to call bells and ignoring her and making her feel unsafe and unimportant. He stated the staff was aware of his involvement and investigation. He said, " I validated the complaint that was lodged on 8/17/15 about the resident's trouble getting staff to respond. Things get better and then another formal complaint about failure to respond. There has been another formal complaint from the resident dated 3/14/16 about the same thing. I have dealt with this issue repeatedly involving other residents, as well."

During an interview with the Administrator on 3/24/16 at 3:30 p.m., he stated he had a grievance from Resident #19 and family about a year ago regarding the nursing staff taking a long

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time to answer call bells, staff rudeness and concerns for the resident's safety. He stated the grievance was forwarded to the DON and Unit 4 manager. He indicated he was not aware of any further concerns from the resident or family. He was told about the resident's daughter not being able to reach him and leaving a voice mail message with no return call. He stated, "I will check on that and check with (DON's name)."

The Unit Manager was interviewed on 3/24/16 at 10:30 a.m. She stated she spoke with the resident and the daughter several times about the skin and not using the Chux pads, as well as the call bell issue. she stated they put the resident a Mybetriq to help with urgency and either decreased the Lasix or discontinued it. She stated a dermatologist saw the skin and triad was ordered and to keep area dry and they had Benadryl for itching from dermatitis/eczema. She stated, because of the nature of unit, it is her expectation that all call bells be answered between 3 to 5 minutes if not sooner. She stated any more than that is not acceptable. When asked if there was a staffing issue on her unit she said, "Yes there is when they take my specially trained staff from the this unit to disperse them all over the building when there are shortages. We do primary nursing in order to provide the special care these residents need. When they substitute a vent trained licensed nurse with a Certified Nursing Assistant (CNA), the care is compromised because they cannot recognize potentially serious situations during care that the trained nurse can."

The facility's Ventilator Unit's services include

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licensed nurses that provide primary nursing and have the ability to perform four components of critical thinking, knowledge, interpersonal and technical skills required to function in a specific position description as evidenced by completion of self-assessment, pre-clinical assessment ratings, education support recommendations and validation methods, as well as respiratory care competency skills that include care of residents with tracheostomies, and those that require mechanical ventilation. There is a Respiratory Therapist also assigned to this unit. The CNAs are only supportive and cannot provide the expertise care in light of a critical need.

An interview was conducted with the DON on 3/24/16 at approximately 5:00 p.m. She stated she was aware of Resident #19's and her daughter's concerns about rudeness, long call bell response times with the resident being wet an extended amount of time because of it. She stated they came to her recently a few weeks ago and stated the problem was getting better and now it was getting bad again. When asked if there was a staffing issue she stated, "When the bodies are in the building, everything is good and call bells should be answered by 3 minutes. On the days when there is no call out that's what I expect. It takes 2-3 months to get a position filled, get them in her, inserviced, oriented and working.

On 3/29/16 at 1:30 p.m., Resident #19's daughter called this surveyor and stated around 11:00 p.m., the resident messaged several family members via her electronic note pad and stated she had been calling the nurse for an hour for assistance on 3/28/16 at around 11:00 p.m., and said she

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had trouble breathing because too much water had collected in the blue O2 tubing. The daughter stated she called the Unit 4 nurse's station and could not get through to anyone. She said another family member got through approximately an hour later. She said, "This is what I am afraid of, what has my mother done to anyone. They say they provide the attention to these types of residents, but they don't."

On 3/29/16 at 1:45 p.m., Resident #19 was interviewed and corroborated everything her daughter relayed to this surveyor. She added, "When that water over collecting in the tubing, it makes you feel like you are going to pass out and I also had to use the bed pan. I wet on myself because I could not hold it that long. After my many phone calls to my family, one of them got through to someone at the nurse's station but it was an hour before I got the help I needed last night."

The Respiratory Therapist (RT) was interviewed on 3/29/16 at 2:15 p.m. He stated, "When a lot of water collects in the tubing, it prevents the flow rate of O2 and builds up a back pressure. That's why there are drainage bags on the blue tubing, but sometimes you have to manually drain the water in the tubing."

The bed activity call logs were reviewed for the month of March 2016. The logs validated too numerous to count instances where the staff response time was well beyond 3-5 minutes. The log recorded a call was placed from the resident's bed on 3/28/16 at 11:34 p.m. with no response

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F 224	Continued From page 16 until 58 minutes and 20 seconds later. On 3/29/16 at 3:00 p.m. the DON was informed of the incident and stated, "I had no idea about that and there is no excuse for it." The facility's policy and procedure titled 'Abuse-Freedom' from dated 1/13/15 indicated residents have the right to be free from verbal, sexual, physical and mental abuse; corporal punishment; and involuntary seclusion, mistreatment, NEGLECT and misappropriation of resident property. Neglect was defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.	F 224		
F 225 SS=D	COMPLAINT DEFICIENCY 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	F225 1. Resident #39 was re-assessed for risk of elopement on 4/20/16 and this alert and oriented x4 resident is not an elopement risk. He has been educated on risks associated with going off property without assistance. Investigation of the incident referenced in the survey report will be completed and submitted to the survey agency. Resident #1 is no longer at this facility.	

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F 225	Continued From page 17 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of the facility's policy, the facility staff failed to report to the State Agency (SA) and investigate unusual occurrences for 2 of 43 residents (Resident #39 and #1) in the survey sample. 1. The facility staff failed to report to the SA and investigate after Resident #39 was found approximately 0.4 miles away from the facility at a convenience store. 2. The facility staff failed to inform the State that Resident #1 drank a hazardous skin cleanser liquid (peri-wash) and was transported to the local	F 225	2. Will review 24 hour report and incident reports for the past two months for other reportable incidents that may not have been reported or investigated. If any incidents are identified, they will be thoroughly investigated and reported to the appropriate agencies including the survey agency. 3. Leadership staff will be in-serviced on investigation and reporting requirements of unusual occurrences, elopement and abuse/neglect by an external long term care consultant. In-service staff on responding to missing person, ingesting hazardous substance. In-service IDT and morning meeting managers on reportable incidents and focus on 24 hour report and incident reports for need to report.	

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F 225	Continued From page 18 ED (emergency room) for evaluation and treatment. The findings included: 1. Resident #39 was admitted to the nursing facility on 1/12/16. The resident was admitted to a local acute care hospital and readmitted to the facility on 2/29/16. Resident #39 diagnoses included hardening of the arteries, reflux disease, diabetes, and high cholesterol, swallowing difficulties, and narrowing of the esophagus. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/7/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #39 cognitive abilities for daily decision making were intact. The assessment states the resident is feeling down, depressed or hopeless 2-6 days over a 14 day period and has no behavior problems. The resident requires limited assistance of 1 with transfers and walking. He is coded as not steady moving from a seated position to standing, walking, turning around while walking, moving on and off the toilet and from surface to surface. The resident requires supervision only with bathing, limited assistance with personal hygiene and toileting but extensive assistance with dressing because of hand contractures and left hemiparesis. The elopement risk assessment dated 1/12/16 was completed with the resident only because no family accompanied him to the facility. The risk assessment indicated the resident was not an elopement risk.	F 225	4. QA/designee will perform weekly audits of 24 hours report x 6 weeks to identify unusual occurrences that may have needed investigation and/or reporting; the QA/designee will audit completed investigations to ensure that they have been completed, reported timely and responsive interventions implemented per the situation. QA/designee will report results of review of 24 hour report and audits to QAPI committee for additional oversight. QA/designee will conduct an unannounced unusual occurrence drill twice a month x 2 months to ensure staff recognizes need for investigation/reporting and that staff response is appropriate to the unusual occurrence. Analysis of the unusual occurrence drills will be completed; staff will be re-educated as needed and a summary of the drills will be submitted to QAPI for additional oversight and recommendation. 5. Completion: 5/13/16	

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A clinical note dated 1/13/16 at 6:10 p.m., stated the facility staff offered a wander guard bracelet (a device that sounds an alarm when a wandering resident walks outside the building) to Resident #39 even though the information provided by the resident indicated it was not necessary. The 1/13/16 clinical note further stated the staff explained the importance of the device to the resident but he declined use of the wander guard bracelet and promised not to leave or go out the door. A clinical note dated 1/15/16 at 11:35 a.m., stated the resident left the facility without notifying staff. He went to (name of the convenience store). Resident assessed by nurse, Registered Nurse and Director of Nursing (DON) and found to be alert and oriented x4. The resident was without injury. Resident agreed to use a wander guard. The wander guard was placed on his left ankle. Resident was instructed on the sign out policy and importance of staff being notified when he was going on leave of absence.

Another clinical note date 1/15/16 at 1:53 p.m., stated the resident walked to (name of the convenience store) stated he was going to the bank to cash his money. Resident returned to the facility alert oriented x4, knew what he did was wrong. Accepted to have wander guard placed for his safety. Son notified and made aware.

The care plan dated 3/16/16 stated the resident had a potential for injury related to wandering/elopement. 1/15/16 walked to (name of the convenience store) without notifying staff. On 2/29/16 the resident walked to the facility's entrance to look for his son. No further episodes of exit seeking behavior. Resident was told when his cardiac monitoring was completed his need

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for the wander guard would be reviewed. The care plan goal stated: Resident will have no injury and will not wander from unit or out the facility on a daily basis for 90 days. The care plan interventions were; Provide diversional activities. Approach calmly and attempt to redirect into appropriate areas of the facility. Wander guard per physician's order. Check for placement every shift and functioning every week. Monitor whereabouts at all times. Adapt environment as needed so resident can identify own room and belongings. Encourage activity attendance. Monitor for signs and symptoms of over tiring and encourage rest periods. Assess for need that may have initiated wandering. Attempt to anticipate needs as indicated. Have picture and accurate description readily available in case resident leaves the facility. Notify appropriate persons and initiate search. Notify physician and Responsible Party as needed.

On 3/28/16 at 6:00 p.m., the resident's elopement route was reviewed by the surveyor. Observation of the route revealed the resident walked a road with 2 lanes through a residential area where the speed limit was 25 miles per hour. Traffic was very heavy at the (name of the convenience store) and a busy 4 lane highway with 4 directions of traffic was 0.1 mile away. According to a weather site for the area, the high temperature on 1/15/16 was 59 degrees.

An interview was conducted with the Director of Nursing on 3/28/16 at approximately 4:15 p.m. The DON stated she was informed at approximately 7:00 a.m. on 1/15/16 by the Maintenance man that he saw Resident #39 at the (name of the convenience store). The DON stated she drove to the (name of the convenience

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store) talked with the resident, encouraged him to get in her vehicle and she returned him to the facility without incident or injury. The DON stated she did not complete an investigation or report the incident to the state agency because he had no physician order which stated he could not leave the facility at will. The DON was asked why did she go get the resident, have a wander guard bracelet applied to his left leg, have a new elopement assessment completed for the resident and an elopement care plan initiated if his leaving the facility was not considered an elopement. The DON again stated Resident #39 could leave at will because there was no physician order stating he could not.

A telephone interview was conducted with Licensed Practical Nurse (LPN) #199 on 3/29/16 at approximately 12:30 p.m. LPN #199 stated on 1/15/16, she observed Resident #39 in his room at approximately 7:00 a.m. and administered his medications to him at approximately 9:00 a.m. LPN #199 stated after breakfast the resident was observed sitting near the water fountain for a short while then he stated he was going to activities at approximately 10:00 a.m. LPN #199 stated that was the last time she saw the resident prior to a Certified Nursing Assistant (CNA) bringing the Resident to her and informing her the resident was just brought back from the (name of the convenience store). LPN #199 stated she assessed the resident and charted what she knew about the event in the clinical notes. LPN #199 stated she was not informed who saw the resident at the (name of the convenience store) or who brought him back to the facility. LPN #199 stated the DON and RN also assessed the resident and initiated use of a wander guard.

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An interview was conducted with CNA #200 on 3/29 16 at approximately 12:45 p.m. CNA #200 stated she was caring for Resident #39 on 1/15/16, the day of the elopement. CNA #200 stated the resident was unsteady when walking and required use of a cane because of weakness on one side. CNA #200 also stated most of the resident's hygienic care was provided by her. She stated the resident was dressed in pants, a shirt and a hoodie and she last saw the resident sitting in his room at approximately 10:30 a.m. CNA #200 stated at approximately 12:00 noon she was informed by LPN #199 that Resident #39 was seen at the (name of the convenience store) and brought back to the facility. CNA #200 said LPN #199 gave her no new instructions for caring for Resident #39.

An interview was conducted with the Palliative Care Nurse Practitioner (NP) on 3/29/16 at approximately 1:30 p.m. The NP stated the resident was enrolled in the Palliative Care program for symptom management on the same day he left the facility unescorted. The NP also stated based upon clinical judgement Resident #39 was not a candidate for a leave of absence with a responsible person accompanying him. The NP stated the Resident had been residing at the facility only 2 days, had cardiac concerns and an unsteady gait with left side weakness.

Another interview was conducted with the DON on 3/29/16 at approximately 2:45 p.m. After further questioning by the surveyor the DON stated she did not pick the resident up from the (name of the convenience store) a little after 7:00 a.m. on 1/15/16. The DON stated it was later in the day based on nurses' notes she had reviewed. The DON further stated she did not

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document the event.

The facility's policy and procedure entitled 'Adverse Events' with a revision date of 1/13/15 stated an Adverse Event is any event that has caused (or potential to cause) harm to staff, resident and/or Sentara Health Care. The policy further states examples of adverse events are elopement; occurs when a resident leaves the premises or safe area without authorization and/ or the necessary supervision to do so and under circumstances that place the Resident's health, safety, or welfare at risk. Under 'Investigation' the policy stated a thorough investigation of the event is conducted and documented by the Administrator and Director of Nursing.

The above information was shared with the Administrator, Director of Nursing and Corporate Representative on 3/29/16 at approximately 4:00 p.m. The facility staff did not offer any additional information prior to the survey team's exit.

2. The facility staff failed to inform the State that Resident #1 drank a hazardous skin cleanser liquid (peri-wash) and was transported to the local ED for evaluation and treatment.

Resident #1 was admitted to the nursing facility on 6/19/15 with diagnoses that included dementia, wandering behavior and insomnia.

The most recent Minimum Data Set (MDS) assessment was a quarterly dated 1/11/16 and coded Resident #1 with short and long term memory and moderately impaired in the skills needed for daily decision making. The resident was coded for wandering behavior that occurred daily. Resident #1 required supervision of one

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staff for walking in corridor, in room, on the unit and off the unit.

The care plan dated 1/20/16 identified Resident #1 had wandering behaviors, dementia with short and long term memory and poor safety awareness. The goal the staff set for the resident was that the resident would maintain current level of function without injury. Some of the approaches the staff would take to accomplish this goal included observe if resident is looking for something, identify anxiety triggers, assist resident, check locations, supervise resident to move about in and out of room and on the unit and redirect as needed.

Review of the nurse's notes dated 8/19/15 at 1:02 a.m. indicated the nurse (no longer employed by the facility) noticed the resident earlier with peri-spray in her hands in her room, which was removed and placed back in the night stand. It was recorded minutes later the same nurse saw the resident again with the spray in her hand, but this time 2/3 of the bottle liquid contents was missing and the bed and floor was dry. The roommate confirmed that she saw the resident ingest/drink the peri-wash. The nurse observed the resident spitting up thick frothy sputum, the on call nurse manager was called and instructions were given to send the resident out via 911.

An incident report was generated on 8/18/15 by the facility as an unknown injury of minor harm caused by altered sensorium behaviorally related. The event was described as noted in the aforementioned nurse's notes.

The facility's Material Safety Data Sheet sheet by the product manufacturer for the peri-wash

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F 225	Continued From page 25 identified ingestion could be hazardous due to presence of one of the ingredients, Benzethonium Chloride and known to have carcinogenic properties. The hospital Emergency Department (ED) progress notes dated 8/18/15 at 11:27 p.m. through 8/19/15 at 4:13 a.m. indicated the resident was administered several cups of water and monitored closely. Discharge orders included "keep all liquids except patient's drinks out of patient room at all times." It was determined the resident was out of danger and was discharged back to the nursing facility on 8/19/15 at 4:50 a.m. On 3/23/16 at 12:00 p.m. an interview was conducted with the Administrator and the Director of Nursing. They stated the event had not been reported to the State Survey and Certification agency, but based on their not knowing exactly what the outcome was going to be and that the resident ingested a hazardous substance, they should have reported it with a 5 day follow-up of the investigation. They stated an incident report was generated called a STARS ({Facility corporation name, Tracking Action and Reporting System) report. The facility's policy and procedure, Incident Reporting of, dated as revised on 1/13/15 indicated unusual and unknown incidents/injuries of unknown sources would be reported to the appropriate agencies within 24 hours.	F 225		
F 250 SS=E	COMPLAINT DEFICIENCY 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250	F250 1. Social worker is working with dentist office to schedule another appointment for resident #5. Resident # 28 and #21 are no longer in this facility.	

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F 250	Continued From page 26 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on the investigation of a complaint, family, resident, and staff interview and clinical record review it was determined for three residents (#s 5, 21 and 28) of 43 residents in the survey sample that facility staff failed to provide social services. 1. For Resident #5 staff failed to provide assistance in making a second dental appointment. 2. Resident #28 did not receive a social service visit per her request. 3. Facility staff failed to provide social services to meet Resident #21's needs. The Social Worker failed to follow up with Resident #21's request for discharge/transfer to another nursing home. The findings included: 1. Resident #5 was admitted to the facility on 11/20/15 from a local hospital. The resident was 54 years old at the time of the survey. His diagnoses included a pressure ulcer, atrial fibrillation, chronic and acute respiratory failure, colostomy, quadriplegia, chronic pain syndrome and malnutrition. This was the resident's second admission to the facility. The resident was ventilator dependent.	F 250	2. All residents will be surveyed to ascertain if they want to have a Social Service visit and if desired, a visit will be made and documented in the medical record. 100% of the current residents will be reviewed to see that consults have been scheduled as ordered; variances will be investigated and appointments will be scheduled per physician order. 3. Social worker will be in-serviced on documenting all contact with residents/families. If unable to fulfill requested service, will report to Administrator/DON. Social worker or other person as designated will be responsible for scheduling resident appointment as ordered. A calendar of appointments will be maintained on each clinical unit. The clinical nurse manager/designee will monitor the calendar to validate residents have kept appointments. MD and RP will be notified of resident's declination or delay of appointments. Appointments will be rescheduled per MD order/RP request.	

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F 250	Continued From page 27 Review of the resident's 11/27/15 admission MDS evidenced the resident was a 13 of 15 on the Brief Interview for Mental Status (BIMS). The resident required total assistance with all activities of daily living. The complaint alleged the resident was not given assistance in making a dental appointment. Review of the clinical record (nursing notes) evidenced that one appointment (12/23/15) with a dentist had been made but the resident refused to attend. No additional information was documented regarding a follow up appointment. . The Social Worker was interviewed on 3/24/16 at 10 am regarding the dental appointment. The SW stated that the resident complained of a hole in one of his teeth while in the hospital and the resident and his family were informed at the hospital that the situation could be handled when the resident was placed in a skilled facility. However, the information was not included in the hospital discharge information. Per the family member the hospital had done an x ray of the resident's tooth and recommended an extraction. A copy of a email dated 12/6/15 from the facility dentist to the administrator stated the dentist had spoken to the family member and the dentist had explained to the family member that services provided inside the facility would not met the resident's needs as they would be unable to extract the tooth and could only perform the same services as provided in the hospital. The dentist included in the email that an oral surgeon or hospital equipped to perform, "this kind of of extraction would have to handle because of the exposure of the procedure."	F 250	4. QA/designee will survey 10% of residents weekly for 4 weeks for need for social service consult or service. Audit will include review of medical record for documentation of resident need and social service response. Analysis of weekly audits will be reported to DON and Administrator and a summary of audit findings will be reported to the QAPI committee for additional oversight and continued frequency of audits. The clinical manager/designee will submit a report of ordered consults, scheduled/completed appointments to the DON monthly for analysis. A report of areas of non-compliance will be submitted to the QAPI committee for discussion and further recommendations. 5. Completion: 5/13/16	

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When the staff was made aware of the dental issue by the resident and the family member they began to make inquires into the community for dentists who could accommodate a ventilator resident. This would include room for a stretcher to enter the treatment area and room to transfer and staff to transfer the resident into a dental chair. The SW was not sure of the date when she became aware of the issue. The SW continued that the Administrator became involved in the arrangements as well. Because of the ventilator the ambulance company would need to send four attendants and two ambulances. The total cost for transportation alone was $1,200.00.

The resident's insurance would not cover the cost of transportation. After the resident refused to go on 12/23/15 the SW stated she was informed by the administrator that if the resident's family still desired a second appointment they would have to make the arrangements.

At 3:30 pm (3/24/16), the Administrator was interviewed and confirmed those were his instructions to the SW. He stated both he and the SW had really worked for over a month to put all the pieces into place and that any additional arrangements would have to made by the family. The administrator stated the family member had been provided the needed information to make arrangements.

The Unit Manager was also interviewed at 11:30 on 3/25/16 regarding the dental appointment. The UM stated both ambulances were at the facility and the resident was dressed and ready to go when he declined. The UM stated she had not heard the resident complain of tooth pain.

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The resident was interviewed on the afternoon of 3/25/16, he stated "not really" in response to a question regarding the tooth bothering him.
2. The facility staff failed to provide appropriate social services to meet Resident #21's needs. The Social Worker failed to follow-up with Resident #21 for a request for transfer/discharge to another nursing facility.

Resident #21 was admitted to the facility on 1/24/16 following a hospitalization for a surgical incision and drainage (I&D) with resection of a toe due to a diabetic foot ulcer related to osteomyelitis (a bone infection) on 1/19/16; with subsequent left foot skin graft on 3/15/16. The resident was admitted for IV (intravenous) antibiotics, wound care, physical and occupational therapy.

The admission MDS (Minimum Data Set) with an assessment reference date of 1/31/16 evidenced the resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section J. Health Conditions Pain Assessment Interview evidenced the resident had experienced occasional pain, with intensity of severe, that limited day-to-day activity. Section M. Skin Conditions evidenced the resident had a surgical wound to a foot and was receiving wound care to include dressings. Section O. Special Treatments, Procedures, and Programs coded the resident as receiving IV medications while a resident.

On 3/23/16 at 5:30 p.m., the resident was observed in a wheelchair sitting outside the room doorway. The resident requested to speak to an

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inspector. At this time an interview was conducted with the resident. The resident expressed concerns over the lack of care and services provided since admission. The resident stated the staff failed to provide wound care as ordered, failed to administer IV antibiotics as ordered, did not provide effective pain management for two days following admission and was not provided a shower for one month. She further stated her daughter had to take her to the emergency room for treatment of a persistent vaginal itch that was not effectively addressed by the facility. The resident stated her daughter had contacted APS (Adult Protective Services) to report the lack of care and concern for the resident's safety. The resident also stated she had spoken to the Social Worker and had requested to be transferred to another facility as she "feared for her safety" due to lack of care. The resident stated the Social Worker had not gotten back with any information regarding the transfer request made on 3/14/16.

Review of the clinical record failed to evidence any documentation by the Social Worker of the resident's safety concerns due to lack of care or the request for transfer.

On 3/23/216 at 7:40 p.m., an interview was conducted with the Social Worker (SW). She stated the resident had spoken to her about the aforementioned concerns i.e., missed IV antibiotic, wound care not being provided as ordered, and transfer request due to fear of her safety. She also stated the resident had expressed concerns of a staff member possibly pretending to be an APS worker. The SW stated she had discussed the resident's transfer and stated this would probably be difficult as the

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resident's insurance would probably not be accepted by most skilled facilities. The SW stated she sent out transfer referrals the following morning (3/15/15), and they had been denied that same day. The SW was asked if she had followed up with the resident about the denied transfer requests, and/or possible other options, she stated, "No". The SW provided copies of the denied transfer request faxed communication. The SW had sent out a transfer request to only two facilities on 3/15/16.
3. Facility staff failed to provide social services to meet resident's needs and solve grievances.

In the course of a complaint investigation Resident #28 was placed in the survey sample as a closed record as this resident is no longer at the facility. Resident #28 was admitted to the facility on 10/2/15 and chose to discharge home on 10/13/15. Diagnoses for Resident #28 included but not limited to CVA (Stroke), left side-weakness, atrial fibrillation, and obesity. Resident #28's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/09/2015 coded Resident #9 with a BIMS (Brief Interview Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #28 requiring extensive assistance with one person physical assistance for Activities of Daily Living, specifically toilet use (3 for extensive assistance defined as resident involved in activity, staff provide weight-bearing support and 2 for one person physical assist). Also Resident # 28 was coded as always continent of bowel and bladder.

On 3/24/16 at 9:50 am a call was placed to the complainant and it was discussed that Resident #28 had pulled the call bell when on the toilet and

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had waited for assistance for 40 minutes until Resident #28 placed a call to family using the cell phone to come help and as a result became very anxious and was unable to sleep.

A clinical note on 10/2/15 at 10:31 pm documented that Resident #28, "was continent of bowel and bladder, was able to stand and reposition, was encouraged to ring for assistance prior to standing with noted left side weakness to upper extremity and was alert and oriented x 4 (no cognitive impairment). In a clinical note on 10/3/15 7:59 pm it was noted, "Continent of bowel and bladder and asks for assistance when needed by using call bell-within reach and asked to have the door closed at night due to noisy hallway/neighbors TV volume." Little is recorded on the clinical nursing notes until 10/11/15 at 7:00 pm where Resident #28 "requested to be D/C (discharged), informed no social worker available at this time and asked how can I help you be more comfortable? Stated, "I just want to go home", much 1:1 given. Family visited." The social worker wrote one note regarding the admission and the discharge on the same day 10/13/15 the actual discharge date at 5:43 pm.

In an interview on 3/24/16 at 12:25 pm with Administration #1 , the staff responsible for keeping a grievance log, it was stated and noted that "no formal grievance was placed in regards to Resident #28. If a family member made a grievance to a unit manager I would expect that manager to report this to me immediately. That did not happen with Resident #28, there should have been a follow-up to the resident's and family grievance."

Also in this interview on 3/24/16 at 12:25 pm with

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F 250	Continued From page 33 Administration #1, the staff responsible for hiring a new social worker, it was discussed that it took the facility six months (from October 2015 to March 2016) to hire another social worker. It was noted that the director of social services had moved on from the facility in October 2015 and the other facility social worker was offered the job but it took two months (until December) before the current social worker became the Social Services Director. The process of hiring an additional social worker began in December 2015. A second social worker was finally hired and was in orientation/training on the day of the current survey 3/22/16. One social worker for the census of 173 residents for six months could not cover all the needs. Resident #28 had to call a family member to come assist while on the toilet waiting for 42 minutes for staff to respond to the call bell resulting in anxiety, lack of sleep, and a decrease in using the call bell. This grievance was not followed nor resolved and as a result Resident #28 made the decision to discharge from the building.	F 250		
F 278 SS=D	Complaint Deficiency 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	F278 1. MDS will be modified to reflect correct wound staging for Resident #9. The modification will be completed and submitted by 5/13/16. 2. MDS assessments of current residents with pressure ulcers will be reviewed to determine if the MDS assessment was accurately coded; variances will be investigated and corrections/modifications will be made in the MDS per RAI guidelines.	

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F 278	Continued From page 34 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review facility staff failed to update the Minimum Data Set (MDS) to reflect a stage III wound for one of 43 Residents in the survey sample, Resident #9. Resident #9 was admitted to the facility on 5/10/2005. Diagnoses for Resident #9 included but not limited to Stage III pressure ulcer, trochanteric fracture (closed fracture at the neck of the femur), anemia, and Dementia. Resident #9's Minimum Data Set (an assessment protocol) with an Assessment Reference Date (ARD) of 09/07/2015 coded Resident #9 with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded	F 278	3. Educate and assign a staff member to complete weekly wound rounds with physician and document in Vision. Educate licensed staff on wound measurement, staging and documentation. In-service MDS on pressure ulcer staging and definition. Educate licensed staff and unit secretaries on need to place wound physician notes immediately in Medical Record. 4. QA/designee will audit 10% of completed MDS Section M for wound documentation accuracy weekly x 6 weeks. Variances will be investigated and corrections made as appropriate. Analysis of audit will be reported to DON, Administrator and summary of audit findings will be reported to QAPI committee for additional oversight and continued frequency of audits. 5. Completion: 5/13/16	

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Resident #9 requiring total dependence on staff for Activities of Daily Living. Resident #9's Minimum Set (an assessment protocol) with an Assessment Reference Date of 09/07/2015 Section M: Skin Conditions coded Resident #9 at risk of developing pressure ulcers with no current ulcers present.

According to the Centers of Medicaid and Medicare Resident Assessment Indicator Version 3.0 Manual which drives the skin assessment in section M0700: stage II pressure ulcers by definition have "partial-thickness loss of dermis." Granulation tissue, slough or eschar are not present in stage II pressure ulcers. Therefore, stage II pressure ulcers should not be coded as having granulation, slough, or eschar tissue.

The National Pressure Ulcer Advisory Panel redefined the definition of a pressure ulcer and the stages of pressure ulcers in 2007 to include but not limited to the definition of a stage II pressure ulcer: "partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open /ruptured serum filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates deep tissue injury). This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation."

According to the National Pressure Ulcer Advisory Panel the definition of a stage III pressure ulcer is "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not

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obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer may varies by anatomical location.

According to Minimum Data Set (MDS) Version 3.0 the term granulation tissue is defined as pink or red tissue with shiny, moist, granular appearance and slough is yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

According to the facility documentation Pressure Ulcer Monitoring sheet for the month of March 2016, Resident #9 was identified with an acquired stage III pressure ulcer to the right heel on 2/16/16 and the treatment was calcium alginate and santyl QD (every day), Prevalon boots. The description on the Pressure Ulcer Monitoring sheet measured Resident #9's pressure ulcer on 3/18/16 as 3.2 x 1.5 x 0.2 cm with 10 % necrotic and 90 % granulation. According to the MDS Version 3.0, necrotic tissue or eschar is a black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin. Stage IV pressure ulcers are defined as full thickness tissue loss with exposed bone, tendon, or muscle. Slough or escahar may be present on some parts of the wound bed. Often includes undermining and tunneling. Resident #9's pressure ulcer on the right heel was identified at an advanced stage III.

The wound doctor (others #2) report dated 2/19/16, Resident #9 was seen at the request of primary doctor for evaluation. The wound care specialist initial evaluation on 2/19/16 reads, "Resident #9 presents with a stage III pressure wound of the right heel of at least one days

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F 278	Continued From page 37 duration. There is sero-sanguinous exudate." The wound specialists doctor (others #2) measured the wound 2.4 x 1.5 x 0.2 cm (length x width x depth) with 3.60 centimeters squared for the surface area with moderate sero-sanguinous, yellow necrotic 15 % and granulation tissue at 85 %. The recommendation reads, "off-load wound, reposition per facility protocol and dressing: Calcium Alginate-once daily." According to the MDS coordinator RN #4 in an interview on 3/23/16 at 5:25 pm regarding the identification of a pressure ulcer a new Braden (formal assessment) scale should be completed, a new MDS with a significant change should reflect a stage III, if a new treatment is ordered-all of this should go immediately onto the care plan...we don't wait until the next meeting. According to RN #4 according to the definitions of the stages found in the MDS manual Resident #9 had a stage III pressure ulcer to the right heel not a stage II. On 3/24/16 at 1:40 pm it was stated by RN #4, "I will modify the MDS now to reflect a stage III...I learned something: there is no slough or granulation tissue nor eschar in a stage II pressure ulcer." On 3/23/16 at 2:00 pm the submitted correction were made to reflect a significant change MDS created 3/24/16 and the corrected quarterly assessment was submitted to reflect the corrected stage III pressure ulcer for Resident #9 based on the identification description in the clinical record on 2/17/2016 and the definitions found in the RAI manual. It was also noted by RN #4 Braden scales were not completed for Resident #9 for the past 6 months.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280 1. Resident #10's care plan was reviewed on 4/20/16 and addresses current skin conditions, treatment and interventions to minimize recurrence. Resident #11's care plan was reviewed on 4/20/16; the plan of care addresses current skin concerns and risks related to contractures. Resident #18's care plan was reviewed on 4/20/16; the plan of care addresses the resident's current skin concerns, treatments and interventions to minimize recurrence or development of new wounds.	

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F 280	Continued From page 38 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, facility documentation, and staff interviews the facility staff failed to ensure that the interdisciplinary care plans were reviewed and revised as the medical status changed for 3 of 43 Residents in the survey sample, Resident #10, Resident #11, and Resident #18. 1. The facility staff failed to revise Resident #10's care plan to include a Stage 3 Right Ankle Pressure Ulcer that was identified on 9/25/15. 2. The facility staff failed to care plan Resident #11's hand contracture to prevent the development of a pressure ulcer and once the	F 280	2. Current residents will be reviewed to ensure that pressure ulcer risk assessments are current and that the residents' plan of care addresses interventions to prevent the development of pressure ulcers or includes interventions to treat current pressure ulcers. 3. In-service licensed staff to care planning process in Vision. New and/or declining pressure ulcers will be reported on the 24-hour report. New wounds and status changes will be discussed weekly in SOC [Standard of Care meeting] and care plan reviewed for updates. In-service licensed staff on the importance of completion of weekly skin assessments. 4. QA/designee will audit 25% of care plans of residents with wounds for accuracy weekly x 6 weeks. Analysis of audits will be reported to DON, Administrator and summary of audit findings will be reported to QAPI committee for additional oversight and continued frequency of audits. 5. Completion: 5/13/16	

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area healed failed to update the care plan to prevent a reoccurrence.

3. The facility staff failed to revise the care plan for Resident #18's Stage 3 Pressure Ulcer on right heel.

The findings include:

1. Resident #10 was a 81 year old admitted to the facility initially on 12/2/12 and readmitted on 12/31/14. Resident #10's diagnoses included *Stage III Pressure Ulcer, *Diabetes Mellitus, *Gastrostomy Tube, *Contractures, and *Dementia.

*Stage III Pressure Ulcer: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Definition derived from the Minimum Data Set (MDS) Assessment-Version 3.0

*Diabetes Mellitus: a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.

*Gastrostomy Tube (G-Tube): surgical creation of an artificial opening into the stomach through the abdominal wall to prevent malnutrition.

*Contractures: an abnormal, usually permanent condition of a joint, characterized by flexion and fixation.

*Dementia: a progressive organic mental

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disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

The most recent Minimum Data Set (MDS) assessment was a Quarterly assessment with an Assessment Reference Date (ARD) of 2/16/16 with a Brief Interview for Mental Status (BIMS) indicating that the resident is rarely or never understood. Resident #10 was also coded to have long and short term memory problems and is severely impaired in cognitive skills for daily decision making. Under functional status Resident #10 is totally dependent with one person physical assist for bed mobility, dressing, eating, bathing and personal hygiene. Under functional limitation in range of motion the resident is coded having upper and lower extremity impairment. Under skin conditions Resident #10 is coded as follows: Number of Stage 2 pressure ulcers=1, Number of these Stage 2 pressure ulcers that were present upon admission/reentry=0, Date of oldest Stage 2 pressure area=2/16/16, Number of Stage 3 pressure ulcers=1, Number of these Stage 3 pressure ulcers that were present upon admission/reentry=0, Dimensions of Unhealed Stage 3 Pressure Ulcer=1.5 cm (centimeters) pressure ulcer length X 2.0 cm pressure ulcer width X 0.2 cm pressure ulcer depth, Most severe tissue type for any pressure ulcer=4 Eschar-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin. Under

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skin and ulcer treatments the following interventions are codes: pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration, pressure ulcer care, application of nonsurgical dressings, and application of ointments/medications.

Resident #10's Comprehensive Care Plans were reviewed in the following sequence: Annual 9/3/15-12/3/15, Quarterly 12/3/15-2/25/16, and Current Quarterly 2/25/16-present.

The Annual Care Plan dated 9/3/15-12/3/15 documented in part:

Problems: Resident #10 at risk of pressure ulcer.
Goals: Resident #10 will remain free of skin breakdown over the next 90 days.
Interventions: Check for redness, skin tears, swelling,or pressure areas. Report any signs of skin breakdown.

There was no entry indicating that Resident #10 had developed a Stage III pressure ulcer on 9/25/15, and no documentation of any interventions or treatments that had been started.

The Quarterly Care Plan dated 12/3/15-2/25/16 documented in part:

Problems: Resident #10 at risk of pressure ulcer.
Goals: Resident #10 will remain free of skin breakdown over the next 90 days.
Interventions: Check for redness, skin tears, swelling,or pressure areas. Report any signs of skin breakdown.

There was no entry indicating that Resident #10 had developed a Stage III pressure ulcer on

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9/25/15, and no documentation of any interventions or treatments that had been started.

The Current Quarterly Care Plan dated 2/25/16-Present documented in part, read as:

Problems: Resident #10 is at risk for further pressure ulcers and other non pressure skin breakdown related to incontinence, immobility, contractures.
Goals: Resident #10 will remain free of skin breakdown over the next 90 days.
Interventions: Check for redness, skin tears, swelling,or pressure areas. Report any signs of skin breakdown. Treatments per MD (doctor) orders.

Problems: Stage 3 pressure ulcer right ankle. Stage 2 pressure ulcer right upper medical foot.
Goals: The size of ulcer will decrease with evidence of healing over the next 90 days.
Interventions: Assess and record the size (Length X Width X Depth), amount and characteristics of exudates, and pain status. Perform complete skin assessment and record. Provide care according to the protocol for Stage 3 and Stage 2 Pressure Ulcers. Off loading boots at all times. Float heels intermittently when in bed.

Resident #10's Physician Order Sheet for October 2015 initialed and signed on 10/6/15 was reviewed. The following dated orders documented in part:

1/5/15- Off loading boots at all times.
4/29/15- High Risk for Skin Breakdown/Pressure Ulcer Prevention Protocol.
4/29/15- Float heels intermittently when in bed.

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9/25/15- Left Great Toe and Left Plantar foot wounds: Poly Mem dressing every 2-3 days until healed.
9/25/15- Right Ankle wound: Cleanse daily with wound cleanser. Apply Santyl/Alginate to wound daily. Cover with dressing daily and PRN (as needed).
12/31/15- Weekly Skin Assessments with vitals.

Resident #10's Wound Care Specialist Evaluations which were completed weekly by the Wound Care Physician were reviewed. The Wound Care Specialist Evaluations documented in part:

Physical Exam

9/11/15: Stage 2 Pressure Wound of the Left, First Toe, Etiology: Pressure, Dressing: Foam-Every Three Days and PRN, Recommendation: Off-Load Wound, Reposition per facility protocol.

9/18/15: Stage 2 Pressure Wound of the Left, First Toe, Etiology: Pressure, Dressing: Foam-Every Three Days and PRN, Recommendation: Off-Load Wound, Reposition per facility protocol.

9/25/15: Stage 2 Pressure Wound of the Left, First Toe, Etiology: Pressure, Dressing: Foam-Every Three Days and PRN, Recommendation: Off-Load Wound, Reposition per facility protocol.

Stage 2 Pressure Wound of the Left, Plantar Foot, Etiology: Pressure, Dressing: PolyMem and Foam every three days, Recommendation: Off-Load Wound, Reposition per facility protocol.

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Stage 3 Pressure Wound of the Right Ankle, Etiology: Pressure, Wound Size: 1.2 cm x 1.4 cm x 0.2 cm (centimeters), Thick Adherent Black Necrotic (Eschar): 10%, Yellow Necrotic: 10%, Granulation Tissue: 80%, Dressing: Santyl- Once daily, Recommendation: Off-Load Wound, Reposition per facility protocol.

The Wound Care Physician's weekly Wound Care Specialist Evaluations were available and complete, the last evaluation available was on 3/18/16 which documented in part:

Stage 3 Pressure Wound of the Right Ankle, Etiology: Pressure, Duration greater than 166 days, Wound Size: 0.6 cm. x 0.8 cm. x 0.2 cm., Yellow Necrotic: 5%, Granulation: 95%, Dressing: Santyl- Once daily, Recommendation: Off-Load Wound, Reposition per facility protocol.

On 3/24/16 at 2:00 p.m. an interview was conducted with MDS Coordinator RN #1. The MDS Coordinator RN #1 was asked, "Do the floor nurses update the resident care plans when there has been a change of condition with a resident?" The MDS Coordinator RN #1 stated, "No, we do it when we do the MDS or when we know something has changed with the resident." The surveyor asked, "How do you find out when there has been a change in the resident's care?" The MDS Coordinator RN #1 stated, "We check the 24 hour report in the morning meeting, but stuff is not getting on the report, and nurses are being let go. Also the Unit Managers are not coming to the morning meeting, we have told the Director of Nursing and the Administrator many times but it hasn't gotten any better." During the interview, the MDS Coordinator RN #1 was asked why

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Resident #10's care plans were not updated on 9/25/15 when the Stage 3 right ankle pressure ulcer was identified. The MDS Coordinator RN #1 stated, "I didn't realize it hadn't been done." The surveyor asked, "When should Resident #10's care plan been updated to address the Stage 3 right ankle pressure ulcer?" The MDS Coordinator RN #1 stated, "Treatments and new care goes on the care plan right away at least by the next day."

Facility policy titled "Care Planning" revised 2/10/15 documented in part, read as:

Purpose: Establish, periodic review maintenance of current plan of care for each resident following guideline through established and periodic review.

Procedure:
4. The MDS Coordinator/Designee is responsible for care plan coordination. The coordinator's responsibilities are: *Collect care plan codes for new care plans at the meetings. *Manually update existing care plans at the meeting. *Generate new care plans and place on charts no later than Friday of the week after the resident's care plan review.
6. For quarterly reviews, each problem will be addressed by the team, and the coordinator will yellow-out and date resolved problems, and/or revise goals and approaches on the care plan.
7. New or revised goals, approaches and dates will be written by hand on the care plan.

The facility policy titled "Physician Approved Pressure Ulcer-Prevention Orders/Protocol" not dated , documented in part, read as:

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All Residents

8. Develop patient-specific written care plan for pressure ulcer prevention.

On 3/24/16 at approximately 4:40 p.m. a pre-exit conference was held with the Administrator, the Director of Nursing, and the Quality Management Nurse Consultant and the above findings were shared. The Director of Nursing was asked, "When would you have expected Resident #10's care plan to have been updated." The Director of Nursing stated, "Right away, when the first pressure ulcer was identified. It was a change in the resident."

Prior to exit no further information was shared by the facility.

2. Resident #11 was not care planned to prevent a pressure ulcer from developing in a recognized contracture and after development of a pressure ulcer at the site, her care plan was not revised to prevent further skin breakdown.

Resident #11 was admitted to the facility on 7/1/13 with a readmission note of 1/26/16. At the time of the survey the resident was 86 years old. The resident's diagnoses included vascular dementia, diabetes, depression, high blood pressure, psychosis, encepalopathy, and thrompocytopenia.

The resident's 1/6/16 quarterly Minimum Data Set (MDS) described the resident as being at risk for the development of pressure areas.

The resident's 2/01/16 significant change MDS evidenced the resident was not understood and did not understand others, with severe long and

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short term memory loss. Resident #11 required assistance with all activities of daily living.

Under the 2/1/16 MDS skin condition (Section M) evidenced the resident had one or more unhealed pressure areas. The stage was identified as unstageable. The measurements were 1.2 centimeters (cm) X 1.1 cm with a depth of 0.3 cm. The MDS defines "unstageable" as a wound that due to the presence of eschar or slough the wound bed is not visible.

The MDS defines a Stage IV as, "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling." The MDS identifies eschar as, brown, black, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin."

Further review of the clinical record (EMR) evidenced the area was found on 1/9/16 and healed on 3/16/16.

The nursing note on 1/9/16 evidenced, "nurse went to clean inside or (sic) resident left contracted hand when she noted resident hand to have a pressure ulcer to the inside of her left index finger where the thumb presses on. ..the area is open with 100% granulation and measures 2.0 cm X 2.0 cm X 0.2 cm. Resident does complain of pain to the hand." MD notified.

The MDS manual instructs that granulating tissue (pink or red tissue with shiny, moist, granular appearance) is not present in a Stage II, as granulating tissue represents a full thickness of skin (dermis) loss to underlying tissue. The MDS

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identifies full thickness tissue loss as a Stage III.

On 1/21/16 the resident was sent to the hospital with pneumonia and returned on 1/27/16. On 1/31/16 the resident was referred to the wound physician who identified the left finger as a Stage IV.

On 2/23/16 at 3:00 p.m. RN #6 was interviewed. RN #6 stated the resident's Stage IV on the left index finger was healed. The area had been caused by the resident's thumb overlapping the index finger causing pressure. The RN was requested to describe the area when found. She stated that "white" was visible when the wound was discovered and identified it as tendon. RN #6 stated the left ring finger also digs into the resident's palm, it is now "red" and a 4 x 4 gauze was placed in between the thumb/index finger and between the ring finger and palm. RN #6 stated the resident would remove a hand roll from her hand.

On 3/23/16 at 4:55 p.m., LPN #8 accompanied the surveyor into Resident #11's room to observe her hand. The LPN stated she had been pulled from another unit so she was not familiar with the resident. The LPN was unable to separate the thumb from the finger as the resident was pulling away, the LPN stopped. There was a gauze between the ring finger and palm but nothing between the thumb and finger.

On 3/24/16 (12:05 pm) the resident was observed in bed, there was no gauze in the resident's hand.

On 3/24/16 (1:30 pm) two surveyors observed the resident's hand. LPN #9 accompanied the surveyors. LPN #9 stated she was the one who

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	495173	A. BUILDING _____ B. WING _____	C 03/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

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had first discovered the pressure area. LPN #9 stated the tendon was clearly visible. When asked how they had healed the wound since the resident's thumb still curled over the index finger. LPN #9 stated we used "Allevyn" a brand name for a padded dressing that has adhesive around the edges. LPN #9 stated the resident did sometimes remove the Allevyn but for the most part left it in place.
But, she (the nurse) had been informed that the Allevyn was too expensive to be used as a preventive measure. The LPN commented that the area was likely to breakdown again. "RN #6 and I have done some brain storming." The resident's thumb and index finger were noted to be misshapen. The thumb was flattened and the index finger had a depressed area from constant pressure/contact with the thumb. The LPN was able to separate the thumb and finger by 3/4 to an inch. The resident immediately clenched them back together when the nurse released the digits. The LPN stated as far as she was aware there was not an Occupation Therapy referral for a possible positioner.

Review of the Treatment Administration Record evidenced the Alleyn was started 1/9/16, and changed every day. The treatment continued but on 1/29/16 kerlix (gauze bandage) was added to be wrapped around the dressing and hand.

The resident's care plan in place from 10/21/15 to 2/10/16 was reviewed for interventions for the prevention of pressure areas.

The care plan evidenced, "Actual contracture of in left hand...." The goal was the resident will not develop further contractures and will have pain management through 90 days. The interventions

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were to administer medications, monitor for side effects and effectiveness of medications, range of motion to resident's tolerance, frequent position changes and encourage resident to exercise.

The residents current care plan was also reviewed and had not been changed from the above. This was discussed with RN #6, on 3/25/16 at approximately 3: 30 pm. RN #6 stated that they are now using a hand roll and Allevyn on the resident's hand. RN#6 stated that the hand roll was found in the resident's closet and that it had been used at one time. RN #6 reviewed the care plan and stated it was not addressing the resident's need for pressure reduction to the left thumb and finger. RN #6 stated the intervention of range of motion was not appropriate as the resident's left hand could not be separated enough and it would be too painful for the resident, "you can't get her hand open to do that."

The resident was observed on 3/28/16 10:40 am and 3/29/16 approximately 3 pm with the Allevyn between thumb and finger and a hand roll in her palm.

3. Resident #18 was originally admitted to the facility on 10/9/15 with re-admitted on 2/16/16 after a hospitalization. Current diagnoses for Resident #18 included but not limited to Stage III pressure ulcer on the right foot and quadriplegia (accidental discharge from firearms) and fracture to the sixth and seventh cervical vertebra.

Resident #18's initial Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/7/15 coded Resident #18 with a BIMS (Brief Interview Mental

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Status) at a 12 indicated minimum impairment of cognition. In addition, the Minimum Data Set coded Resident #18 requiring total dependence on staff for Activities of Daily Living.

Resident #18 was re-admitted to the facility on 2/16/2016 and according to the clinical admission note had a stage II pressure ulcer to the sacrum and a stage I on the bilateral heels. According to the MDS-Version 3.0 manual a stage 1 pressure ulcer is described: "intact skin with non-blanchable redness of a localized area over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues."

During the course of the rectification/complaint survey on 3/25/16 at 5:45 pm two surveyors(#1 and #3) were approached by Resident #18 and a family member with some concerns. Resident #18 stated, "I do not refuse care for my pressure ulcer treatment and it seems that people are saying I refuse care...the only thing I refuse is a Heparin injection in the same location because its painful." In the course of following-up with Resident #18's concerns it was identified that Resident #18, per clinical notes, had only refused Heparin injection on occasion and asked staff to rotate the site.

According to the TAR (Treatment Administration Record) for the month of February and March 2016 all treatments to the right heel for the stage I pressure ulcer and all treatments for the stage II sacral wound were completed as ordered from the re-admission date on 2/16/16 to current survey date 3/25/16. However, the weekly skin assessments were found to be missing, the

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Braden scale inaccurately reflected Resident #18's conditions.

The care plan was not updated to reflect the identification of progressed stage III right heel wound. The care plan dated 2/4/16 to present identified Resident #18 at risk for further pressure ulcer and skin breakdown also it reads sensation is to the chest only and is totally dependent on staff for activities of daily living (bathing, turning and repositioning). The care plan does not include an update of the stage II sacral wound or the stage III right heel wound.

In an interview with RN # 4 on 3/29/16 at 10:35 am Resident #18 transferred from one unit to another unit at the facility on 3/19/16. While Resident was on (name of unit) RN #4 stated, "I searched for two hours and I could not find any information on the wounds while Resident (#18) was on (name of unit), only the admission assessment from the hospital was available which indicated a stage one to both heels." No weekly skin assessments were completed as ordered by the physician from 2/16/16 until 3/19/16 when Resident #18 moved to (name of unit). Weekly skin assessments were checked off but the facility could not produce the documentation to support the completion of the weekly skin assessments. In a interview with the DON (Administration #2) on 3/28/16 at 5:45 pm, I would at least expect a body check assessment when a resident transfers from a different unit."

The Braden Scale (a tool to predict pressure sore risk) submitted by the facility scored Resident #18 with a 16 on 3/20/15. According to the Pressure

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Ulcer Prevention Policy (revision 11/12/2013) the Braden Score Risk : High Risk = a score of 12 or less, Moderate Risk = a score of 13 to 14 and Low Risk = 15 to 18. On the Braden Scale on 3/20/16 (the only one submitted for Resident #18) under the section entitled Sensory Perception: Ability to respond to meaningfully to pressure-related discomfort, has sensory impairment which limits the ability to feel pain or discomfort over half of the body...this section was coded with no impairment for a Resident #18 with a diagnoses of quadriplegia.

In an interview with Resident #18 during pressure ulcer treatment observation on 3/29/16 at 11:45 am two surveyors (#1 and #2) observed Resident #18 have no reaction to the treatment of a stage III pressure ulcer to the right heel. Resident #18 stated, "only sometimes it burns but I can not feel anything on my feet and I did not know my heel was so bad."

According to the wound treatment LPN (LPN #1) on Unit II, the treatment order for the wound on the right heel started on 3/13/16. According to the Physician's Orders Resident #18's treatment was Mepliex to right heel one time daily starting 3/13/16 discontinued on 3/19/16. On 3/19/16 the order reads, "Cleanse wound with normal saline, apply santyl (debridement) and cover with foam dressing daily starting 3/19/16 and discontinued on 3/15/16. The wound specialist made a visit to the facility on 3/25/16 and documented in the wound care specialist evaluation that Resident #18's right heel was a stage III with the size 2.5 x 3.7 x 0.2 cm (length x width x depth) and was described as moderate sero-sanguinous with eschar 20% and granulation tissue 80% with the treatment order of Calcium Alginate-once daily

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F 280	Continued From page 54 and Santyl-once daily. The treatment change on 3/13/16 indicated a change in the wound but there is no documentation regarding a description of the wound on 3/13/16. The right heel was not mentioned in any note or documentation from 2/17/16 to 3/19/16. The only clinical documentation made regarding the description of the wound that went from a stage I to a stage III was made on 3/19/16 which noted, "right heel wound measures 2.5 x 2.2 x x .03. Beefy red around the edges with small amount of slough in the center. Spoke with physician new orders given: Cleanse right heel wound with normal saline. Apply Santyl and cover with foam dressing daily. Have wound specialist assess next time in the facility." The care plan dated 2/4/16 to present identified Resident #18 at risk for further pressure ulcer and skin breakdown. It also states sensation is to the chest only and is totally dependent on staff for activities of daily living (bathing, turning and repositioning). The care plan does not include an update of the stage II sacral wound or the stage III right heel wound. According to the MDS coordinator RN #4 in an interview on 3/23/16 at 5:25 pm regarding the identification of a pressure ulcer a new Braden (formal assessment) scale should be completed, a new MDS with a significant change should reflect a stage III, if a new treatment is ordered-all of this should go immediately onto the care plan...we don't wait until the next meeting.	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=G	Continued From page 55 HIGHEST WELL BEING	F 309	F309	

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observations, resident interview, staff interviews, clinical record reviews, facility document reviews and during the course of complaint investigations the facility staff failed to provide the necessary care and services to promote and maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, for 11 residents out of 43 residents in the survey sample, Residents #21, #41, #32, #21, #20, #29, #33, #34, #31, #30 and #9.

1. The facility staff failed to provide effective pain management for Resident #21 resulting in harm. In addition for Resident #21, the facility staff failed to provide IV (intravenous) antibiotics and post surgical wound care as ordered by the physician, and failed to obtain effective treatment for a vaginal yeast infection.

2. The facility staff failed to provide surgical wound care and administer IV antibiotics as ordered by the physician for Resident #41.

1. Resident #21 has been discharged from facility.

While there is missing documentation on the MAR for 3/24/16 and 3/25/16 for the administration of the IV antibiotic for Resident #41; there is documentation in the nurses notes for each of those days that resident was administered the IV antibiotic.

The treatment order for Resident #41 wound to his foot was changed by the physician on 3/24/16 to be done every 7 days instead of every 2 days. On 3/28/16, wound care was once again changed to every other day. The lack of documentation for wound care to the foot on 3/25/16 and 3/27/16 was in compliance with physician orders.

Resident #32 experienced no hypoglycemia events related to the blood sugar not being done at 4:30 pm. The 9:00 pm blood sugar was 197 requiring no sliding scale coverage. The physician has been notified that the FSBS was not obtained at 4:30 pm on 3/24/16.

Resident #21 has been discharged from the facility.

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F 309	Continued From page 56 3. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals at 4:30 p.m. with sliding scale insulin for Resident #32. 4. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and 5:00 p.m. medications (*Coreg and *Psysillium) for Resident #21. 5. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and administer routine insulin at 5:00 p.m., for Resident #20. 6. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals and routine medications (*Renvela/Sevelamer Carbonate F/C 800 mg (3 tabs), both scheduled at 5:00 p.m., for Resident #29. 7. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals and administer routine insulins for Resident #33, as well as administer other oral medication due at 5:00 p.m. 8. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals at 4:30 p.m. and administer routine insulin, also due at 4:30 p.m., for Resident #34.	F 309	A medication error report has been completed for Resident #20 for omission of Humalog and FSBS on 3/24/16. The physician has been notified. The nurse, who failed to administer the Humalog insulin and do the FSBS as ordered, has been counseled regarding following physician orders for timely administration of medications and physician notification of medications and FSBS not being done as ordered. The blood sugar for Resident #29 was checked at 8:23 pm at which time it was123 requiring no sliding scale insulin. The physician has been notified of the omitted FSBS and Renvela. The nurse, who failed to administer the Renvela and do the FSBS as ordered, has been counseled regarding following physician orders for timely administration of medications and physician notification of medications and FSBS not being done as ordered. A medication error report has been completed.	

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F 309	Continued From page 57 9. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals, as well as administer other oral medication due at 5:00 p.m. for Resident #31. 10. The facility staff failed to obtain Resident #30's Accucheck at 4:30 p.m. per physician's orders. The blood sugar history records indicated the staff obtained the blood sugar at 6:05 p.m., but recorded a reading of 324 on 3/24/16 in the 4:30 p.m. box on the Medication Administration Record (MAR). In addition, the 4:30 p.m. scheduled Humalog 2 units before meals was not administered until 6:05 p.m., after the resident consumed the evening meal. 11. The facility staff failed to provide pain management for Resident #9 when the resident was identified as exhibiting pain during a treatment. The findings include: 1. The facility staff failed to provide effective pain management for Resident #21's acute pain, resulting in harm. Resident #21 was admitted to the facility at 8:00 p.m., Sunday 1/24/16 following a hospitalization for surgical incision and drainage (I&D) with resection of a toe due to a diabetic foot ulcer related to osteomyelitis (a bone infection) on 1/19/16, with subsequent left foot skin graft on 3/15/16. The resident was admitted for IV (intravenous) antibiotics, wound care, physical	F 309	Resident #33 experienced no signs or symptoms of hyperglycemia related to missed FSBS and omission of diabetic medications. An incident report was completed. Resident experienced no adverse effect for omission of fish oil and Tylenol. Physician has been notified of the omission of FSBS and medications at 4:30 pm and 5:00 pm on 3/24/16. The nurse, who failed to administer the medication and do the FSBS as ordered, has been counseled regarding following physician orders for timely administration of medications and physician notification of medications and FSBS not being done as ordered. Resident #34 exhibited no systems of hyperglycemia. The physician has been notified that the Humalog was administered 2 hours 43 minutes late on 3/24/16. The nurse, who failed to administer the Humalog insulin and do the FSBS as ordered, has been counseled regarding following physician orders for timely administration of medications and physician notification of medications and FSBS not being done as ordered.	

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F 309	Continued From page 58 and occupational therapy. The admission MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 1/31/16 evidenced the resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section J. Health C Pain Assessment Interview evidenced the resident had experienced occasional pain, with intensity of severe, that limited day-to-day activity. Section M. Skin Conditions evidenced the resident had a surgical wound to a foot and was receiving wound care to include dressings. Section O. Special Treatments, Procedures, and Programs coded the resident as receiving IV medications while a resident. A comprehensive Care Plan had not been developed based on an admission MDS ARD of 1/31/16. An Interim Care Plan dated 1/27/16 evidenced the facility failed to include the resident's need for comfort related to actual or potential pain symptoms due to the resident's stated pain to the post operative wound site. On 3/23/16 at 5:30 p.m., the resident requested to speak to a surveyor. At this time an interview was conducted with the resident. The resident expressed concerns over the lack of care and services provided since admission and her safety due to the care. Resident #21 stated the facility did not provide effective pain management for the first two days following admission to the facility. She stated, "...I was not able to get any sleep at all due to my pain...I had surgery and they removed two bones and ligaments, my bone was infected...I kept saying the Tramadol was not working for two days...they would not give me	F 309	FSBS was done on Resident #31 at 6:28 pm at which time it was 110. The 5:00 pm medicines were administered at 6:28 pm. A medication error report has been completed. Physician has been notified about the FSBS and the medication being administered late on 3/24/16. The resident experienced no adverse effects because of the late administration of medications. The nurse, who failed to administer the medication and do the FSBS as ordered, has been counseled regarding following physician orders for timely administration of medications and physician notification of medications and FSBS not being done as ordered. FSBS for Resident #30 was obtained at 6:05 pm on 3/24/16. Resident also received standing order of Humalog, 2 units at 6:05 pm. Resident blood sugar was obtained after eating meal and was in typical range for resident. Medication error has been completed. Physician was notified of FSBS and Humalog being administered late. The nurse, who failed to administer the Humalog insulin and do the FSBS as ordered, has been counseled regarding following physician orders for timely administration of medications and physician notification of medications and FSBS not being done as ordered.	

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F 309	Continued From page 59 anything stronger than Ibuprofen...I was in pain, I kept saying what do I have to do to get you all to understand...at first the nurse said my birth date was wrong and that is why pharmacy would not fill the prescription...then they said I was allergic to hydrocodone...which I am not, it makes me itch and at the hospital they gave it to me with an antihistamine...by the morning I was livid...that's when (name of unit 3 manager), the administrator and (name of the director of nursing) came into my room and apologized...after that they (the unit 3 nurse manager) gave me a dose of liquid morphine around 9:00 a.m., it knocked me out, I slept until 6:00 p.m.,... my pain came back and I asked for some more morphine and they told me it had not come in from the pharmacy, they gave me Tylenol." Resident #21 was asked what her pain goal level was, and stated, "I can handle a lot of pain...my goal would be a five to five and a half on a scale of one to ten...for those two days my pain was a ten out of a ten...It made me feel depressed, like nobody was listening to me...I was yelling at the nurse...I couldn't sleep well, I was literally trembling...I wasn't eating much". The clinical record notes were reviewed, the nurse documented the following, in part: 1/27/16 at 1:48 a.m.,"...client c/o (complains of) pain/discomfort attempted to administer Tramadol client refused: client stated "Tramadol does not work". at this time I called pharmacy spoke with the pharmacist she stated, "I need clarification for the prescription (Percocet)"...called (name of attending physician) @ (at) 0126 am message box full. Redirected client and she took two Tramadol...called (name of attending physician) @ 0147 am message box full..."	F 309	The stage III pressure ulcer for Resident #9 was resolved on 4/8/16. Resident remains on an air mattress for comfort and preventive treatment. Care plan has been updated to reflect resolved wound and preventive treatment. The physician discontinued the use of Prevalon boots on 3/28/16 and also discontinued the order for floating heels.	

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F 309	Continued From page 60 Clinical record notes dated 1/27/16 at 9:27 a.m., documented by the unit 3 nurse manager, read, in part: Resident complaint of left leg pain. She has orders for Tramadol and she has been refusing stating it is not strong enough for her pain. MD gave orders for Percocet on 1/26/16. The order was discontinued {sic} allergy to Hydrocodone. The night nurse called MD and received orders for Morphine. This nurse called the MD and received orders to give morphine sulfate liquid now and morphine tablet as needed. Pharmacy notified of the new orders to send the medications. Morphine sulfate liquid now order pulled from emedstart (pharmacy electronic storage box). Clinical record notes dated 1/27/16 at 10:43 p.m., documented by the unit 3 nurse manager, read, in part: "...At about 10:00 pm she asked for pain medication. Medication had not arrived from pharmacy (Morphine). Pharmacy informed this nurse this morning that medication will arrive before 10:00 pm. Resident was medicated with PRN (as needed) Tylenol..." Clinical record noted dated 1/28/16 at 12:32 a.m., documented by the night nurse, read, in part: "...client c/o pain/discomfort pain level 10/10 received morphine sulfate tabs 15 mg (milligrams) via po (by mouth) and pain subside {sic} pain level at 2/10..." The Medication Administration Record (MAR) for January 2016 was reviewed and evidenced the resident was administered Ibuprofen 800 mg one tablet three times a day starting on 1/25/16. The Ibuprofen was scheduled and administered at 6 am, 2 pm and 10 pm. It was discontinued on	F 309	2. Residents with wounds are at risk for having pain related to treatment. Pain medication will be offered prior to treatment. Orders will be reviewed for residents with orders to float heels. Clinical manager will validate position of heels during routine rounds. A review will be completed of MARs for those residents with orders for IV antibiotics to validate no other missed doses. Variances will be investigated and physicians will be notified. The clinical managers/designee will review FSBS documentation on those residents with a diagnosis of diabetes to validate documentation. Physician will be notified of missing documentation. Review MARs for residents who receive medicines from LPN #10 since 4/1/16 to validate if other residents were affected by this practice of administration of medications and FSBS. Variances will be investigated and physicians will be notified.	

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F 309	Continued From page 61 1/26/16. The MAR for January 2016 evidenced the resident was administered the following for pain management: 1. On 1/26/16 at 00:21 (12:21a.m.) a.m., Tramadol 50 mg (1-2) tabs was administered for a pain level of 6/10 at 01:21 a.m., effective. 2. On 1/27/16 at 22:46 (10:46 p.m.) p.m., Tylenol Extra Strength 500 mg one tablet administered, pain level was not documented, at 23:46 (11:46 p.m.)., effective. On 3/23/16 at 7:40 p.m., the unit 3 manager was interviewed. The unit manager was asked about the resident's pain and stated, "She (the resident) was in severe pain, she said the Tramadol was not effective...the night nurse called the doctor; his mail box was full...she was able to get an order right before she left in the morning. I called the doctor that morning and got an order for the Morphine liquid and gave it to her right away." She was asked if the resident had filed any grievances concerning her pain management. The unit manager stated, "Yes". A Customer Communication Form (grievance form) was provided to this inspector by the Administrator. The form dated 1/27/16 was filled out by the unit 3 nurse manager. The form read under Comments/Concerns: Did not receive stronger pain medication since admission. Breakdown of communication between nursing and pharmacy per patient. Investigation: There was a delay on pharmacy calling the unit to inform them of contraindication of Percocet that was ordered on 1/26/16. Resolution or Final Outcome: New orders received to give Morphine sulfate liquid 10 ml	F 309	3. Educate nurses on following physician orders, completion of FSBS, on the administration of medication as ordered and to include when to notify physician. In-service licensed nurses on submission of medication error reports for late or missed FSBS and medications. Educate licensed nurses on pain management of wound care.	

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(milliliters) now. Morphine 15 mg Q (every) 6 hrs (hours) PRN (as needed) ordered. Resident medicated @ 9:30 am and stated while this nurse was in the room that she was feeling its effect. The form was signed by both the unit manager and the Administrator.

1b. The facility staff failed to provide IV antibiotics as ordered by the physician for Resident #21. The resident received IV antibiotics via a PICC line to the right arm (peripherally inserted central catheter).

Resident #21 was admitted to the facility on 1/24/16 for post operative care of an infected bone in the left foot. The Infectious Disease physician ordered IV antibiotics of Vancomycin one gram every eight hours and Meropenem one gram IV every eight hours for forty-two days for the treatment of the bone infection. The pharmacy was to monitor and dose the Vancomycin.

On 3/23/16 at 5:30 p.m., an interview was conducted with the resident. The resident expressed concerns about the lack of care and services provided since admission and her safety due to the care. Resident #21 stated when she was receiving IV antibiotics the nursing staff would leave the empty IV container hanging for extended periods of time after it had infused and this limited her ability to move about. The resident also stated the staff failed to administer the IV antibiotics as ordered. She stated she expressed this to the infectious disease physician who then changed the IV antibiotic and scheduled it to be given once a day.

The IV antibiotic order was changed on 2/22/16 to

4. Clinical manager/designee will randomly review 10% of residents with FSBS weekly to validate completion as ordered. This will be done weekly X 2 months, then monthly review of 10%.

   Clinical manager/designee will randomly review 10% of residents with MAR weekly to validate completion as ordered. This will be done weekly X 2 months, then monthly review of 10%.

   Weekly x 6 weeks during treatment, the clinical manager/designee will accompany the nurse during treatments to validate resident is not having pain on 25% of residents receiving treatment. If pain medication is not offered prior to treatment, the nurse will immediately be re-educated and resident will be assessed for pain prior to start of the treatment

   A report of areas of non-compliance will be reported to the DON/designee for analysis and submission to the QAPI committee for discussion and further recommendations.

5. Completion: 5/13/16

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Ivanz 1 gram once a day for twelve days, scheduled to be administered at 9:00 p.m.

The Medication Administration Record evidenced that on 2/27/16 the 9:00 p.m., IV Ivanz was not administered. As a result the IV was extended an additional day.

Review of the clinical record evidenced the resident was no longer receiving IV antibiotics.

On 3/23/16 at 7:40 p.m., the unit 3 manager was interviewed. The unit manager was asked about the omission of the IV antibiotic on 2/27/16. She stated, "Yes, the resident was on leave of absence that evening and returned at 7:30 p.m. The nurse did not administer the scheduled 9:00 p.m., antibiotic, stating, "I am not sure why". She stated as a result the IV antibiotic was extended an additional day to ensure the resident received the full course of the IV antibiotic therapy. The unit manager stated this was brought to her attention by the resident on 2/29/16.

A Customer Communication Form (grievance form) dated 2/29/16 filled out by the unit three nurse manager read, in part:
Comments/Concerns: IV ABT (antibiotic) not administered on 2/27/16. Resident stated she was out of the facility that day and returned at 7:30 pm. Investigation: MAR checked for signature for 2/27/16. There was no signature by the nurse who worked on 2/27/16 on 3-11 shift.

Further review of the clinical record for February 2016 evidenced there was no signature by the nurse; indicating the IV antibiotics were not administered on the following dates:
1. Vancomycin one gram 2/2/16 at 9:00 p.m.,

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2/7/16 at 12:30 p.m., 2/15/16 at 9:00 p.m., and 2/20/16 at 9:00 p.m.
2. Meropenem one gram 2/1/16 at 2:00 p.m., 2/7/16 at 2:00 p.m., and 2/15/16 at 10:00 p.m.

1c. The facility staff failed to provide post surgical wound care as ordered by the physician. An order dated 1/25/16 directed the staff to apply wound VAC therapy to the resident's post surgical foot wound and change it every three days (there were no settings on this order).

A wound VAC is a negative pressure wound therapy. It is a therapeutic technique using a vacuum dressing to promote healing in acute or chronic wounds. The therapy involves the controlled application of sub-atmospheric pressure to the local wound environment, using a sealed wound dressing connected to a vacuum pump.

On 3/23/16 at 5:30 p.m., an interview was conducted with the resident. The resident expressed concerns for her safety due to the lack of care provided. The resident stated that the staff failed to change the wound VAC every three days as ordered, she stated some days the nurses did not know how to change it and therefore it did not get done. The wound VAC has been discontinued.

Review of the TAR (Treatment Administration Records) for February 2016 evidenced the wound VAC was not changed as ordered on the following dates: 2/16/16, 2/18/16, 3/3/16, 3/5/16 and 3/10/16.

The wound care order was changed on 3/13/16 to cleanse the wound with normal saline, apply a

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wet to dry dressing and kerlix daily for three days.

Review of the TAR (Treatment Administration Records) for February 2016 evidenced the wet to dry dressing was not changed on 3/13/16.

On 3/23/216 at 7:40 p.m., an interview was conducted with the Social Worker (SW). She stated the resident had expressed concerns for her safety due to lack of care and requested a transfer to another facility. The Social Worker stated the resident did state that the wound VAC dressing changes were not, "being consistently done or correctly, and she later found out that one of the nurses did not have the correct wound VAC dressing size".

1d. The facility staff failed to assess and obtain effective treatment for a vaginal yeast infection for Resident #21, subsequently the resident was taken to the emergency room by a family member for evaluation and treatment.

On 3/23/16 at 5:30 p.m., the resident was observed in a wheelchair sitting outside the residents room doorway. The resident requested to speak to an inspector. At this time an interview was conducted with the resident. The resident expressed concerns about the lack of care and services provided since admission and her safety due to the care. The resident stated, "When I first came in I was on a medication for a UTI and it changed my urine orange (Pyridium), I still had complaints of itching down there (vaginal area)...I didn't get anything for the itching for a couple weeks...it was after a care plan meeting around February 8th...I told them at that time what was going on...they got a prescription for Diflucan a

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one time pill...I was still itchy the nurse said it would take three to five days to work...another two weeks went by and I just couldn't take it anymore...one of the nurses said they faxed they doctor and he never responded...I was suffering...my daughter came in one day from work and told me that I can't stand to see you suffering any longer and took me to the emergency room. I was given a Monistat (an antifungal cream) prescription there, I filled the prescription on my way back to the facility and the nurses kept it in the cart. I would have to go to them and ask for it." The resident was asked if the staff had assessed her for a vaginal yeast infection prior to her going to the emergency room, she stated, "No".

The clinical record notes dated 2/10/16 read, in part: "She was started on Diflucan...". No additional information as to why the resident was started on the Diflucan followed.

The clinical record notes dated 2/20/16 at 3:50 p.m., read, in part: "Resident complains of urethral pain and right flank pain. Resident refused straight catheterization for urine specimen for culture and sensitivity. Stated she was going to the emergency room, and her daughter was driving her as she believes she has a UTI..."

Review of the emergency room notes dated 2/20/16 read, in part: "Reports vaginal itching x 2 weeks. Onset of burning and soreness in urethra x 2 days with right sided abdominal pain. Also reporting urgency and frequency." The resident was worked up for a UTI (urinary tract infection)the urinalyses was negative, CT of the abdomen/pelvis were negative, a vaginal swab

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was obtained, and lab work. The resident was diagnosed with a vaginal yeast infection and prescribed Monistat (Miconazole 7/ antifungal) 2% vaginal cream insert applicator vaginally every night at bedtime and discharged.

The clinical record notes dated 2/21/16 at 1:06 a.m., read, in part: "client returned from ER...client received order of Monistat r/t (related) to yeast infection d/t (due to) ABT (antibiotics)..."

The nurse who documented on 2/20/16 at 3:50 p.m., was interviewed on 3/28/16 at approximately 1:00 p.m. She stated the resident was complaining of pain and thought it might be from a UTI (urinary tract infection). The nurse stated she remembered trying to call the physician for an order but he did not respond to her call. She stated she then notified the north 4 unit manager. She was instructed by the unit manager to obtain a urine specimen and then start the resident on Pyridium. The nurse was asked if this was a physician standing order, she stated she did not know but followed the unit managers instructions. The resident refused the straight cath for the urine sample and instead went to the emergency room. The nurse stated she remembered the resident did have the Monistat inside the medication cart and would ask the nurses for it.

The MAR evidenced an order entry for Pyridium 100 mg (milligrams) three times a day for three days, dated 2/20/16.

Pyridium is used to treat pain, burning, increased urination, and increased
urge to urinate. These symptoms are usually caused by infection, injury,

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surgery, catheter, or other conditions that irritate the lower urinary
tract. Pyridium will treat the symptoms of a urinary tract infection, but this medication does not treat the actual infection. Do not use Pyridium for longer than 2 days unless your doctor has told you to.

The MAR evidenced an order entry for Diflucan (an antifungal) 150 mg one time daily for one day starting 2/9/16, and the same order on 2/10/16. The resident was administered both doses.

The MAR and the physician orders did not evidence an order entry for the Monistat as prescribed by the ER physician.

Further investigation evidenced a faxed communication sheet sent to Resident #21's attending physician (the medical director) dated 2/11/16. The fax read, in part: Subject: Topical for burning sensation? Notes: (Resident name and room number) has a request for a topical cream to relieve the burning sensation of her vaginal area. She is extremely uncomfortable, what would you like to prescribe? Please respond with any new orders?

There was no physician response found in the clinical record addressing this fax reporting the resident's symptoms and need for treatment.

A copy of all physician standing orders/protocols was requested. A stack of standing orders/protocols was provided to the inspector for review. The inspector was told there were no other standing orders/protocols. This stack did not contain a standing order/protocol for the treatment of suspected UTI.

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On 2/26/16 the attending physician documented, in part: "...pt (patient) has persistent UTI she was previously treated with Diflucan but symptoms persisted, family took her to the ER (emergency room) and she was prescribed Monistat b/c (because) Diflucan was insufficient symptoms has since resolved..."

2. The facility staff failed to provide surgical wound care and intravenous (IV) antibiotics per physician's order for Resident #41.

Resident #41 was admitted to the nursing facility on 3/18/16 at 5:00 p.m. with diagnoses that included partial traumatic amputation of left foot at ankle level, *osteomyelitis of left foot, diabetes mellitus (DM), *gangrene and cellulitis of left lower leg and sepsis (systemic infection)

*Osteomyelitis is an infection in a bone. Infections can reach a bone by traveling through the bloodstream or spreading from nearby tissue. Infections can also begin in the bone itself if an injury exposes the bone to germs (www.mayoclinic.org/diseases-conditions/osteomyelitis/basics/definition/CON-20025518).

*Gangrene refers to the death of body tissue due to a lack of blood flow or a bacterial infection. Gangrene most commonly affects the extremities, including your toes, fingers and limbs (www.mayoclinic.org/diseases-conditions/gangrene/basics/definition/con-20031120).

*Cellulitis (sel-u-LIE-tis) is a common, potentially serious bacterial skin infection. Cellulitis appears as a swollen, red area of skin that feels hot and

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tender. It can spread rapidly to other parts of the body (www.mayoclinic.org/diseases-conditions/cellulitis/basics/definition/CON-20023471).

Resident #41 was to recently admitted to have a Minimum Data Set (MDS) completed.

Resident #41 was to recently admitted to have a completion of a care plan, thus physician's orders and nursing assessments directed care for the resident. The Nursing Admission Assessment dated 3/18/16 assessed the resident to have no cognitive deficits and was responsive, communicative and oriented to person, place and time.

Resident #41 had physician's orders dated 3/19/16 at 2:53 p.m. for *Ivanz SDV 1 gram (1 g) vial (EA) intravenous (IV) for Wound/Bone/Sepsis infection of left foot. The resident received the first dose in the facility on 3/19/16 at 9:00 p.m. The clinical record revealed two consecutive doses were missed on 3/24/16 and 3/25/16 with no recorded justification as to why the IV was not administered.

*Ivanz SDV/Ertapenem injection is an antibiotic used to treat certain serious infections, including diabetic foot infections, that are caused by bacteria. It works by killing bacteria. The injection is to be used the same time(s) every day.

Use ertapenem injection until you finish the prescription, even if you feel better. If you stop using ertapenem injection too soon or if you skip doses, your infection may not be completely treated and the bacteria may become resistant to antibiotics(www.nlm.nih.gov/medlineplus/druginfo

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An interview with the resident on 3/28/16 at approximately 2:00 p.m. revealed that the nursing staff did not perform his dressing change to the left foot surgical wound every other day as ordered and he had to personally call the physician to inform him; in addition to the omission in administration of the IV antibiotic on 3/24 and 3/25/16.

On 3/29/16 at 10:40 a.m., an interview was conducted with the Director of Nursing (DON) and the Unit Four Registered Nurse (RN) Manager. They stated two sets of orders were put in the system for the dressing change to the left foot surgical wound, one for wound care every seven days and one for wound care every other day. They stated the resident had the dressing change completed on Friday by the physician before he left the facility. There was no explanation as to why the two conflicting orders were not clarified, but the resident knew the dressing change was every other day. The resident called the physician on Monday (3/21/16) to complain that his dressing change had not been done and the physician came in to complete the dressing change herself. Apparently, the resident called again on 3/25/16 to complain his dressing changes were not being done and the physician lodged an official complaint on 3/25/16. It was not until 3/28/16 that the surgical wound care order was corrected to every two days on day shift. Resident #41 was signed off on 3/28/16 to have received surgical wound care to the left foot and scheduled for the next dressing change on 3/30/16. The DON and Unit Four Manager stated they did not know how both orders were transcribed with conflicting wound care treatment

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times, but the nurses should have clarified immediately which one should have been implemented.

During the above interview, the DON and Unit Four Manager stated the IV antibiotics were in the facility to be administered, but no explanation as to why they were not given because the nurse involved had not been scheduled to work since the errors were identified.

The physician's official complaint 3/25/16 indicated she did not mind coming in after hours on Monday and did not mind going above and beyond, but when the resident called her again about failure to have treatment done, she thought it was understood the reason the resident was in the nursing facility was "for antibiotics and care of his surgical site".

The facility's policy and procedure entitled Verification of Orders dated 5/14/13 indicated nurses were to verify accuracy of orders on Medication Administration Record (MAR) and the Treatment Administration Record (TAR) by comparing to the orders. Also, verify accuracy of transcription by comparing order to the MAR and/or TAR.

3. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals at 4:30 p.m. with sliding scale insulin for Resident #32.

Resident #32 was admitted to the nursing facility on 11/13/12 with a diagnoses of Insulin Dependent Diabetes Mellitus.

The Minimum Data Set (MDS) quarterly

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assessment dated 1/27/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was cognitively intact in the skills needed for daily decision making. Resident #32 was assessed to have diabetes that required insulin injections.

The care plan dated 1/30/16 identified Resident #32 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention.

Resident #32 had physician's orders dated 8/1/15 for Stick Blood Sugar (FSBS)/accuchecks before meals at 4:30 p.m. with sliding scale insulin.

On 03/24/16, at approximately 7:03 p.m. the Licensed Practical Nurse (LPN) #10 took over the medication cart to began passing medications. The LPN stated she called early in the morning to inform the unit, she would not be working, but received phone calls asking where she was. The Director of Nursing (DON) stated she did not know Licensed Practical Nurse (LPN) #10 was not scheduled to work at 3:00 p.m. and there was no one assigned on the cart to administer any medications that may have been scheduled from 3:00 p.m. to 7:00 p.m. to also include FSBS/accuchecks, thus no accucheck was obtained to determine if the resident required

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sliding scale insulin and the resident had already eaten the evening meal. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

4. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and administer 5:00 p.m. medications (*Coreg and *Psysillium) for Resident #21.

*Coreg is used to treat high blood pressure and heart failure (http://www.webmd.com/drugs/2/drug-5574/carvedilol-oral/details).

*Psyllium is used to treat constipation. It increases the bulk in your stool, an effect that helps to cause movement of the intestines (http://www.webmd.com/drugs/2/drug-797/psyllium-oral/details).

Resident #21 was admitted to the nursing facility on 1/24/16 with a diagnosis of Diabetes Mellitus, high blood pressure and constipation.

The Minimum Data Set (MDS) Admission assessment dated 1/31/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which

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indicated she was cognitively intact in the skills needed for daily decision making. Resident #21 was assessed to have diabetes that required insulin injections.

The care plan dated 2/5/16 identified Resident #21 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The resident was also care planned for high blood pressure. The goal set by the staff for the resident indicated the resident would have no adverse effects from hyper/hypotension. Some of the interventions the staff would implement to accomplish this goal included to administer medication per physician's order and to notify the physician as needed.

Resident #21 had current physician's orders dated 1/26/16 for FSBS/accuchecks at 4:30 p.m. before the evening meal, Coreg 6.25 milligrams (mg) at 5:00 p.m., Psyllium Fiber 0.52 gram (1 capsule) at 12:00 p.m. and 6:00 p.m.

On 03/24/16, at approximately 7:03 p.m. the Licensed Practical Nurse (LPN) #10 took over the medication cart to began passing medications. The LPN stated she called early in the morning to inform the unit, she would not be working, but received phone calls asking where she was. The Director of Nursing (DON) stated she did not know Licensed Practical Nurse (LPN) #10 was

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not scheduled to work at 3:00 p.m. and there was no one on the cart to administer any medications that may have been scheduled from 3:00 p.m. to 7:00 p.m. to also include FSBS/accuchecks, and the Coreg and Psyllium Fiber, which were omitted. She stated because there was no one assigned to the cart from 3:00 p.m. to 7:00 p.m., thus no accucheck was obtained to determine if the resident required sliding scale insulin and the resident had already eaten her evening meal. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done or medications were not administered, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

5. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and administer routine insulin at 5:00 p.m., for Resident #20.

Resident #20 was admitted to the nursing facility on 2/5/14 with a diagnosis of Diabetes Mellitus.

The Minimum Data Set (MDS) quarterly assessment dated 2/22/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #20 was assessed to have diabetes that required

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insulin injections.

The care plan dated 2/29/16 identified Resident #20 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention.

Resident #20 had current physician's orders dated 8/1/15 for Finger Stick Blood Sugar (FSBS)/accuchecks, before meals at 4:30 p.m., with sliding scale insulin and routine *Humalog 5 units subcutaneous at 5:00 p.m.

*Humalog insulin (insulin lispro) is a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood (http://www.drugs.com/humalog.html).

On 03/24/16, at approximately 7:03 p.m. the Licensed Practical Nurse (LPN) #10 took over the medication cart to began passing medications. The LPN stated she called early in the morning to inform the unit, she would not be working, but received phone calls asking where she was. The Director of Nursing (DON) stated she did not know Licensed Practical Nurse (LPN) #10 was not scheduled to work at 3:00 p.m. and there was no one on the cart to administer any medications that may have been scheduled from 3:00 p.m. to 7:00 p.m. to also include FSBS/accuchecks, thus no accucheck was obtained to determine if the

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resident required sliding scale insulin and the resident had eaten the evening meal. Also the facility staff omitted Resident #20's routinely scheduled Humalog Insulin at 5:00 p.m. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done and insulin not administered, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

6. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals and administer routine medications (*Renvela/Sevelamer Carbonate F/C 800 mg (3 tabs), both scheduled at 5:00 p.m., for Resident #29.

*Renvela (sevelamer carbonate) is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis (http://www.rxlist.com/renvela-drug/indications-dosage.htm).

Resident #29 was admitted to the nursing facility on 11/28/15 with a diagnosis of Diabetes Mellitus and End Stage Renal Disease (ESRD) on Dialysis.

The Minimum Data Set (MDS) quarterly assessment dated 2/22/16 coded the resident with a score of 15 out of a possible score of 15 on

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the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #29 was assessed to have diabetes that required insulin injections.

The care plan dated 2/29/16 identified Resident #29 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The care plan also identified the resident had ESRD and the goal set for the resident by the staff was that she would have the disease managed on a daily basis. Some of the approaches the staff would take to accomplish this goal was that she would have her medications administered per physician's orders and to report ineffective medications/concerns to the physician.

Resident #29 had current physician's orders dated 12/1/15 for Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin four times a day with one of those times at 5:00 p.m. before meals. The resident also had Sevelamer Carbonate F/C 800 mg (3 tabs) ordered at 5:00 p.m.

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse

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scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 p.m. and 5:00 p.m.

Resident #29's FSBS/accucheck was not obtained before meals at 5:00 p.m., to determine if the resident required sliding scale insulin and the resident had already eaten the evening meal. Also, the Sevelamer Carbonate was omitted and not administered at 5:00 p.m. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done and medications not administered, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

7. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals and administer routine insulins for Resident #33, as well as administer other oral medication due at 5:00 p.m.

Resident #33 was admitted to the nursing facility on 8/4/09 with diagnoses of Diabetes Mellitus,

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stroke and high blood pressure.

The Minimum Data Set (MDS) Annual assessment dated 1/21/16 coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was cognitively intact in the skills needed for daily decision making. Resident #33 was assessed to have diabetes that required insulin injections.

The care plan dated 1/27/16 identified Resident #33 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The care plan also identified the resident had high blood pressure and pain. The goal set for the resident by the staff was that he would have his pain and the disease managed on a daily basis. Some of the approaches the staff would take to accomplish this goal was that medications would be administered per physician's orders, and to report ineffective medications/concerns to the physician.

Resident #33 had current physician's orders dated 1/24/13 for Finger Stick Blood Sugar (FSBS)/accuchecks before meals two times a day with one of those times at 4:30 p.m. The resident also had physician's orders dated 8/1/15 for routine *Levemir insulin 44 units and routine *Humalog 10 units subcutaneously to be

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administered daily at 4:30 p.m. The resident also had physician's orders for *Janumet 50-1,000 milligrams (mg) (1 tablet) and *Fish oil 340 -1,000 mg (2 caps) at 5:00 p.m. Additionally, the resident had physician's orders for *Tylenol 500 mg (1 tab) at 5:00 p.m.

*Levemir insulin (insulin detemir) is a long acting insulin used to treat diabetes in adults and children. Includes Levemir side effects, interactions and indications (www.drugs.com/levemir.html).

*Humalog insulin (insulin lispro) is a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood (http://www.drugs.com/humalog.html).

*JANUMET (sitagliptin/metformin HCl) tablets contain two oral antihyperglycemic drugs used in the management of type 2 diabetes: sitagliptin and metformin hydrochloride. ... Sitagliptin is present in JANUMET tablets in the form of sitagliptin phosphate monohydrate (www.rxlist.com/janumet-drug.htm).

*Fish oil is a general health supplement, and is taken as a source of omega-3 fats (https://examine.com/supplements/fish-oil).

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not

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given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 p.m. and 5:00 p.m.

On 3/24/16, Resident #33's FSBS/accucheck was not obtained before meals at 4:30 p.m. and the resident had already eaten his evening meal. Also the routine insulin's Levemir 44 units and Humalog 10 units were omitted and not administered at 4:30 p.m. In addition, the Janumet and Tylenol was not administered at 5:00 p.m. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done, the insulin's and medications were not administered, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

8. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals at 4:30 p.m. and administer routine insulin, also due at 4:30 p.m., for Resident #34.

Resident #34 was admitted to the nursing facility on 11/12/15 with a diagnosis of Diabetes Mellitus.

The Minimum Data Set (MDS) quarterly assessment dated 3/4/16 coded the resident with

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a score of 4 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was severely impaired in the skills needed for daily decision making. Resident #34 was assessed to have diabetes that required insulin injections.

The care plan dated 3/4/16 identified Resident #34 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention.

Resident #34 had current physician's orders dated 1/11/16 for Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin four times a day with one of those times at 4:30 p.m. before meals. The resident also had routinely scheduled *Humalog 5 units due at 4:30 p.m. before meals, which was administered at 7:13 p.m. (2 hours and 43 minutes after it was due).

*Humalog insulin (insulin lispro) is a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood (http://www.drugs.com/humalog.html).

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed

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over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 and 5:00 p.m. At 7:13 p.m., LPN #6 obtained an accucheck reading of 250 and stated, "I wonder should I give it or not give it, and write a note it was not given because the resident had already eaten." LPN #6 did administer the routine Humalog 5 units, at 7:13 p.m., that was due at 4:30 p.m., which was 2 hours and 43 minutes late. The LPN entered the following note on the Medication Administration Record (MAR): "No sliding scale given due to accucheck reading completed after resident ate. Only routine insulin given."

Resident #34's FSBS/accucheck was not obtained before meals at 5:00 p.m., to determine if the resident required sliding scale insulin and the resident had already eaten the evening meal. Also the routine insulin was administered late and after meals. There was there any evidence the physician was called and informed of the aforementioned medication errors or an inquiry for further guidance.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

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9. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals, as well as administer other oral medication due at 5:00 p.m. for Resident #31.

Resident #31 was admitted to the nursing facility on 11/27/15 with a diagnosis of Diabetes Mellitus, anemia, stroke and high blood pressure.

The Minimum Data Set (MDS) quarterly assessment dated 3/2/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #31 was assessed to have diabetes that required insulin injections.

The care plan dated 3/9/16 identified Resident #31 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The care plan also identified the resident had high blood pressure and anemia. The goal set for the resident by the staff was that he would have medical conditions managed on a daily basis. Some of the approaches the staff would take to accomplish this goal was that medications would be administered per physician's orders, and to report ineffective medications/concerns to the physician.

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Resident #31 had current physician's orders dated 12/15/15 for Finger Stick Blood Sugar (FSBS)/accuchecks before meals four times a day with one of those times at 4:30 p.m. The resident also had physician's orders dated 12/8/15 for *Hydralazine HCL 100 mg (1 tab), *Coreg 25 mg (1 tab) and *Ferrous Sulfate 325 mg (1 tab) to be administered at 5:00 p.m.

*Coreg is used to treat high blood pressure and heart failure (http://www.webmd.com/drugs/2/drug-5574/carvedilol-oral/details).

*Hydralazine is used to treat high blood pressure (http://www.webmd.com/drugs/2/drug-8662/hydralazine-oral/details).

*Ferrous Sulfate is used in the treatment of iron deficiency anemia(www.drugs.com/imprints/-21385.html)

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 and 5:00 p.m.

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On 3/24/16, Resident #31's FSBS/accucheck was not obtained before meals at 4:30 p.m. and the resident had already eaten the evening meal. In addition, the oral medications scheduled for 5:00 p.m. were administered 1 hour and 28 minutes late (out of the 1 hour window). There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done and medications were not administered on time, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

10. The facility staff failed to obtain Resident #30's Accucheck at 4:30 p.m. per physician's orders. The blood sugar history records indicated the staff obtained the blood sugar at 6:05 p.m., but recorded a reading of 324 on 3/24/16 in the 4:30 p.m. box on the Medication Administration Record (MAR). In addition, the 4:30 p.m. scheduled Humalog 2 units before meals was not administered until 6:05 p.m., after the resident consumed the evening meal.

Resident #30 was admitted to the nursing facility on 7/16/15 with a diagnosis of Diabetes Mellitus.

The Minimum Data Set (MDS) assessment dated 1/13/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily

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decision making. Resident #30 was assessed to have diabetes that required insulin injections.

The care plan dated 3/23/16 identified Resident #30 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention.

Resident #30 had current physician's orders dated 12/30/15 for Finger Stick Blood Sugar (FSBS)/accuchecks before meals three times a day with one of those times at 4:30 p.m. Humalog 2 units was scheduled to be routinely administered every day at 4:30 p.m. before the evening meal.

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 and

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5:00 p.m.

On 3/24/16, Resident #30's FSBS/accucheck was not obtained before meals at 4:30 p.m., as well as the routinely scheduled Humalog insulin. The resident had already eaten the evening meal. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done on time, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

On 3/29/16 at approximately 4:00 p.m., the Administrator was made aware of all of the aforementioned problems with nursing staff's failure to administer medications per physician orders, along with lack of nursing coverage as the root cause.

11. Facility staff failed to provide pain interventions once pain was identified during a pressure ulcer treatment and repositioning of Resident #9.

Resident #9 was admitted to the facility on 5/10/2005. Diagnoses for Resident #9 included but not limited to Stage III pressure ulcer, trochanteric fracture (closed fracture at the neck of the femur), anemia, and Dementia. Resident #9's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date (ARD) of 09/07/2015 coded Resident #9 with severely impaired cognitive skills for daily

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decision making. In addition, the MDS coded Resident #9 requiring total dependence on staff for Activities of Daily Living.

During a routine observation on 3/23/16 at 12:40 pm by two surveyors (#1 and #2) of Resident #9's stage III left heel pressure ulcer treatment with LPN #2 and CNA #2 present, Resident #9 began to grimace and groan and pull feet away from treatment in noticeable pain. Neither non-pharmacological interventions nor pharmacological interventions were provided for Resident #9 during the application of the treatment. The treatment given by LPN #2 comprised of Calcium Alginate, wound cleanser, Allevyn cover and Santyl for debridement of the wound bed and gauze wrapping.

The Physicians Orders noted on 3/18/16: "Right heel wound, cleanse daily with wound cleanser, apply Santyl and Alginate daily. Cover with Mepliex/Allevyn daily and as needed. Also available for pain or fever/temp greater than 100 was an order on the March 2016 Physician Order sheet for MAPAP (brand name for tylenol)160 milligrams/5 milliliters (20 ML) G-tube (gastrostromy) as needed every four hours starting 08/01/2015.

According to the Medication Administration Record Resident #9 had not received MAPAP (acetaminophen analgesic) for the entire months of January, February, and up to March 24, 2016, the third day of the survey. In the clinical progress notes pain was not identified for Resident #9 after the identification of a stage III pressure ulcer to the left heel on 2/16/16 and multiple stage II pressure ulcers on the sacrum identified on 1/20/16.

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Resident #9's MDS with an ARD of 09/07/2015 coded Resident #9 with no pain. The care plan dated 12/3/2015 to present 3/23/16 does not identify pain as a concern. The updated care plan dated 2/23/2016 to present, 3/23/16, identified a stage II pressure ulcer with interventions but did not care plan for pain. Under 'communication' on both care plans it stated, "monitor for signs of restlessness or agitation, If present assess for pain/discomfort or other physical needs." No interventions are mentioned on the care plan for pain associated with pressure ulcers or wounds.

In an interview with LPN #2 on 3/24/15 at 2:10 pm, it was agreed that Resident #9 moaned and groaned in pain during the treatment application on 3/23/16 at 12:40 pm. It was also stated, "No, I did not pre-medicate Resident #9 with pain medication prior to treatment. I am not sure Resident #9 has medication for pain so I will look it up. Yes, there is an order for MAPAP 20 ML as needed for pain. No, I have not given Resident #9 pain medication prior to treatments."

In an interview with CNA #2 on 3/25/16 at 10:30 am when asked about the positioning of the heels he/she replied, "no, the heels are not floating when touching the bed." CNA #2 attempted to reposition Resident #9's heels in the Prevalon boots to ensure proper placement when Resident #9 was observed moaning in pain. It was also observed that the Stage III pressure ulcer on the right heel had a bandage that was not properly covering the wound and blood was found on the boot. It was stated, "I took boot off this am around 8:30 am during am care but I did not check for placement of the dressing and when we wash a

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F 309	Continued From page 93 resident we do skin checks...this am I changed resident but did not do a head to toe skin assessment." When asked in Resident #9 was in pain, CNA #2 stated, "I would say she is in pain, grimacing, withdrawn legs when I was just looking at the wound-just moving the leg...I did not touch the wound." When asked about the pain during the treatment observation on 3/23/16 at 12:40 pm, CNA #2 stated, "today there was more pain expressed then during the treatment." CNA #2 notified LPN #2 of Resident #9's pain. At 10:45 am on 3/25/16, LPN stated, "I gave Resident #9 pain medication 20 ml of Tylenol prior to replacing the bandage on the wound...I am now waiting to place it on the wound...based on what was reported the pain level was coded at a 5 today and at a level 2 during the treatment yesterday." is this pertinent? LPN #2 also added, "I should see if I could get something scheduled for Resident (#9) for pain."	F 309		
F 312 SS=E	COMPLAINT DEFICIENCY 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	F312 1. Resident #21 is no longer at this facility. 2. 100% review of current residents will be completed to ensure that showers are scheduled for at least twice per week.	

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F 312	Continued From page 94 Based on observations, clinical record review, staff interview and resident interview, the facility staff failed to ensure for residents that are not able to carry out activities of daily living, received the necessary services to maintain good personal hygiene for 1 of 43 residents (Resident #21) in the survey sample. The facility staff failed to offer a shower to Resident #21 for approximately one month after admission to the facility. The findings included: Resident #21 was admitted to the facility at 8:00 p.m., Sunday 1/24/16 following a hospitalization for surgical incision and drainage (I&D) with resection of a toe due to a diabetic foot ulcer related to osteomyelitis (a bone infection) on 1/19/16; with subsequent left foot skin graft on 3/15/16. The resident was admitted for IV (intravenous) antibiotics, wound care, physical and occupational therapy. The admission MDS (Minimum Data Set) with an assessment reference date of 1/31/16 evidenced the resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section G. Functional Status coded the resident as requiring supervision with transfers from bed to the wheelchair with one staff, and set up assistance for bathing. The resident was wheelchair bound with orders for non-weight bearing of the left lower extremity. The physician orders for 1/15/16 included a wound VAC to the left foot. A wound VAC is a negative pressure wound therapy. It is a therapeutic technique using a vacuum dressing to promote healing in acute or	F 312	3. C.N.A.'s will be educated on documenting ADL care for showers and baths in Vision. If a resident refuses a shower, it will be reported to licensed nurse and the refusal will be documented in the medical record. Persistent refusal of a shower or resident's preference for bathing/shower that is not consistent with the schedule will be addressed in the resident's care plan 4. QA/designee will audit ADL Care, Showers for 10% of resident's weekly X 6 weeks. Variances will be investigated and addressed according to the situation. Analysis of weekly audits will be reported to DON and Administrator and summary of audit findings will be reported to QAPI committee for additional oversight and continued frequency of audits. 5. Completion: 5/13/16	

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chronic wounds. The therapy involves the controlled application of sub-atmospheric pressure to the local wound environment, using a sealed wound dressing connected to a vacuum pump.

On 3/23/16 at 5:30 p.m., the resident was observed in a wheelchair sitting outside the residents room doorway. The resident requested to speak to an inspector. At this time an interview was conducted with the resident. The resident expressed concerns over the lack of care and services provided since admission and her safety due to the care. The resident stated she was not provided a shower for the first month after admission. She stated one day a certified nurse aide (CNA) entered her room one morning and stated, "Are you ready for your shower?". The resident stated she did not know she was allowed to take a shower and the CNA's response was, "You've been on the shower list for Tuesday and Friday day shift". The resident was asked how it felt to not have received/ offered a shower for a month, she stated, "It made me feel like an animal". The resident stated her preference for a shower would be to have one everyday.

The clinical notes dated 3/13/16 read, in part: "Requires moderate assist for showers..."

Review of the clinical record evidenced the resident did not receive and or was not offered a shower from 1/25/16 through 2/18/16; a total of 25 days.

F 314 SS=H	COMPLAINT DEFICIENCY 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 96 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 observations, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to prevent and to treat pressure ulcers for four (4) residents (Resident #17, #11, #10, #9) of a 43 resident survey sample which constituted harm for all four (4) residents which resulted in Sub-Standard Quality of Care. The findings included: 1. For Resident #17, the faciity staff failed to provide medical treatment for ten days to a pressure ulcer on his coccyx which had been identified on 08/04/15. On 8/14/15 it was an unstageable Pressure Ulcer due to Necrotic Tissue, causing harm. 2. For Resident #11, the facility staff failed to identify a pressure ulcer to Resident #11's left index finger before it reached an advanced stage which constitutes harm. 3. For Resident #10, the facility staff failed to identify a Stage III right ankle pressure ulcer prior	F 314	F314 1. Resident #17 pressure ulcer continues to be treated. The wound has been accessed on 4/15/16 by the wound physician who states it is showing improvement. The pressure ulcer for Resident #11 is now resolved. The pressure ulcer for Resident #10 is now resolved. The pressure ulcer for Resident #9 is now resolved. 2. Current residents with pressure ulcers will be assessed by the physicians to ensure treatments are appropriate for the condition of the pressure ulcers. Current residents will have pressure ulcer risk assessments reviewed and care plans will be reviewed to ensure that preventive interventions are in place.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 97 to it developing to an advanced stage on 9/25/15, which constitutes harm. 4. For Resident #9, the facility staff failed to identify a pressure ulcer to the right heel before it reached an advanced stage III and failed to follow physicians orders to float heels resulting in harm. The findings included: 1. Resident #17 was originally admitted to the facility on 06/30/15, readmission on 07/17/15, readmission on 07/24/15 and readmitted on 10/06/15. Diagnoses included but were not limited to Fracture Cervical (neck) Spine resulting in quadriplegia (inability to move upper and lower extremities independently), status post (previous) tracheostomy (tube inserted into windpipe to allow for breathing), Atrial Fibrillation (irregular heart function), Hypertension and Major Depression. The resident also has been on a Vegan (excludes all meat and animal products including milk and dairy and no soy) for 30 years. Review of the resident's clinical record noted the most recent comprehensive MDS (minimum data set-an assessment protocol) was a Significant Change with an ARD (assessment reference date) of 11/23/15. The resident's BIMS (brief interview for mental status) score was coded a 15 which indicated the resident was cognitively intact. Further review of the record revealed the resident was totally dependent on one staff member for toileting, personal hygiene and bathing. The resident was coded as requiring extensive assistance of one staff member for bed mobility and eating. The resident was also coded as having a condom catheter for urine control and	F 314	3. Full body checks will be performed on all residents to establish baseline and identify any new areas. Physician will be contacted for any new identified areas or areas that have changed and orders will be implemented. A full body check will be completed on admission/re-admission by a licensed nurse. Braden scale completed on admission and reentry and weekly X 4 after admission/re-admission; quarterly and with a change in the resident condition or the development of a new pressure ulcer. Weekly skin assessments completed on all residents by licensed nurse and observation of new areas or areas that have changed reported weekly at SOC. CNA's will be educated on importance of reporting to licensed nurse any observation of change in skin condition and on policy for repositioning and protective barriers	

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F 314	Continued From page 98 was incontinent of bowel. It was further noted under Section M-Skin Conditions that the resident was at high risk for developing a pressure and at the time of the assessment had a Stage IV at present and had also been present on his re-admission to the facility from the hospital on 10/06/15. Review of the resident's clinical record noted that he had been admitted to the hospital on 07/10/2015 for evaluation, due to low blood pressure, desating oxygen levels and having an elevated temperature of 102 degrees F (Fahrenheit). Review of the resident's discharge summary dated 07/15/15, revealed that the resident had diagnoses of Pneumonia (possible aspiration), Urinary Tract Infection (UTI) and Sepsis. The resident was not discharged back to the facility until 07/17/15. Review of the hospital notes dated 07/10/15, revealed that when the resident had been transferred from ICU (intensive care unit) to the medical floor the resident was noted to have a Stage II pressure ulcer to his coccyx and mepilex treatment was in place. No additional information could be obtained from the hospital regarding the status of the resident's Stage II pressure ulcer to his coccyx, if it had been resolved or if further treatment was required. On his readmission to the facility on 07/17/15, Resident #17 was placed on a specialized unit due to his need for RT (respiratory therapy) and specialized tracheostomy care. The resident had an upgraded mattress as all on the specialized unit have on their beds. The resident was also repositioned every two hours which is documented in the resident's clinical record. RD (registered dietician) also did an assessment and	F 314	Licensed staff will be assigned to complete weekly wound rounds with the facility contracted wound physician and document in Vision. Licensed staff will be educated on Pressure Redistribution devices and other interventions for reducing risk of skin breakdown. Licensed nurse will be re-educated on pressure ulcer documentation, including measurement, description of wound and surrounding area and staging.	

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F 314	Continued From page 99 had multiple interviews with the resident regarding his Vegan diet. Supplements were added daily as well as being repositioned every two hours. The resident's spouse agreed to bring in the resident's meals from home knowing his likes and dislikes until the facility was able to have a wider selection of foods the resident could choose from. The resident also received preventative perineal care after every incontinent episode of bowel in addition to a moisture barrier to his coccyx area every shift which was documented in the resident's clinical record. No formal nursing admission had been done on the resident's return from the hospital. Review of the nursing notes on 07/17/15, revealed that when the resident had been readmitted his skin was intact. Review of Daily Skilled Nurse's Note/Med Spec dated 08/04/15, noted that the resident had a pressure ulcer, but assesment or description included. No formal wound assessment could be located in the resident's clinical record. Review of the August 2015 TAR (treatment administration record) revealed that weekly skin inspections to be done on the day shift starting 07/20/15, had been signed off as done on 08/04/15, 08/11/15, 08/18/15 and 08/25/15. The inspections were signed as done but no documentation of the assessment of the resident's skin status could be found in the record. Review of the August MAR (medication administration record) revealed an order dated 08/13/15: Polymim foam dressing to sacral wound every 2 days and PRN (as needed).	F 314	4. QA/designee will audit documentation of 10% of weekly X 6 weeks for weekly skin assessments. Analysis of weekly audits will be reported to DON, and administrator and summary of findings will be reported to QAPI committee for additional oversight The clinical manager/designee will complete a review of 25% of Braden scale completed weekly with validation of care plan addressing prevention and/or treatment. The clinical manager/designee will complete a random review of weekly skin assessments with validation of accuracy by completing a full body skin assessment. Variances will be investigated and staff re-educated as appropriate. Results of these audits will be reviewed by the DON/designee for analysis with a report of areas of non-compliance submitted to the QAPI committee for discussion and further recommendations. 5. Completion: 5/13/16	

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Review of the August TAR noted that the aforementioned treatment did not start until 08/15/15 and had been signed off as being done by the facility staff on 08/15/15, 08/17/15, 08/19/15, 08/21/15 and 08/25/15.

Review of the August MAR revealed an order dated 08/14/15: Santyl (debridement agent)250 unit/gram (nickel size) Ointment (Gram) Transdermal Every twenty-four hours for fourteen days starting 08/16/15, which had not been started until 08/17/15.

A Wound Care Specialist Initial Evaluation dated 08/14/15 noted: The resident presents with an unstageable (due to necrosis) of the sacrum of at least 1 days duration. Wound Size L-4.5 cm. (centimeters) x W (width) -8.5 cm. D (depth) -not measurable due to necrosis. Assessment & Plan: Discontinue: Foam Every Two Days. Add: Santyl-Once Daily.

A Wound Care Specialist Evaluation dated 08/21/15 noted: The resident presents with a stage 3 pressure wound of the sacrum of at least 7 days duration. Wound Size L-2.8 cm. x W-1.0 cm x D-0.2 cm. Procedure: Surgical excisional debridement of subcutaneous tissue. Discontinue Santyl-Once Daily. Add: Foam-every two days and PRN.

A Wound Care Specialist Evaluation dated 08/31/15 noted: The resident presents with a stage 3 pressure wound of the sacrum of at least 17 days duration. Wound Size L-4.5 cm. x D-6.0 cm. x 0.2 cm. Discontinue: Foam-Every two days and PRN Add: Santyl-Once Daily.

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An interview was conducted on 3/28/16 at apporoximately 12:15 p.m. with LPN #11. She stated, "When he was first admitted and he had his trach and cervical collor, he preferred to tell us how he was to be positioned and where his pillows were to be placed. If he didn't like you, he wouldn't let you do anything."

Resident #17 was observed 3/25/16 at 9:12 a.m., 3/25/16 at 12:07 p.m., 3/25/16 at 4:15 p.m. and 3/28/16 at 8:15 a.m. in bed with the head of the bed elevated, wound vac to sarcum and an air mattress in place on bed.

Resident #17's care plan dated 8/5/15 to 12/02/15 documented:
At risk for pressure ulcer: Perform nutrional screening. Adjust diet/supplements as indicated to reduce the risk of skin breakdown - dietary
Impaired bed mobility: Use pilows. pads, or wedges to reduce pressure on heels and pressure ooints. Resident #17 is to be turned side to side as needed no greater than 30 degrees with appropriate positioning devices to relieve pressure and provide comfort and support
At risk for altered nutrition as related to poor skin integrity and risk for skin breakdown/pressure AEB (as evidenced by) pressure ulcers
Pressure Ulcer r/t (related to) immobility AEB Stage 4 to sacrum, Wound vac Therapy begun 2/1/16.

2. Resident #11 was admitted to the facility on 7/1/13 with a readmission note of 1/26/16. At the time of the survey the resident was 86 years old. The resident's diagnoses included vascular dementia, diabetes, depression, high blood pressure, psychosis, encepalopathy, and thrompocytopenia.

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The resident's 1/6/16 quarterly minimun data set (MDS) described the resident as being at risk for the development of pressure areas.

The resident's 2/01/16 significant change MDS evidenced the resident was not understood and did not understand others, with severe long and short term memory loss. Resident #11 required assistance with all activities of daily living.

The nursing note on 1/9/16 evidenced, "nurse went to clean inside or (sic) resident left contracted hand when she noted resident hand to have a pressure ulcer to the inside of her left index finger where the thumb presses on. ..the area is open with 100% granulation and measures 2.0 cm X 2.0 cm X 0.2 cm. Resident does complain of pain to the hand." MD notified.

The MDS manual instructs that granulating tissue (pink or red tissue with shiny, moist, granular appearance) is not present in a Stage II, as granulating tissue represents a full thickness of skin (dermis) loss to underlying tissue. The MDS identifies full thickness tissue loss as a Stage III.

On 1/21/16 the resident was sent to the hospital with pneumonia and returned on 1/27/16. On 1/31/16 the resident was referred to the wound physician who identified the left finger wound as a Stage IV.

Under the 2/1/16 MDS skin condition (Section M) evidenced the resident had one or more unhealed pressure areas. The stage was identified as unstagable. The measurements were 1.2 centimeters (cm) X 1.1 cm with a depth of 0.3

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cm. The MDS defines "unstagable" as a wound that due to the presence of eschar or slough the wound bed is not visible.

The MDS defines a Stage IV as, "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling." The MDS identifies eschar as, "brown, black, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin."

Unit I did not have a unit manager but RN #6 was identified as helping the DON cover the unit pending the position being filled. On 2/23/16 RN #6 was interviewed. RN #6 stated the resident's Stage IV on the left index finger was healed. The area had been caused by the resident's thumb overlapping the index finger causing pressure. The RN was requested to describe the area when found. She stated that "white" was visible when the wound was discovered and identified it as tendon. RN #6 stated the left ring finger also digs into the resident's palm, it is now "red" and a 4 x 4 gauze was placed in between the thumb/index finger and between the ring finger and palm. RN #6 stated the resident would remove a hand roll from her hand.

On 3/23/16 at 4:55 p.m., LPN #8 accompanied the surveyor into Resident #11's room to observe her hand. The LPN stated she had been pulled from another unit so she was not familiar with the resident. The LPN was unable to separate the thumb from the finger as the resident was pulling away, the LPN stopped. There was a gauze between the ring finger and palm but nothing

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between the thumb and finger.

On 3/24/16 (12:05 pm) the resident was observed in bed, there was no gauze in the resident's left hand.

On 3/24/16 (1:30 pm) two surveyors observed the resident's hand. LPN #9 accompanied the surveyors. LPN #9 stated she was the one who had first discovered the pressure area. LPN #9 stated the tendon was clearly visible. When asked how they healed the wound since the resident's thumb still curled over the index finger. LPN #9 stated we used "Allevyn" a brand name for a padded dressing that has adhesive around the edges. LPN #9 stated the resident did sometimes remove the Allevyn but for the most part left it in place. But, she (the nurse) had been informed that the Allevyn was too expensive to be used as a preventive measure. The LPN commented that the area was likely to breakdown again. "RN #6 and I have done some brain storming." The resident's thumb and index finger were noted to be misshapen. The thumb was flattened and the index finger had a depressed area from constant pressure/contact with the thumb. The LPN was able to separate the thumb and finger by 3/4 to an inch. The resident immediately clenched them back together when the nurse released the digits. The LPN stated as far as she was aware there was not an Occupation Therapy referral for a possible positioner.

Review of the Treatment Administration Record evidenced the Alleyn was started 1/9/16, and changed every day. The treatment continued but on 1/29/16 Kerlix (gauze bandage) was added to be wrapped around the dressing and hand.

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The resident's care plan in place from 10/21/15 to 2/10/16 was reviewed for interventions for the prevention of pressure areas.

The care plan evidenced, "Actual contracture of in left hand...." The goal was the resident will not develop further contractures and will have pain management through 90 days. The interventions were to administer medications, monitor for side effects and and effectiveness of medications, range of motion to resident's tolerance, frequent position changes and encourage resident to exercise.

The residents current care plan was also reviewed and had not included any interventions to prevent the pressure ulcer. This was discussed with RN #6, on 3/25/16 at approximately 3: 30 pm. RN #6 stated that they are now using a hand roll and Allevyn on the resident's hand. RN #6 stated that the hand roll was found in the resident's closet and that it had been used at one time. RN #6 reviewed the care plan and stated it was not addressing the resident's need for pressure reduction to the left thumb and finger. RN #6 stated the intervention of range of motion was not appropriate as the resident's left hand could not be separated enough and it would be too painful for the resident, "you can't get her hand open to do that."

The resident was observed on 3/28/16 10:40 am and 3/29/16 approximetely 3 pm with the Allevyn between thumb and finger and a hand roll in her palm.

3. The facility staff failed to identify a Stage III right ankle pressure ulcer prior to it developing to

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an advanced stage on 9/25/15 for Resident #10, which constitutes harm.

Resident #10 was a 81 year old admitted to the facility initially on 12/2/12 and readmitted on 12/31/14. Resident #10's diagnoses included *Stage III Pressure Ulcer, *Diabetes Mellitus, *Gastrostomy Tube, *Contractures, and *Dementia.

*Stage III Pressure Ulcer: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Definition derived from the Minimum Data Set (MDS) Assessment-Version 3.0

*Diabetes Mellitus: a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.

*Gastrostomy Tube (G-Tube): surgical creation of an artificial opening into the stomach through the abdominal wall to prevent malnutrition.

*Contractures: an abnormal, usually permanent condition of a joint, characterized by flexion and fixation.

*Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses.

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The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

The most recent Minimum Data Set (MDS) assessment was a Quarterly assessment with an Assessment Reference Date (ARD) of 2/16/16 with a Brief Interview for Mental Status (BIMS) indicating that the resident is rarely or never understood. Resident #10 was also coded to have long and short term memory problems and is severely impaired in cognitive skills for daily decision making. Under functional status Resident #10 is totally dependent with one person physical assist for bed mobility, dressing, eating, bathing and personal hygiene. Under functional limitation in range of motion the resident is coded having upper and lower extremity impairment. Under skin conditions Resident #10 is coded as follows: Number of Stage 2 pressure ulcers=1, Number of these Stage 2 pressure ulcers that were present upon admission/reentry=0, Date of oldest Stage 2 pressure area=2/16/16, Number of Stage 3 pressure ulcers=1, Number of these Stage 3 pressure ulcers that were present upon admission/reentry=0, Dimensions of Unhealed Stage 3 Pressure Ulcer=1.5 cm (centimeters) pressure ulcer length X 2.0 cm pressure ulcer width X 0.2 cm pressure ulcer depth, Most severe tissue type for any pressure ulcer=4 Eschar-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin. Under skin and ulcer treatments the following interventions are codes: pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration, pressure ulcer care, application of nonsurgical dressings, and application of ointments/medications.

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Resident #10's Comprehensive Care Plans were reviewed in the following sequence: Annual 9/3/15-12/3/15, Quarterly 12/3/15-2/25/16, and Current Quarterly 2/25/16-present.

The Annual Care Plan dated 9/3/15-12/3/15 documented in part:

Problems: Resident #10 at risk of pressure ulcer.
Goals: Resident #10 will remain free of skin breakdown over the next 90 days.
Interventions: Check for redness, skin tears, swelling,or pressure areas. Report any signs of skin breakdown.

There was no entry indicating that Resident #10 had developed a Stage III pressure ulcer on 9/25/15, and no documentation of any interventions or treatments that had been started.

The Quarterly Care Plan dated 12/3/15-2/25/16 documented in part:

Problems: Resident #10 at risk of pressure ulcer.
Goals: Resident #10 will remain free of skin breakdown over the next 90 days.
Interventions: Check for redness, skin tears, swelling,or pressure areas. Report any signs of skin breakdown.

The Current Quarterly Care Plan dated 2/25/16-Present documented in part:

Problems: Resident #10 is at risk for further pressure ulcers and other non pressure skin breakdown related to incontinence, immobility, contractures.

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Goals: Resident #10 will remain free of skin breakdown over the next 90 days.
Interventions: Check for redness, skin tears, swelling,or pressure areas. Report any signs of skin breakdown. Treatments per MD (doctor orders.

Problems: Stage 3 pressure ulcer right ankle. Stage 2 pressure ulcer right upper medial foot.
Goals: The size of ulcer will decrease with evidence of healing over the next 90 days.
Interventions: Assess and record the size (Length X Width X Depth), amount and characteristics of exudates, and pain status. Perform complete skin assessment and record. Provide care according to the protocol for Stage 3 and Stage 2 Pressure Ulcers. Off loading boots at all times. Float heels intermittently when in bed.

The facility staff was asked for all Braden Scales For Predicting Pressure Sore Risk that had been completed on Resident #10 in 2015 and 2016. Only one Braden Scale was completed in the 2015-2016 time frame for Resident #10 and it was dated 6/30/15. Resident #10's Braden Scale Score on 6/15/15 was a 12 indicating that the resident was HIGH RISK.

On 3/25/16 at approximately 12:20 p.m. an interview was conducted with the Quality Management Nurse Consultant who was asked if the facility had done a new Braden Scale on Resident #10 when the new Stage 2 and Stage 3 pressure ulcers were were identified. The Quality Management Nurse Consultant stated, "Evidently not, no we didn't do it."

Resident #10's Physician Order Sheet for

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October 2015 initialed and signed on 10/6/15 was reviewed. The following dated orders documented in part:

1/5/15- Off loading boots at all times.
4/29/15- High Risk for Skin Breakdown/Pressure Ulcer Prevention Protocol.
4/29/15- Float heels intermittently when in bed.
9/25/15- Left Great Toe and Left Plantar foot wounds: Poly Mem dressing every 2-3 days until healed.
9/25/15- Right Ankle wound: Cleanse daily with wound cleanser. Apply Santyl/Alginate to wound daily. Cover with dressing daily and PRN (as needed).
12/31/15- Weekly Skin Assessments with vitals.

A review of Resident #10's Weekly Skin Assessments was completed. The Weekly Skin Assessments documented in part:

Does this patient have a Pressure Ulcer?
9/8/15- No
9/15/15-Yes, Location-open area to left great toe.
9/22/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
9/30/15- Yes, Location-open area to left great toe.
10/6/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
10/13/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
10/20/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
10/27/15- No
11/3/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
11/10/15- No
11/17/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE

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11/24/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
12/1/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
12/7/15- Yes, Location right foot.
12/15/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
12/22/15- Yes, Location right ankle.
12/29/15- NO WEEKLY SKIN ASSESSMENT AVAILABLE
1/5/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
1/12/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
1/19/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
1/29/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
2/2/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
2/9/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
2/16/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
2/23/16- NO WEEKLY SKIN ASSESSMENT AVAILABLE
3/1/16- Yes, Location right ankle
3/9/16- Yes, Location right ankle
3/16/16- Yes, Location right ankle

From 9/8/15 though 3/16/16 Resident #10 had 18 Weekly Skin Assessments that were unaccountable for.

Resident #10's Wound Care Specialist Evaluations which were completed weekly by the Wound Care Physician were reviewed. The Wound Care Specialist Evaluations documented in part:

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Physical Exam

9/11/15: Stage 2 Pressure Wound of the Left, First Toe, Etiology: Pressure, Dressing: Foam-Every Three Days and PRN, Recommendation: Off-Load Wound, Reposition per facility protocol.

9/18/15: Stage 2 Pressure Wound of the Left, First Toe, Etiology: Pressure, Dressing: Foam-Every Three Days and PRN, Recommendation: Off-Load Wound, Reposition per facility protocol.

9/25/15: Stage 2 Pressure Wound of the Left, First Toe, Etiology: Pressure, Dressing: Foam-Every Three Days and PRN, Recommendation: Off-Load Wound, Reposition per facility protocol.

Stage 2 Pressure Wound of the Left, Plantar Foot, Etiology: Pressure, Dressing: PolyMem and Foam every three days, Recommendation: Off-Load Wound, Reposition per facility protocol.

Stage 3 Pressure Wound of the Right Ankle, Etiology: Pressure, Wound Size: 1.2 cm x 1.4 cm x 0.2 cm (centimeters), Thick Adherent Black Necrotic (Eschar): 10%, Yellow Necrotic: 10%, Granulation Tissue: 80%, Dressing: Santyl- Once daily, Recommendation: Off-Load Wound, Reposition per facility protocol.

The Wound Care Physician's weekly Wound Care Specialist Evaluations were available and complete, the last evaluation available was on 3/18/16 which documented in part:

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Stage 3 Pressure Wound of the Right Ankle, Etiology: Pressure, Duration greater than 166 days, Wound Size: 0.6 cm. x 0.8 cm. x 0.2 cm., Yellow Necrotic: 5%, Granulation: 95%, Dressing: Santyl- Once daily, Recommendation: Off-Load Wound, Reposition per facility protocol.

On 3/24/16 at 5:00 p.m. an interview was conducted with the Wound Care Physician. The Wound Care Physician was asked what was the stage of Resident #10's right ankle pressure when it was first identified. The Wound Care Physician stated, "The right ankle was first identified at a Stage 3." Surveyor asked, "Is it a pressure area?" The Wound Care Physician stated, "It is absolutely from pressure, those wounds are not diabetic ulcers. My perspective is that she favors the right side, so she needs to be off-loaded and use the prevalon boots. I want both interventions in place. She should be off-loaded all the time completely, no pressure at all. There should be dead space between the prevalon boot and the bed. The wounds are healing, they are not diabetic ulcers."

On 3/22/16 at 4:35 p.m. Resident #10 was observed lying in bed with the prevalon boots on but the resident's boots were touching the bed, the heels were not being floated.

On 3/23/16 at 10:30 a.m. Resident #10 was again observed lying in bed positioned on the right side. The resident's prevalon boots were on bilateral feet; however, the heels were not being floated causing direct pressure on the Stage 3 right ankle pressure area.

On 3/23/16 at 12:45 p.m. after the completion of

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a wound care observation Resident #10's prevalon boots were reapplied but the heels were not floating; they remained touching the bed. Also, prior to the beginning of the wound care observation LPN #1 was asked what was the stage of Resident #10's right ankle when it was first identified. LPN #1 stated, "We found the right ankle at a Stage 3."

On 3/24/16 at 11:20 a.m. Resident #10 was observed lying in bed on her right side with the prevalon boots on but the heels were not floating. The left prevalon boot was positioned on top of the right prevalon boot with the right ankle making contact with the bed.

The facility policy titled "Physician Approved Pressure Ulcer-Prevention Orders/Protocol" not dated, documented in part:

All Residents

3. All Residents are assessed for pressure ulcer risk on admission; weekly times four weeks, then quarterly, with significant change and annually using the Braden scale. Re-evaluate if a pressure ulcer is identified.
6. Weekly skin inspections.
8. Develop patient-specific written care plan for pressure ulcer prevention.

If Braden score is 14 or less add:

12. Suspend heels when in bed intermittently.

The facility policy titled "Pressure Ulcer Prevention" revised 11/12/16 documented in part:

Policy Statement: To prevent development of

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pressure ulcers.

*All Residents are assessed for pressure ulcer risk on admission, every week times 4 after admission, quarterly, with significant change and annually using the Braden scale.
*Weekly skin inspections are conducted and documented on all residents by licensed staff.
*Complete weekly skin inspection form.
*Turning and repositioning frequency is dependent on resident assessment and chart on TAR (Treatment Administration Record).
*Pressure ulcer prevention order set is implemented based on need.

On 3/24/16 at approximately 4:40 p.m. a pre-exit conference was held with the Administrator, the Director of Nursing, and the Quality Management Nurse Consultant and the above findings were shared. The Director of Nursing was asked, "At what stage would you have expected your nursing staff to identify Resident #10's right ankle pressure ulcer?" The Director of Nursing stated, "During the skin assessments, when it was pink or red and blanchable. At a Stage 1, so we could start prevention.'

Prior to exit no further information was shared by the facility.

#4. For Resident #9, the facility staff failed to identify a pressure ulcer to the right heel before it reached an advanced stage III and failed to follow physicians orders to float heels resulting in harm.

Resident #9 was admitted to the facility on 5/10/2005. Diagnoses for Resident #9 included but not limited to Stage III pressure ulcer, trochanteric fracture (closed fracture at the neck

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of the femur), anemia, and Dementia. Resident #9's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date (ARD) of 09/07/2015 coded Resident #9 with severely impaired cognitive skills for daily decision making. In addition, the MDS coded Resident #9 requiring total dependence on staff for Activities of Daily Living. Resident #9's MDS with an ARD of 09/07/2015 Section M: Skin Conditions coded Resident #9 at risk of developing pressure ulcers with no current ulcers present.

A review of Resident #9's clinical record was conducted during the survey. A clinical note written by LPN #2 on 2/16/16 at 7:13 pm read: "writer advised by CNA (certified nursing assistant) identified an open area to the right heel. Pressure ulcer noted stage 3. Wound bed noted as beefy red, surrounding area macerated and white. 5% slough noted. Wound measures 1.5 cm (centimeters) in length, 1.0 cm in width and .1 cm in depth." The treatment ordered, "Solosite to wound bed and covered with foam dressing." The wound was reported to the MDS coordinator RN #4 and clinical supervisor RN #1. An additional note was made on 2/16/2016 at 7:21 pm that the family was notified and on 2/16/2016 at 7:24 the doctor was notified with a message to call back with orders for wound care and wound consult if appropriate.

On 2/18/2016 at 7:32 am a note was added to the clinical record by the clinical supervisor RN #1 which read, "Note for 2/17/2016. Reassessed the resident's left heal pressure ulcer wound. The site had bright red blood. Area measured 3.5 x 4.0 x 0.1 cm presenting as stage two. Surrounding

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wound bed with 5% maceration. Wound bed has 100% granulation. MD and RP (responsible party) were notified. Will continue the same treatment. Prevalon boots to bilateral feet. No facial grimacing during the procedure."

The National Pressure Ulcer Advisory Panel redefined the definition of a pressure ulcer and the stages of pressure ulcers in 2007 to include but not limited to the definition of a stage II pressure ulcer: "partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open /ruptured serum filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates deep tissue injury). This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation."

According to the National Pressure Ulcer Advisory Panel the definition of a stage III pressure ulcer is "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer may varies by anatomical location.

According to Minimum Data Set (MDS) Version 3.0 the term granulation tissue is defined as pink or red tissue with shiny, moist, granular appearance and slough is yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous.

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According to the facility documentation Pressure Ulcer Monitoring sheet for the month of March 2016, Resident #9 was identified with an acquired stage III pressure ulcer to the right heel on 2/16/16 and the treatment was calcium alginate and santyl (debridement agent) QD (every day), Prevalon boots. The description on the Pressure Ulcer Monitoring sheet measured Resident #9's pressure ulcer on 3/18/16 as 3.2 x 1.5 x 0.2 cm with 10 % necrotic and 90 % granulation.

According to the MDS Version 3.0, necrotic tissue or echar is a black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin. Stage IV pressure ulcers are defined as full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Resident #9's pressure ulcer on the right heel was identified at an advanced stage III.

The wound doctor (others #2) report dated 2/19/16, documented Resident #9 was seen at the request of the primary doctor for evaluation. The wound care specialist's initial evaluation on 2/19/16 read, "Resident #9 presents with a stage III pressure wound of the right heel of at least one days duration. There is sero-sanguinous exudate." The wound specialist doctor (others #2) measured the wound 2.4 x 1.5 x 0.2 cm (length x width x depth) with 3.60 centimeters squared for the surface area with moderate sero-sanguinous, yellow necrotic 15% and granulation tissue at 85%. The recommendation reads, "off-load wound, reposition per facility protocol and dressing: Calcium Alginate-once daily."

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Also in the clinical record are current standing orders from Resident #9's physician to float heels in bed starting 08/01/2015 and Prevalon boots starting 08/01/2015 and pressure relief surface for chair by shift starting 08/01/2015. No order for a pressure relieving mattress was made until the 3/23/2016 at 2:25 pm by the clinical manager RN #1, the second day of the current survey directly following an observation by two surveyors (#1 and #2) of the wound care treatment on 3/23/16 at 12:40 pm.

The only weekly skin assessments produced by the facility were completed on 1/29/16, 2/12/16 both indicated no pressure ulcer and on 2/26/16, 3/11/16 reflected the presence of a right heel pressure ulcer. Weekly skin assessments were not completed for Resident #9 who was identified at risk for the development of pressure ulcers.

Resident #9's care plan indicates risk for developing pressure ulcer with impaired bed mobility and impaired cognition dated 2/23/16 to present. This care plan reflects a stage II pressure ulcer only with no update regarding the stage III pressure area on the right heel. The impaired bed mobility had an intervention of a specialized mattress indicated on a care plan dated 12/3/2015 to present but was not observed in place until 3/23/16.

On 3/22/16 at 5:30 pm Resident #9 was observed by Surveyor #1 in bed positioned on back with Prevalon boots on both feet lying flat on the bed with no pressure relieving mattress. On 3/23/16 at 10:45 am Resident #9 was observed in the same position on back in bed with Prevalon boots on both feet lying directly on the bed with no

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pressure relieving mattress. On 3/23/16 at 12:40 pm during the observation of the wound care treatment two surveyors (#1 and #2) observed Resident #9 in bed with Prevalon boots on both feet lying directly on the bed with no pressure relieving mattress. Another observation of Resident #9 lying on back in bed with Prevalon boots in place on both feet without floating heels was made on 3/23/16 at 5:30 pm. On 3/24/16 at 10:50 am Resident #9 was observed on back in bed with Prevalon boots in place on both feet without floating heels. Finally, Resident #9 was observed on 3/24/16 at approximately 2:50 pm sitting in the dining room with Prevalon boots on both feet but both feet were directly on the floor.

The clinical manager RN #1 who staged the wound at a Stage II on 2/17/16 was interviewed by two surveyors (#1 and #3) on 3/23/16 at 6:05 pm and stated that "granulation equals red beefy and I saw 100 % granulation or red beefy on the wound bed and maceration around the wound and staged this at a stage II for Resident #9."

According to the Centers of Medicaid and Medicare Resident Assessment Indicator Version 3.0 Manual which drives the skin assessment in section M0700: stage II pressure ulcers by definition have "partial-thickness loss of dermis." Granulation tissue, slough or eschar are not present in stage II pressure ulcers. Therefore, stage II pressure ulcers should not be coded as having granulation, slough, or eschar tissue.

According to the MDS coordinator RN #4 in an interview on 3/23/16 at 5:25 pm regarding the identification of a pressure ulcer, a new Braden (formal assessment) scale should be completed, a new MDS with a significant change should

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reflect a stage III, if a new treatment is ordered-all of this should go immediately onto the careplan...we don't wait until the next meeting. According to RN #4 the definitions of the stages found in the MDS manual, Resident #9 had a stage III pressure ulcer to the right heel not a stage II. On 3/24/16 at 1:40 pm it was stated by RN #4, "I will modify the MDS now to reflect a stage III...I learned something: there is no slough or granulation tissue nor eschar in a stage II pressure ulcer." On 3/23/16 at 2:00 pm the submitted correction were made to reflect a significant change MDS created 3/24/16 and the corrected quarterly assessment was submitted to reflect the corrected stage III pressure ulcer for Resident #9 based on the identification description in the clinical record on 2/17/2016 and the definitions found in the RAI manual. It was also noted by RN #4 that no Braden scales were completed for Resident #9 for the past 6 months.

An interview with the wound care specialist (others #2) with surveyor #4 on 3/24/15 by phone and again with surveyor #1 on 3/25/15 in person at approximately 11:10 am noted, "When I write an order to float heels and Prevalon boots...I want both to off load pressure and without pressure reducing mattress heels should be floating." The recommendation of the wound specialists was to off-load wound and treat with Calcium Alginate daily - for an advanced stage III pressure ulcer.

In an interview with the Director of Nursing Administration #2 on 3/25/16 approximately at 3:00 pm the facility Pressure Ulcer Policy (revision date 11/12/2013) was provided with a specific comment regarding residents with stage III pressure ulcers, "Resident #9 should have Prevalon boots and pressure relieving mattress or

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without the mattress offload the heels per policy." It was agreed that a pressure ulcer first identified at a stage III, an advanced stage, is not acceptable. If skin assessments and interventions are applied with no medical cause a pressure ulcer should be identified prior than at a stage III.

On the Facility Policy: Nursing Documentation (revision date 10/04/2013) under weekly skin assessments it reads, "Weekly skin assessments are completed and documented weekly on all residents." On the facility produced Pressure Ulcer Support Surface Matrix diagram it noted, "Residents with stage III/IV should have an alternating air/low air loss mattress." On the Pressure Ulcer Prevention Policy (revision 11/12/2013) it reads, "All residents are assessed for pressure ulcer risk on admission, every week x 4 after admission, quarterly, with significant change and annually using the Braden scale."

In an interview with LPN # 2 on 3/25/16 at 10:45 am it was stated, "I just saw the Pressure Ulcer Protocol for the first time today- I did not see this in orientation and I have been working one month after orientation." LPN #2 was the staff observed giving the pressure ulcer treatment for Resident #9 on 3/23/16 at 12:40 pm. Also, in an interview with LPN #6 on 3/25/16 at approximately 11:00 am, it was stated, "I have worked in this facility for 18 years...I know the protocols sit in a binder on the unit but no formal training of Pressure ulcer protocol has been given in a while...I know it was mentioned when the records went electronic in December 2014 or 2015...but no one has approached me with any training for this protocol annually."

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F 323 SS=G	Continued From page 123 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on information obtained during a complaint investigation, family interview, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to provide supervision and interventions to prevent accidents and elopement for 3 of 43 residents in the survey sample (Resident #24, #39 and #7) 1. The facility staff failed to implement fall prevention strategies and to provide necessary supervision to prevent a fall resulting in a fracture and debilitating pain for Resident #24. The outcome of this fall constituted harm for Resident #24. 2. The facility staff failed to provide adequate supervision to Resident #39 to prevent elopement from the facility. Resident #39 eloped from the facility and was found approximately 0.4 miles away at a convenience store. 3. The facility staff failed to provide adequate supervision to Resident #7 to prevent elopement from the facility. The findings included: 1. Resident #24 was originally admitted to the	F 323 F 323	F323 1. Resident #24 is no longer at this facility. Resident #39 was reassessed for risk of elopement on 4/20/16 and this alert and oriented x4 resident is not an elopement risk. He has been educated on risks associated with going off property without assistance. Resident #7 was reassessed for elopement risks on 4/21/16; the residents' plan of care has been reviewed to minimize recurrence. No further incidents leaving facility has occurred. 2. Current residents will have elopement risk assessments completed/reviewed and if identified at risk, their care plan will be reviewed to include interventions to minimize elopement. Current residents will have fall risk assessment completed/reviewed and if identified at risk, the residents' plan of care will be reviewed to ensure that fall prevention interventions are in place.	

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F 323	Continued From page 124 facility 9/7/16 for rehabilitation therapy after a fall at home resulting in a left closed femur neck fracture. The resident was discharged on 10/2/15 after sustaining a closed lumbar 1 vertebra fracture after a fall in the nursing facility on 10/2/15. Resident #24 diagnoses at the time of the discharge included, brain cancer, high blood pressure, obesity, reflux disease, a left femur fracture and a closed fracture of lumbar 1 vertebra. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/14/15 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #24 cognitive abilities for daily decision making were intact. Resident #24 was coded unsteady moving from a seated position to a standing position, activity did not occur walking, turning around and facing the opposite direction, moving on and off the toilet and unsteady with surface-to-surface transfers. The resident was also assessed to need extensive assistance of 1 person with transfers, unable to walk, total assistance with dressing and bathing, and requiring limited assistance with personal hygiene and eating. The resident was coded as having an indwelling catheter and occasionally incontinence of bowels. The resident was not coded on the MDS assessment with behavioral symptoms/problems or indicators of delusions, psychosis, physical, verbal or behavioral symptoms towards others, and she did not reject care. A facility Fall Risk Assessment was not completed for Resident #24 upon admission or anytime	F 323	3. Educate staff on facility Fall Prevention Program including all policies and procedures. Fall assessment will be completed on admission, quarterly, with change in resident condition, and with any new fall. Residents at risk for falls will be screened for appropriate assistive device and included in care plan if appropriate Elopement risk assessments will be completed on admission / re-admission, quarterly, with significant change and preventive interventions will be addressed in the residents plan of care. All incidents of falls and/or elopement will be thoroughly investigated, preventive actions implemented and discussed by the IDT during the weekly Standards of Care meeting. In-service staff on responding to missing person alert.	

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F 323	Continued From page 125 doing the 25 day stay. The facility's policy entitled Fall Prevention Program - Assessment and Care Planning with a revision date of 10/4/13 read a Fall Risk Assessment is to be completed within 24 hours following admission. An interim care plan will be instituted for residents determined to be at-risk on admission. Residents assessed at high risk will have a yellow armband ... All residents who have fallen will have Fall Prevention interventions placed on their care plan. Individualized care plan interventions will be implemented for residents found to be at high risk for falls, through Fall Risk Assessment or MDS. The care plan with an effective date of 9/21/15 identified as a problem; at risk for falls related to impaired mobility. The goal (resident name) will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 day review period. The approaches listed to achieve the goal were listed as; keep areas free of obstructions to reduce the risk of falls or injury. Place call bell/light within easy reach. Remind (resident name) to call for assistance before moving from bed to chair and from chair to bed. Respond promptly to calls for assistance to the toilet. Use alarm to monitor attempts to rise. Footwear will fit properly and have non-skid soles. Provide reminders to use ambulation and transfer assist devices. Review of the clinical record revealed on 9/8/15 a nurses' note written at 1:46 a.m., stating the family member (daughter in law) reported to the facility's staff the resident had "sun downers" and would become a little confused. The staff documented the resident became very confused, repeatedly yelled out for help and stating she did not want to be alone, then called 911. Another	F 323	4. QA/designee will audit 10% of all residents' weekly X 6 weeks for fall risk and elopement risk assessment completion and care plan being developed/modified. Variances will be corrected and responsible staff re-educated. Analysis of audit will be reported to the DON and administrator and summary of findings will be reported to QAPI committee for additional oversight. QA/designee will conduct an unannounced unusual occurrence drill twice a month x 2 months to ensure staff recognizes need for investigation/reporting and that staff response is appropriate to the unusual occurrence. Analysis of the unusual occurrence drills will be completed; staff will be re-educated as needed and a summary of the drills will be submitted to QAPI for additional oversight and recommendation. 5. Completion: 5/13/16	

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nurses' note dated 9/13/15 indicated the resident continued with periods of confusion and was now incontinent of bladder and sometimes bowels.

The clinical record further revealed a nurses' note dated 9/19/15 written at 3:42 a.m., which stated Resident #24 was requesting the bedpan and the staff was aiding to transfer her from bed to the bedside commode for elimination. Another nurses' note dated 9/24/15 at 7:16 p.m., stated the resident was diagnosed with a urinary tract infection (UTI) based on laboratory results and started on an antibiotic for 7 days. On 9/27/15 at 3:37 p.m., a nurses' note stated the resident is now continent of her bowels and bladder but requires assistance of 1-2 staff to the bedside commode or to get out of bed.

Review of the Physical therapist note dated 10/5/15, revealed Resident #24 was discharged from physical therapy on 10/1/15 to travel back home with family because maximum potential with skilled services had been reached. At the time of Resident #24 discharge she was capable of walking 100 feet with contact guard assistance and rest breaks. The physical therapist documented on 9/29/15 the resident had a high risk for falls.

On 10/2/15 a nurses' note written at 7:01 a.m., states "found resident on the floor in room. Resident states she was trying to use the bedside commode without assistance. She did not use the call bell to inform staff. Resident stated she hit her head on the bed adjacent to her. Complained of back and head hurting. Resident has not been moved, awaiting medical transport. Vital signs blood pressure 175/75, pulse 75, respirations 22, temperature 97.8 oral, oxygen saturation 87%".

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Another nurses' note dated 10/2/15 7:04 a.m., stated in the hallway up from (room number), heard a yell then a thump, entered room and found resident on the floor, lying on her back. She was alert, but confused to time and date. Asked if she was in pain, she stated my spine hurts. Supervisor present and several nurses. Roommate said resident hit her head on the bed. Examined head, no bruising or tenderness noted. Resident not moved, for safety reasons. Did note bed in low position and resident had removed entire alarm system and put in chair. Physician called and 911 called. Another nurses' note dated 10/2/15 at 7:16 a.m. stated, 911 in to transfer via stretcher. Resident verbal and alert. A nurses' note dated 10/2/15 at 7:46 a.m., stated the physician and family were updated.

An incident report with an event date of 10/2/15 stated entered room, found resident lying on her back. Alert but confused. Complained of spinal pain. Able to move arms. Supervisor called. The incident report with an event date of 10/2/15 further revealed; Preliminary cause; impulsive, non-compliant, Patient severity index; minor injury, Primary injury; pain- no physical harm.

Review of the 10/2/15 hospital emergency room physician documentation revealed Resident #24 was seen for a fall. The resident reported she had to use the bathroom and became tired waiting for the nurse to come help her therefore; she walked to the bedside commode. The resident stated her sock got caught on the rug/mat causing her to trip and fall backwards landing on her bottom. The resident reported hitting her head on the bed, denied loss of consciousness but complained of pain to her low back and left hip. The resident

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was diagnosed with a closed fracture of first lumbar vertebra, unspecified fracture morphology. Percocet (a narcotic pain medication) was prescribed for pain and the resident was discharged because she and the family stated they had flights to another state in 2 days.

*A closed fracture is a broken bone that does not penetrate the skin.
*Lumbar vertebras are located in the lower back and support most of the upper body's weight. The lumbar vertebras are most vulnerable to spinal conditions that can cause chronic and debilitating pain.

The nurses' note dated 10/2/15 at 7:09 p.m. stated the resident returned to the facility from the emergency department of a local hospital on a stretcher. The nurse stated the social worker and family member stated the resident was leaving the facility today instead on tomorrow. Discharge orders were received and the resident was given all medications for the week. The resident did not exhibit signs of distress or pain and was wheeled out the facility by the family and placed in the car.

A telephone interview was conducted with the emergency contact/family member on 3/24/16 at approximately 12:45 p.m. The family member stated she had been informed on 9/30/15 by the physical therapist the resident had been getting confused and was observed out of bed grabbing furniture to get to the bedside commode therefore the family member requested the staff use a bed alarm to keep the resident safe for the next 2 days. The resident was scheduled to be discharged on 10/4/15. The family member stated during visits with Resident #24, she noted the

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facility was always short of staff and it sometimes took the staff 30 minutes to respond to the resident's call bell.

*An alarm device alerts the staff; by sounding if the resident forgets to call for assistance with transfers.

The family stated on 10/2/15 between 7:00 a.m. and 7:10 a.m. she received a call from the nursing facility stating Resident #24 had fallen in her room and was being transported to a local emergency room. The family member stated she came to the nursing facility to ask the staff and Unit 4 Manager how did the fall occur and they responded the resident had been taking the clip bed alarm off her shirt. The family member stated she asked the facility staff why did they not attempt another intervention and they did not respond to the question.

Resident #24 family member stated prior to the 10/2/15 fall the resident was able to sit in a wheelchair without pain, aid with transfers on and off the bedside commode, walk with the therapist/staff and participate in her daily care. She further stated after the 10/2/15 fall the resident was unable to sit, walk or lie down without severe debilitating pain and the resident often cried because the pain was often so severe. The family member stated narcotic pain medications were required to achieve some comfort but not eliminate the pain. The family member further stated the pain after the fall resulting in the lumbar 1 vertebra fracture required a delay in resumption of therapy sessions. The family member stated the in home therapy had to be put on hold for 2 weeks while some degree of pain control was being

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accomplished. The family member stated it was 6 weeks before the resident was able to tolerate sitting again without use of narcotic pain medication.

An interview was conducted with the Unit 4 Manager on 3/26/16 at approximately 2:20 p.m. The Unit 4 Manager stated Resident #24 was found lying on the floor at 6:55 a.m. The Unit 4 Manager also stated Resident #24 was utilizing a clip type alarm because the family requested an alarm as there had been reports of the resident transferring herself without assistance. The Unit 4 Manager stated Resident #24 was known to repetitively remove the alarm but no other interventions had been instituted at the time of the fall. The Unit 4 Manager stated usually when the alarm system was deemed ineffective for a fall risk resident the individual would be moved closer to the nurses' station for more frequent monitoring by the staff but for some reason this did not occur neither were more effective interventions institute to prevent further falls for the resident.

An interview was conducted with the Director of Nursing (DON) on 3/28/16 at approximately 4:20 p.m., when it was discovered a Nursing admission assessment had never been completed for Resident #24. The DON stated the assessment was likely not completed because there was not sufficient staff to perform the duty. The DON stated the nursing admission assessment is a valuable tool in determining care needs for the resident. The DON stated the nursing admission assessment aids the staff in determining potentials for pain, skin breakdown, elimination needs, incontinence care, elopement risk and aids in development of an individual pall

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prevention program and necessary care planning interventions. The DON further stated she was aware the nursing admission assessments were not being completed but no action plan had been developed to ensure this would not continue to be a facility practice.

During the interview with the Director of Nursing (DON) on 3/26/16 at approximately 4:20 p.m., the DON was asked to provide information on how the admission nursing assessment could have benefited Resident #24. The DON stated completing the nursing admission assessments would have alerted the staff the resident was a high fall risk resident and prompt them to respond quickly to calls for assistance, encourage increased monitoring and frequent reinforcement of using the call bell to contact the staff.

Review of the call bell activity for Resident #24 bed revealed on the day of the fall 10/2/16, the resident had called at 12:44 a.m. and the call bell was not answered for 16:08 minutes, another call was made at 3:33 a.m. and the staff responded 10:15 minutes later, the resident called again at 5:42 a.m. and waited 7:58 minutes for assistance, at 5:58 the resident called and staff responded within 3:54 minutes , another call was made at 6:03 a.m. and staff responded in 4:41 minutes. There were no further calls from that bed until 14:08. There was no call logged for the time of the fall at approximately 6:55 a.m. on 10/2/15.

The above information was shared with the Administrator, Director of Nursing and Corporate Representative on 3/29/16 at approximately 4:00 p.m. The facility staff did not offer any additional information prior to the survey team's exit.

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2. The facility staff failed to ensure supervision was maintained and assistance devices were in place to prevent elopement from the facility for Resident #39.

Resident #39 was admitted to the nursing facility on 1/12/16. The resident was admitted to a local acute care hospital and readmitted to the facility on 2/29/16. Resident #39 diagnoses included hardening of the arteries, reflux disease, diabetes, and high cholesterol, swallowing difficulties, and narrowing of the esophagus.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/7/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #39 cognitive abilities for daily decision making were intact. The assessment states the resident is feeling down, depressed or hopeless 2-6 days over a 14 day period and has no behavior problems. The resident requires limited assistance of 1 with transfers and walking. He is coded as not steady moving from a seated position to standing, walking, turning around while walking, moving on and off the toilet and from surface to surface. The resident requires supervision only with bathing, limited assistance with personal hygiene and toileting but extensive assistance with dressing because of hand contractures and left hemiparesis.

The elopement risk assessment dated 1/12/16 was completed with the resident only because no family accompanied him to the facility. The risk assessment indicated the resident was not an elopement risk.

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A clinical note dated 1/13/16 at 6:10 p.m., stated the facility staff offered a wander guard bracelet (a device that sounds an alarm when a wandering resident walks outside the building) to Resident #39 even though the information provided by the resident indicated it was not necessary. The 1/13/16 clinical note further stated the staff explained the importance of the device to the resident but he declined use of the wander guard bracelet and promised not to leave or go out the door. A clinical note dated 1/15/16 at 11:35 a.m., stated the resident left the facility without notifying staff. He went to (name of the convenience store). Resident assessed by nurse, Registered Nurse and Director of Nursing (DON) and found to be alert and oriented x4. The resident was without injury. Resident agreed to use of a wander guard. The wander guard was placed on his left ankle. Resident was instructed on the sign out policy and importance of staff being notified when he was going on leave of absence.

Another clinical note date 1/15/16 at 1:53 p.m., stated the resident walked to (name of the convenience store) stated he was going to the bank to cash his money. Resident returned to the facility alert oriented x4, knew what he did was wrong. Accepted to have wander guard placed for his safety. Son notified and made aware.

The care plan dated 3/16/16; stated the resident had a potential for injury related to wandering/elopement. 1/15/16 walked to (name of the convenience store) without notifying staff. On 2/29/16 the resident walked to the facility's entrance to look for his son. No further episodes of exit seeking behavior. Resident was told when his cardiac monitoring was completed his need for the wander guard would be reviewed. The

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care plan goal stated; Resident will have no injury and will not wander from unit or out the facility on a daily basis for 90 days. The care plan interventions were; Provide diversional activities. Approach calmly and attempt to redirect into appropriate areas of the facility. Wander guard per physician's order. Check for placement every shift and functioning every week. Monitor whereabouts at all times. Adapt environment as needed so resident can identify own room and belongings. Encourage activity attendance. Monitor for signs and symptoms of over tiring and encourage rest periods. Assess for need that may have initiated wandering. Attempt to anticipate needs as indicated. Have picture and accurate description readily available in case resident leaves the facility. Notify appropriate persons and initiate search. Notify physician and Responsible Party as needed.

On 3/28/16 at 6:00 p.m., the resident's elopement route was reviewed by the surveyor. Observation of the route revealed the resident walked a road with 2 lanes through a residential area where the speed limit was 25 miles per hour. Traffic was very heavy at the (name of the convenience store) and a busy 4 lane highway with 4 directions of traffic was 0.1 mile away. According to a weather site for the area, the high temperature on 1/15/16 was 59 degrees.

An interview was conducted with the Director of Nursing on 3/28/16 at approximately 4:15 p.m. The DON stated she was informed at approximately 7:00 a.m. on 1/15/16 by the Maintenance man that he saw Resident #39 at the (name of the convenience store). The DON stated she drove to the (name of the convenience store) talked with the resident, encouraged him to

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get in her vehicle and she returned him to the facility without incident or injury. The DON stated she did not complete an investigation or report the incident to the state agency because he had no physician order which stated he could not leave the facility at will. The DON was asked why did she go get the resident, have a wander guard bracelet applied to his left leg, have a new elopement assessment completed for the resident and an elopement care plan initiated if his leaving the facility was not considered an elopement. The DON again stated Resident #39 could leave at will because there was no physician order stating he could not.

A telephone interview was conducted with Licensed Practical Nurse (LPN) #199 on 3/29/16 at approximately 12:30 p.m. LPN #199 stated on 1/15/16, she observed Resident #39 in his room at approximately 7:00 a.m. and administered his medications to him at approximately 9:00 a.m. LPN #199 stated after breakfast the resident was observed sitting near the water fountain for a short while then he stated he was going to activities at approximately 10:00 a.m. LPN #199 stated that was the last time she saw the resident prior to a Certified Nursing Assistant (CNA) bringing the Resident to her and informing her the resident was just brought back from the (name of the convenience store). LPN #199 stated she assessed the resident and charted what she knew about the event in the clinical notes. LPN #199 stated she was not informed who saw the resident at the (name of the convenience store) or who brought him back to the facility. LPN #199 stated the DON and RN also assessed the resident and initiated use of a wander guard.

An interview was conducted with CNA #200 on

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3/29 16 at approximately 12:45 p.m. CNA #200 stated she was caring for Resident #39 on 1/15/16, the day of the elopement. CNA #200 stated the resident was unsteady when walking and required use of a cane because of weakness on one side. CNA #200 also stated most of the resident's hygienic care was provided by her. She stated the resident was dressed in pants, a shirt and a hoodie and she last saw the resident sitting in his room at approximately 10:30 a.m. CNA #200 stated at approximately 12:00 noon she was informed by LPN #199 that Resident #39 was seen at the (name of the convenience store) and brought back to the facility. CNA #200 said LPN #199 gave her no new instructions for caring for Resident #39.

An interview was conducted with the Palliative Care Nurse Practitioner (NP) on 3/29/16 at approximately 1:30 p.m. The NP stated the resident was enrolled in the Palliative Care program for symptom management on the same day he left the facility unescorted. The NP also stated based upon clinical judgement Resident #39 was not a candidate for a leave of absence with a responsible person accompanying him. The NP stated the Resident had been residing at the facility only 2 days, had cardiac concerns and an unsteady gait with left side weakness.

Another interview was conducted with the DON on 3/29/16 at approximately 2:45 p.m. After further questioning by the surveyor the DON stated she did not pick the resident up from the (name of the convenience store) a little after 7:00 a.m. on 1/15/16. The DON stated it was later in the day based on nurses' notes she had reviewed. The DON further stated she did not document on the event.

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The facility's policy and procedure entitled 'Adverse Events' with a revision date of 1/13/15 states the definition of an Adverse Event is any event that has caused (or potential to cause) harm to staff, resident and/or Sentara Health Care. The policy further states examples of adverse events are elopement; occurs when a resident leaves the premises or safe area without authorization and/ or the necessary supervision to do so and under circumstances that place the Resident's health, safety, or welfare at risk. Under 'Investigation' the policy states a thorough investigation of the event is conducted and documented by the Administrator and Director of Nursing.

The above information was shared with the Administrator, Director of Nursing and Corporate Representative on 3/29/16 at approximately 4:00 p.m. The facility staff did not offer any additional information prior to the survey team's exit.

3. The facility staff failed to provide adequate supervision for Resident #7 to prevent elopement from the facility.
Resident #7 was admitted to the facility with diagnoses which included schizophrenia, type 2 diabetes, dysphagia, asthma, glaucoma and history of alcoholism. The facility staff failed to provide supervision to prevent elopement.

A Quarterly Minimum Data Set (MDS) dated 10/1/15 assessed this resident as being able to understand and makes self understood with clear comprehension. This resident was assessed as having scored an 11 on the Brief Interview Mental Status (BIMS) assessment indicating moderate cognitive impairment. This resident was not

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assessed as having wandering behaviors.

An Elopement Risk Assessment was performed on 1/27/16 at 2:57 P.M. The assessment indicated: "Applicable Diagnosis-Schizophrenia. The resident has attempted to leave a residence or other place unescorted that places him/her in danger. (Yes). The resident is cognitively impaired with poor decision-making skills (i.e. intermittent confusion, cognitive deficits or disoriented all the time) and independently ambulatory. (Yes).

The resident has a history of elopement. (No).

The resident is on medication to manage the wandering behavior. (No).

There has been a recent change in this medication. (No).

Resident has verbalized intent to leave facility. (Yes)

The resident is wandering/seeking to find spouse or family. (No)

The resident is wandering aimlessly. (No).

The resident is actively exhibiting exit-seeking behavior. (Yes).

Comment on wandering behavior: Resident has been leaving facility unsupervised and not notifying staff. Resident has been rolling in wheelchair down (sic) street to nearby store."

Resident #7 was observed throughout the survey walking from one unit to the other and

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participating in smoking activities.

A Care Plan dated 10/8/15 indicated: "Short term memory impaired-unable to recall after 5 minutes. Interventions- maintain consistent routine, introduce changes slowly to reduce confusion. Provide direct guidance when resident is unable to follow through with instructions."

A Care Plan dated 3/18/16 indicated: "Potential for injury related to wandering/elopement- Intervention Provide diversional activities; wander guard per MD order; monitor whereabouts at all times hourly check in.

A Social Services Progress Note dated 12/23/15 indicated: Resident is A+Ox3 (alert and oriented times 3) and able to effectively communicate his needs. He is very pleasant and cooperative with care. He does have a history of being non-compliant with dietary restrictions. Resident has family that is actively involved in his care. He serves as a great advocate on his behalf. The plan is for resident to remain LTC (long term care) due to his need for supervision and assistance with ADL'S."

A Nursing note dated 1/26/16 at 9:52 A.M. indicated: "Resident is (sic) verbal abusive cussing at staff and calling them out of name."

A Nursing note dated 1/26/16 at 11:54 A.M. indicated: "Resident had dried blood on left elbow and was asked what happened? Resident stated it happened in the courtyard when he was outside drinking. This nurse cleaned elbow and noticed a small scratch in place. This nurse asked resident if he had anything besides his meds and resident

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stated "yes I had, wine, beer, and (sic) (illicit drugs). Nurse called MD (medical doctor) and notified him that resident was acting erratically and needed to be evaluated at ER (emergency room) for possible drug toxicity. MD gave order for ER to evaluate for possible drug toxicity and once resident is stabilized medically to send resident for a psych evaluation."

Nursing note dated 1/26/16 at 2:36 P.M. indicated: " Psych evaluator stated resident is very cooperative and no danger to himself or others and does not meet the criteria to be TDO (Temporary Detaining Order), and resident is not willing to check himself in for mental help. Nurse stated resident stated he was going to come back to facility and chill."

Nursing note dated 1/27/16 at 7:18 A.M. indicated: " Resident slept until 5 this morning. Woke up and start rolling himself towards the court yard. Noted resident hard to redirect. Blood sugar this morning 252 coverage given. At 6 A.M. morning staff spotted Resident #7 rolling back to the facility from local store. 11-7 staff encourage and re-directed resident back inside. Resident keep refusing."

Nursing note dated 1/27/16 at 2:42 P.M. indicated: "Resident left building once again today in wheelchair headed to store. This nurse received call from front desk and went up to the desk and saw resident rolling down street in wheelchair. Nurse called out to resident and he turned around and came back to facility. Resident states he was going to get cigarettes and this nurse made it perfectly clear to resident on several occasions that he is not to leave facility without notifying staff and how dangerous it is for

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him to be on the road alone. Social worker and POA (power of attorney) are aware that resident left building again and at the request of the POA and social worker, MD was called and a wanderguard and outpatient Psych evaluation and med adjustment were ordered. Wanderguard placed on left ankle and explained to resident."

An Incident Abstract Report dated 1/27/16 indicated: "Facility employee reported to this writer via telephone that this resident was seen at local store without supervision or acknowledgement by the nurse on duty. Responsible Party made aware and Director of Nursing (DON) notified. Returned without any obvious injury."

Nursing note dated 1/27/16 at 7:24 P.M. indicated: "Resident attempted to leave facility this evening at approx 1600 (4:00 pm). received call from lobby front desk stating, resident attempted to leave facility, but was unable due to having wanderguard. Receptionist stated that resident proceeded to walk to door alarm system and enter in code to unlock door. Attempt was successful and resident was stopped by staff. Resident stated he was leaving to 'Hit the streets' and engage in illegal activities. Resident was counseled by this nurse regarding his safety and the reasoning for the wanderguard. Resident did not seem to be content about the new device and stated the facility has him on 'house arrest.' Attempted to reassure resident the device is for his safety. Device is currently on left ankle."

Nursing note dated 1/27/16 at 10:27 P.M. indicated: "This nurse received notice that resident eloped from building and was seen at

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local store drinking beer and smoking. This nurse arrived at (name of store) and witness resident drinking and smoking. DON and POA were notified. Another facility employee saw incident and assisted with leading resident back to facility. Resident left building and entered door code himself. Will inform oncoming shift. No injury noted to resident."

Nursing note dated 1/29/16 at 1:53 P.M. indicated: "Resident was placed on hourly monitoring sheet per DON. Sheets must be signed every hour after laying eyes on patient. Resident has been directed by MD not to leave facility at all."

Nursing note dated 1/30/16 at 8:09 A.M. indicated: "During med pass the Maintenance Director stated that he saw Resident #7 at local store and brought him back to the facility."

During an interview on 3/24/16 at 11:06 A.M. with the Maintenance Director he stated, resident #7 was found at the local store down the street from the facility. When asked how did the resident know the code, he stated, "I think he was watching as other staff and family members were going and coming." The Maintenance Director was asked if the code had been changed and he stated, Yes.

A Missing Resident Policy, as provided by Administrator, indicated: Should an employee observe a resident attempting to leave the premises, he/she should attempt to prevent the departure; obtain assistance from other staff members in the immediate vicinity and inform Charge Nurse that a resident is attempting to leave the premises.

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F 323	Continued From page 143 During an interview on 3/24/16 at 1:15 P.M. with the Administrator he stated, we were finally able to get Resident #7 sent out for a psych eval and in-house services. The facility staff failed to provide Resident #7 with supervision to prevent elopement from the facility.	F 323		
F 328 SS=E	Complaint Deficiency 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on the investigation observation, clinical record review, family, and resident and staff interviews it was determined for three of 43 residents in survey sample (Residents #5, 35 and 40) that facility staff failed to follow physician's orders for respiratory care. 1. Resident #4 was not "weaned" from his ventilator as ordered.	F 328	F328 1. Resident #5 will be re-evaluated by the physician. Physician orders for respiratory services are being followed. Resident #35 will have oxygen maintained at 2 liters per minute as ordered. Resident #40 is no longer at this facility. 2. All vent/trach patients have the potential to be affected; the residents will be assessed for potential for weaning and respiratory therapy services will be provided per physician orders. Residents with orders for oxygen therapy may be at risk. Current residents will have oxygen therapy orders reviewed and clearly documented on the treatment record.	

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F 328	Continued From page 144 2. Resident #35 did not have his oxygen maintained at 2 liter per minutes as ordered. 3. Resident #40 had no orders for oxygen therapy. The findings included: 1. Resident #5 was admitted to the facility on 11/20/15 from a local hospital. The resident was 54 years old at the time of the survey. His diagnoses included a pressure ulcer, atria fibrillation, chronic and acute respiratory failure, colostomy, quadriplegia, chronic pain syndrome and malnutrition. This was the resident's second admission to the facility. The resident was ventilator dependent. Review of the resident's 11/27/15 admission MDS evidenced the resident was a 13 of 15 on the Brief Interview for Mental Status (BIMS). The resident required total assistance with all activities of daily living. Review of the discharge information from the hospital evidenced the resident was being admitted to the facility for wound care. Weaning from the ventilator was not included in the discharge instruction. The attending physician visited and completed an 11/24/15 History and Physical on Resident #5. His plan included, to reduce pain medications, increase physical functioning, proper use of pain medications, and improvement of sleep, mood and interactions with others. The pulmonologist came into the facility on	F 328	3. Licensed nursing and respiratory therapy staff will be re-educated on the importance for following physician orders for respiratory care including oxygen administration and weaning from the ventilator. This education will also include review of documentation of respiratory services by nursing and/or respiratory therapy. The physician will be notified of the resident's progress toward weaning from the ventilator when established goals are not being met. Care Plans will be updated as status changes and will include prognosis / goal for weaning from the ventilator and other respiratory care such as oxygen administration. Physicians will be notified of change in respiratory status of residents and orders will be clarified as needed.	

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F 328	Continued From page 145 12/2/15 and wrote an order to "begin ventilator independence protocol." The facility protocol for ventilation weaning evidenced that a individual plan for weaning be indicated by the physician. This plan was not evidenced in the clinical record. Review of the respiratory notes from 12/2/15 to 1/13/16 noted only one note regarding the weaning. The Respiratory Therapist (RT) documented 12/15/15, "discussed weaning ... to remove him from vent and place on a humidified teach mask - pt (patient) stated that 'he wanted to think about it'." On 3/24/16 at 4:25 pm the RT caring for Resident #5 was interviewed. The RT stated he did not recollect any specifics regarding weaning. The RT stated the resident is highly anxious and is rarely able to tolerate his 10 minute breathing treatment that requires him to be off the vent. The RT stated the resident had not expressed any desire to be weaned from the vent. "The vent is his comfort zone." Review of the RT notes confirmed that the resident is not always able to complete his breathing (nebulizer treatments). The order to discontinue the weaning was written 1/13/16. 2. The facility staff failed to maintain Resident #35's 'as needed' oxygen administration at 2 liters per minute as ordered by the physician. Resident #35 is a 96 year old admitted to the facility initially on 8/25/14 and readmitted on 1/8/15. Resident #35's diagnoses included	F 328	4. QA/Designee will audit weekly X 6 weeks residents with M.D. orders to wean from vent/trach. Progress or lack of progress will be noted, and all other necessary documentation will be checked for compliance with facility protocol and implementation through care plans. QA/Designee will visually audit and review documentation of oxygen administration weekly X 6 weeks 25% of residents on each unit . Variances found during the above audits will be investigated, corrected as appropriate and staff re-educated. Analysis of weekly audits will be reported to DON and administrator and summary of audit findings will be reported to QAPI committee for additional oversight and continued frequency of audits. 5. Completion: 5/13/16	

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*Chronic Obstructive Pulmonary Disease, *Anxiety Disorder, *Dementia, and *Cerebrovascular Accident.

*Chronic Obstructive Pulmonary Disease: a progressive and irreversible condition characterized by diminished inspiratory and expiratory capacity of the lungs.

*Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal.

*Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses.

*Cerebrovascular Accident: an abnormal condition of the brain characterized by occlusion by an embolus, thrombus, or cerebrovascular hemorrhage or vasospasm, resulting in ischemia of the brain tissues normally perfused by the damaged vessels.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual

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assessment with an Assessment Reference Date (ARD) of 2/25/16 with a Brief Interview for Mental Status (BIMS) indicating that the resident is rarely or never understood. Resident #35 was also coded to have long and short term memory problems and is moderately impaired in cognitive skills for daily decision making. Under Section 0 the resident is coded for Oxygen Therapy and Hospice Care.

Resident #35's Comprehensive Care Plan last reviewed 3/9/16 documented in part, read as:

Problem: Use of nasal 02 (oxygen) as needed and dx (diagnosis) of COPD (chronic obstructive pulmonary disease). (Resident #35's name) reports SOB (shortness of breath) with exertion.

Interventions: Administer medications as ordered and monitor for s/s (signs and symptoms) of effectiveness.

Resident #35's Physician Orders for March signed and dated on 3/3/15 indicated the following physician order that was ordered on 1/8/15: OXYGEN AT 2 LITERS VIA NC (nasal cannula) PRN (as needed).

The Clinical Notes for Resident #35 were reviewed and documented in part:

2/24/16 at 11:50 a.m. OXYGEN AT 3 LITERS PER NASAL CANNULA.

3/2/16 at 1:50 p.m. Remains on 3L 02 via NC (3 liters of oxygen via nasal cannula).

On 3/28/16 at 2:00 p.m. Resident #35 was observed lying in bed with oxygen on via nasal

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cannula. The oxygen concentrator was checked and it was set at 3 liters per minute.

On 3/28/16 at 3:00 p.m. Resident #35 was again observed lying in bed with oxygen on at 3 liters per minute via nasal cannula.

On 3/28/16 at 3:00 p.m. the surveyor and LPN #7 entered Resident #35's room. LPN #7 was asked, "What is the resident's oxygen set at?" LPN #7 stated, "It is on 3 liters per minute." The surveyor asked, "Is that the correct dose for her?" LPN #7 stated, "I have to check her record I don't usually work here." After checking Resident #35's oxygen order LPN #7 stated, "She is on 3 liters per minute but she should be on 2 liters per minute." LPN #7 adjusted Resident #35's oxygen concentrator to deliver 2 liters of oxygen per minute via the nasal cannula.

On 3/28/16 at 5:00 p.m. an interview was conducted with the Medical Director. The Medical Director was asked, "If you give an order for oxygen at 2 liters per minute as needed via nasal cannula what would be your expectations of nursing?" The Medical Director stated, "To follow my orders and make sure if the resident is receiving the oxygen it is at 2 liters per minute."

On 3/28/16 at 4:30 p.m. the Quality Management Consultant for the facility was made aware of the above findings as was the Director of Nursing.

The facility policy, "Oxygen Therapy" revised on 8/13/13 documented in part:

Purpose: Oxygen therapy will be provided as ordered.

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Procedure: 6. Adjust flow rate to prescribed liters/minute.

Prior to exit no further information was provided by the facility.

3. Resident #40 was admitted to the facility on 3/12/16 from a local hospital to the Skilled Nursing Facility for rehabilitation services. The resident's diagnoses included but are not limited to: Acute and chronic respiratory failure secondary to Chronic Obstructive Pulmonary Disease (COPD - a lung disease that makes it hard to breathe), with acute exacerbation (worsening) in the setting of possible HCAP (hospital acquired aspiration pneumonia).

The current MDS (Minimum Data Set) an admission with an assessment reference date of 3/19/16 coded the resident as scoring a 10 out of 15 on the Brief interview for Mental Status, indicating the resident had moderately impaired cognition. The resident was coded as having shortness of breath. In addition, the resident was coded as requiring extensive assistance with the assistance of one staff person for bed mobility, hygiene, and bathing.

On 3/28/16 at approximately 2:30 p.m., Resident #40's oxygen flow rate was observed at 2 Liters Per Minute via nasal cannula. On 3/28/16 at approximately 6:00 p.m., Resident #40's oxygen flow rate was observed to be at 2.5 Liters Per Minute via nasal cannula. Resident #40 was not observed to be in any respiratory distress during these two observations.

An interview was conducted on 3/28/16 at approximately 6:00 p.m. with LPN # 41. When

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asked what Resident #40's current order for oxygen was, she proceeded to look in her computer and stated: "Currently no order for oxygen." LPN (licensed practical nurse) #41 was asked to walk to Resident #40's room and tell me what the oxygen flow rate was. She stated: "Current 2 1/2 Liters". The LPN proceeded to obtain a pulse oximetry (test for percentage of oxygen in body). The pulse oximetry result was 96%. The LPN stated: "I will obtain an order for oxygen."

The hospital "History and Physical Examination" documented COPD on chronic 2 L (Liters) oxygen.

The hospital "Discharge Summary" documented the following: "Per son, he was called by HHA (home health agency) today that his father was very sob (short of breath) and had n/v/d (nausea, vomiting, and diarrhea) He recommended transfer to Ed (emergency department). Per son, he last saw his father on Tuesday or Wednesday of last week. He states his father chronically wears 2 L of Oxygen and he did not note anything unusual...."
"...now back on home 2 L oxygen." In addition, the discharge summary documented:
"Discharge: Oxygen per nasal cannula Restrictions: chronic 2 L (Liters) NC (Nasal cannula) oxygen Liters per minute 2 LPM (liters per minute)"

The current treatment orders include an order for oxygen written on 3/28/16. This order is 16 days after admission of Resident #40 and 16 days after Resident #40 has been using oxygen per review of clinical notes. The 3/28/16 Physician order was for 02 (oxygen) via NC (nasal cannula), at 2

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L (liters) continuous.

The clinical notes were reviewed and documented the following:

3/12/16 07:53 p.m. O2 at 2L via nasal cannula
NOTE: 3/12/16 was admission day
3/13/16 03:39 a.m. ...receiving 2L of oxygen...
3/13/16 07:07 p.m. O 2 at 2L via nasal cannula.
3/15/16 02:37 a.m. ... O2 infusing at 2L via NC...
3/16/16 04:07 p.m. O2 at 2 lpm (liters per minute)
3/22/16 11:05 p.m. ... O2 infusing at 2L via NC...
3/23/16 06:58 a.m. ...O2 infusing via NC...
3/23/16 04:40 p.m. ... nasal cannula on but at times he refuses.
3/24/16 01:24 a.m. ...O2 infusing at 2L via NC...
3/25/16 05:40 a.m. On O2 2L via NC, O2 sat (saturation) at 94%
3/25/16 05:40 p.m. O3 (type as written on record) via NC at 3L
3/26/16 07:32 p.m. O2 via nasal cannula at 3 lpm...
3/27/16 02:50 a.m. Pt (patient) on O2 at 2 lpm
3/27/16 07:30 p.m. O2 via nasal cannula at 3 lpm
3/28/16 03:18 a.m. Pt on O2 at 3 lpm
3/28/16 03:28 p.m. O2 @ (at) 3L NC

Review of the Treatment Administration Record (TAR) evidenced oxygen via NC at 2 L, continuous by shift starting 03/28/16 with Notes: Continuous O2 to maintain sat greater than 90 % was documented to the TAR on 3/28/16, with the first nursing assessment of oxygen completed on night shift with a pulse oximeter reading of 95%. The TAR documented "X" in all shifts from

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F 328	Continued From page 152 3/12/16 until 3/28/16 night shift. Review of the Interim Care Plan documented "Resident Need" as Oxygenation related to: with a Goal of "Breathing pattern will be maintained as evidenced by patent airway, resp. WNL (respirations within normal limits), oxygenation saturation 90% higher or as directed by MD (Medical Doctor)". The policy and procedure entitled: "Oxygen Therapy" with a revision date of 08/13/13 documented the "Purpose" as: "Oxygen therapy will be provided safely as ordered. The policy documented the following required action steps: #6. "Adjust flow rate to prescribed liters/minute." and #8. "Record flow rate used and resident response." The facility's nursing guidance document published by Cinahl Information Systems entitled: "Oxygen Therapy: An Overview" was reviewed and documented the following: "How: Medical oxygen is classified as a medication and can be toxic...therefore it should be administered only as prescribed."... The policy and procedure entitled: Life Care - MD (Medical Doctor) Orders Including Admission" with a revision date of 4/14/15 was reviewed. It documented the following: Each resident admitted to (name of facility) facilities must have initial orders for immediate care including: Diagnoses, Diet, Ambulation Status, Medication Orders, Code status and Treatment orders."	F 328		

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F 328	Continued From page 153 An interview was conducted with the Medical Director and Resident #40's physician on 3/28/16 with the survey team. At approximately 5:00 p.m., when asked how a resident's initial orders are done, he stated: "Nurses put in orders and I sign after verifying." When asked if oxygen should be put into the orders, he stated: "Yes." An interview was conducted with the Unit Manager RN (Unit Manager Registered Nurse) #2 on 3/29/16 at approximately 11:40 a.m. She stated: "Oxygen was not originally in orders. It was found yesterday." 3/28/16 was date that facility staff found they did not have orders for oxygen. The Director Of Nursing (DON) was made aware of these findings on 3/29/16 in a meeting at approximately 1:20 p.m., no further information was presented.	F 328		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing	F 353	F353 1. Residents #32, #21, #20, #29. #33, #24, #31, #30 will have med error report and incident report completed and physician notified for AccuCheck missed on 3/24/16. Nurses will be re-educated on the importance of following physician orders for medications including monitoring of blood sugars, administration of sliding scale and scheduled insulin, administration of medications. Staffing models have been reviewed and sufficient staff will be available to carry out physician orders.	

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F 353	Continued From page 154 personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interviews and facility documentation, the facility staff failed to assure sufficient nursing staff was in place to provide nursing related services in order to attain and maintain the highest practicable physical well-being for 8 of 43 residents (Residents #32, #21, #20, #29, #33, #34, #31, #30) in the survey sample. Random observations, interviews, as well as review of Medication Administration Records (MAR) and Administration History Reports revealed omitted and late administration of medications for 34 additional residents on 3/24/16 due to lack of nursing coverage. 1. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals at 4:30 p.m. with sliding scale insulin for Resident #32. 2. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and 5:00 p.m. medications (*Coreg and *Psysillium) for Resident #21. 3. The facility staff failed to follow physician's	F 353	2. All residents with physician orders for medications including monitoring blood sugars and administration of insulin have the potential to be affected by this same deficient practice. Nurses will be re-educated on the importance of following physician orders for medications including monitoring of blood sugars, administration of sliding scale and scheduled insulin, administration of medications. Staffing models have been reviewed and sufficient staff will be available to carry out physician orders.	

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F 353	Continued From page 155 orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and administer routine insulin at 5:00 p.m., for Resident #20. 4. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals and routine medications (*Renvela/Sevelamer Carbonate F/C 800 mg (3 tabs), both scheduled at 5:00 p.m., for Resident #29. 5. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals and administer routine insulin's for Resident #33, as well as administer other oral medication due at 5:00 p.m. 6. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals at 4:30 p.m. and administer routine insulin, also due at 4:30 p.m., for Resident #34. 7. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals, as well as administer other oral medication due at 5:00 p.m. for Resident #31. 8. The facility staff failed to obtain Resident #30's Accucheck at 4:30 p.m. per physician's orders. The blood sugar history records indicated the staff obtained the blood sugar at 6:05 p.m., but recorded a reading of 324 on 3/24/16 in the 4:30 p.m. box on the Medication Administration Record (MAR). In addition, the 4:30 p.m. scheduled Humalog 2 units before meals was not	F 353	3. Staffing models will be reviewed and modified to ensure sufficient staff to provide care ordered by the physician. Interim nursing service will be utilized to supplement facility staff as needed to ensure there is sufficient staff to carry out physician orders. Inservice licensed staff on submission of medication error report and incident report for late or missed AccuCheck and medications and notification of physicians Inservice staff on attendance and call off policy to give sufficient notice if unable to perform scheduled shift. Facility leadership will work with corporate HR office on strategy for improving recruitment and retention of staff. DON will report any staffing shortages to Administrator and both will report to Corporate Office. DON and administrator will provide report weekly to the corporate office and HR of vacant positions and a summary of "call-in" requiring unplanned coverage until established staffing can be maintained with minimum interim staff.	

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F 353	Continued From page 156 administered until 6:05 p.m., after the resident consumed the evening meal. The findings included: 1. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals at 4:30 p.m. with sliding scale insulin for Resident #32. Resident #32 was admitted to the nursing facility on 11/13/12 with a diagnoses of Insulin Dependent Diabetes Mellitus. The Minimum Data Set (MDS) quarterly assessment dated 1/27/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was cognitively intact in the skills needed for daily decision making. Resident #32 was assessed to have diabetes that required insulin injections. The care plan dated 1/30/16 identified Resident #32 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. Resident #32 had physician's orders dated 8/1/15 for Stick Blood Sugar (FSBS)/accuchecks before meals at 4:30 p.m. with sliding scale insulin.	F 353	4. QA/Designee will monitor daily staffing hours per patient day for 8 weeks and take results to QAPI committee for additional oversight and continued frequency of audits. Clinical manager or designee will randomly review 10% of residents with FSBS weekly to validate completion as ordered. This will be done weekly X 1month, then quarterly review of 10% . Variances will be investigated and staff re-educated as appropriate. Clinical manager or designee will randomly review 10% of residents with MAR weekly to validate completion as ordered. This will be done weekly X 1month, then quarterly review of 10%. Variances will be investigated and staff re-educated as appropriate. A report of areas of non-compliance will be reported to the DON/Designee for analysis and submission to the QAPI committee for discussion and further recommendations. 5. Completion: 5/13/16	

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On 03/24/16, at approximately 7:03 p.m. the Licensed Practical Nurse (LPN) #10 took over the medication cart to began passing medications. The LPN stated she called early in the morning to inform the unit, she would not be working, but received phone calls asking where she was. The Director of Nursing (DON) stated she did not know Licensed Practical Nurse (LPN) #10 was not scheduled to work at 3:00 p.m. and there was no one assigned on the cart to administer any medications that may have been scheduled from 3:00 p.m. to 7:00 p.m. to also include FSBS/accuchecks, thus no accucheck was obtained to determine if the resident required sliding scale insulin and the resident had already eaten the evening meal. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

2. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and 5:00 p.m. medications (*Coreg and *Psysillium) for Resident #21.

*Coreg is used to treat high blood pressure and heart failure (http://www.webmd.com/drugs/2/drug-5574/carvedilol-oral/details).

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*Psyllium is used to treat constipation. It increases the bulk in your stool, an effect that helps to cause movement of the intestines (http://www.webmd.com/drugs/2/drug-797/psyllium-oral/details).

Resident #21 was admitted to the nursing facility on 1/24/16 with a diagnosis of Diabetes Mellitus, high blood pressure and constipation.

The Minimum Data Set (MDS) Admission assessment dated 1/31/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #21 was assessed to have diabetes that required insulin injections.

The care plan dated 2/5/16 identified Resident #21 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The resident was also care planned for high blood pressure. The goal set by the staff for the resident indicated the resident would have no adverse effects from hyper/hypotension. Some of the interventions the staff would implement to accomplish this goal included to administer medication per physician's order and to notify the physician as needed.

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Resident #21 had current physician's orders dated 1/26/16 for FSBS/accuchecks at 4:30 p.m. before the evening meal, Coreg 6.25 milligrams (mg) at 5:00 p.m., Psyllium Fiber 0.52 gram (1 capsule) at 12:00 p.m. and 6:00 p.m.

On 03/24/16, at approximately 7:03 p.m. the Licensed Practical Nurse (LPN) #10 took over the medication cart to began passing medications. The LPN stated she called early in the morning to inform the unit, she would not be working, but received phone calls asking where she was. The Director of Nursing (DON) stated she did not know Licensed Practical Nurse (LPN) #10 was not scheduled to work at 3:00 p.m. and there was no one on the cart to administer any medications that may have been scheduled from 3:00 p.m. to 7:00 p.m. to also include FSBS/accuchecks, and the Coreg and Psyllium Fiber, which were omitted. She stated because there was no one assigned to the cart from 3:00 p.m. to 7:00 p.m., thus no accucheck was obtained to determine if the resident required sliding scale insulin and the resident had already eaten her evening meal. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done or medications were not administered, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

3. The facility staff failed to follow physician's

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orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals with sliding scale insulin at 4:30 p.m. and administer routine insulin at 5:00 p.m., for Resident #20.

Resident #20 was admitted to the nursing facility on 2/5/14 with a diagnosis of Diabetes Mellitus.

The Minimum Data Set (MDS) quarterly assessment dated 2/22/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #20 was assessed to have diabetes that required insulin injections.

The care plan dated 2/29/16 identified Resident #20 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention.

Resident #20 had current physician's orders dated 8/1/15 for Finger Stick Blood Sugar (FSBS)/accuchecks, before meals at 4:30 p.m., with sliding scale insulin and routine *Humalog 5 units subcutaneous at 5:00 p.m.

*Humalog insulin (insulin lispro) is a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood

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(http://www.drugs.com/humalog.html).

On 03/24/16, at approximately 7:03 p.m. the Licensed Practical Nurse (LPN) #10 took over the medication cart to began passing medications. The LPN stated she called early in the morning to inform the unit, she would not be working, but received phone calls asking where she was. The Director of Nursing (DON) stated she did not know Licensed Practical Nurse (LPN) #10 was not scheduled to work at 3:00 p.m. and there was no one on the cart to administer any medications that may have been scheduled from 3:00 p.m. to 7:00 p.m. to also include FSBS/accuchecks, thus no accucheck was obtained to determine if the resident required sliding scale insulin and the resident had eaten the evening meal. Also the facility staff omitted Resident #20's routinely scheduled Humalog Insulin at 5:00 p.m. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done and insulin not administered, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

4. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals and routine medications (*Renvela/Sevelamer Carbonate F/C 800 mg (3 tabs), both scheduled at 5:00 p.m., for Resident #29.

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*Renvela (sevelamer carbonate) is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis (http://www.rxlist.com/renvela-drug/indications-dosage.htm).

Resident #29 was admitted to the nursing facility on 11/28/15 with a diagnosis of Diabetes Mellitus and End Stage Renal Disease (ESRD) on Dialysis.

The Minimum Data Set (MDS) quarterly assessment dated 2/22/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #29 was assessed to have diabetes that required insulin injections.

The care plan dated 2/29/16 identified Resident #29 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The care plan also identified the resident had ESRD and the goal set for the resident by the staff was that she would have the disease managed on a daily basis. Some of the approaches the staff would take to accomplish this goal was that she would have her medications administered per physician's orders

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and to report ineffective medications/concerns to the physician.

Resident #29 had current physician's orders dated 12/1/15 for Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin four times a day with one of those times at 5:00 p.m. before meals. The resident also had Sevelamer Carbonate F/C 800 mg (3 tabs) at 5:00 p.m.

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 p.m. and 5:00 p.m.

Resident #29's FSBS/accucheck was not obtained before meals at 5:00 p.m., to determine if the resident required sliding scale insulin and the resident had already eaten the evening meal. Also the Sevelamer Carbonate was omitted and not administered at 5:00 p.m. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done and medications not administered, nor was there any evidence the physician was called and informed of the same.

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The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

5. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals and administer routine insulin's for Resident #33, as well as administer other oral medication due at 5:00 p.m.

Resident #33 was admitted to the nursing facility on 8/4/09 with a diagnosis of Diabetes Mellitus, stroke and high blood pressure.

The Minimum Data Set (MDS) Annual assessment dated 1/21/16 coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was cognitively intact in the skills needed for daily decision making. Resident #33 was assessed to have diabetes that required insulin injections.

The care plan dated 1/27/16 identified Resident #33 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The care plan also identified the resident had high blood pressure and pain. The goal set for the resident by the staff was that he

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would have his pain and the disease managed on a daily basis. Some of the approaches the staff would take to accomplish this goal was that medications would be administered per physician's orders, and to report ineffective medications/concerns to the physician.

Resident #33 had current physician's orders dated 1/24/13 for Finger Stick Blood Sugar (FSBS)/accuchecks before meals two times a day with one of those times at 4:30 p.m. The resident also had physician's orders dated 8/1/15 for routine *Levemir insulin 44 units and routine *Humalog 10 units subcutaneously to be administered daily at 4:30 p.m. The resident also had physician's orders for *Janumet 50-1,000 milligrams (mg) (1 tablet) and *Fish oil 340 -1,000 mg (2 caps) at 5:00 p.m. Additionally, the resident had physician's orders for *Tylenol 500 mg (1 tab) at 5:00 p.m.

*Levemir insulin (insulin detemir) is a long acting insulin used to treat diabetes in adults and children. Includes Levemir side effects, interactions and indications (www.drugs.com/levemir.html).

*Humalog insulin (insulin lispro) is a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood (http://www.drugs.com/humalog.html).

*JANUMET (sitagliptin/metformin HCl) tablets contain two oral antihyperglycemic drugs used in the management of type 2 diabetes: sitagliptin and metformin hydrochloride. ... Sitagliptin is present in JANUMET tablets in the form of sitagliptin phosphate monohydrate (www.rxlist.com/janumet-drug.htm).

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*Fish oil is a general health supplement, and is taken as a source of omega-3 fats (https://examine.com/supplements/fish-oil).

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 p.m. and 5:00 p.m.

On 3/24/16, Resident #33's FSBS/accucheck was not obtained before meals at 4:30 p.m. and the resident had already eaten his evening meal. Also the routine insulin's Levemir 44 units and Humalog 10 units were omitted and not administered at 4:30 p.m. In addition, the Janumet and Tylenol was not administered at 5:00 p.m. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done, the insulin's and medications were not administered, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well

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as completion of a medication error report and incident report, which was not done.

6. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin before meals at 4:30 p.m. and administer routine insulin, also due at 4:30 p.m., for Resident #34.

Resident #34 was admitted to the nursing facility on 11/12/15 with a diagnosis of Diabetes Mellitus.

The Minimum Data Set (MD'S) quarterly assessment dated 3/4/16 coded the resident with a score of 4 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was severely impaired in the skills needed for daily decision making. Resident #34 was assessed to have diabetes that required insulin injections.

The care plan dated 3/4/16 identified Resident #34 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that she would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention.

Resident #34 had current physician's orders dated 1/11/16 for Finger Stick Blood Sugar (FSBS)/accuchecks with sliding scale insulin four times a day with one of those times at 4;30 p.m. before meals. The resident also had routinely

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scheduled *Humalog 5 units due at 4:30 p.m. before meals, which was administered at 7:13 p.m. (2 hours and 43 minutes after it was due).

*Humalog insulin (insulin lispro) is a fast-acting form of insulin that works by lowering levels of glucose (sugar) in the blood (http://www.drugs.com/humalog.html).

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 and 5:00 p.m. At 7:13 p.m., LPN #6 obtained an accucheck reading of 250 and stated, "I wonder should I give it or not give it, and write a note it was not given because the resident had already eaten." LPN #6 did administer the routine Humalog 5 units, at 7:13 p.m., that was due at 4:30 p.m., which was 2 hours and 43 minutes late. The LPN entered the following note on the Medication Administration Record (MAR): "No sliding scale given due to accucheck reading completed after resident ate. Only routine insulin given."

Resident #34's FSBS/accucheck was not obtained before meals at 5:00 p.m., to determine

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if the resident required sliding scale insulin and the resident had already eaten the evening meal. Also the routine insulin was administered late and after meals. There was there any evidence the physician was called and informed of the aforementioned medication errors or an inquiry for further guidance.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

7. The facility staff failed to follow physician's orders and obtain Finger Stick Blood Sugar (FSBS)/accuchecks before meals, as well as administer other oral medication due at 5:00 p.m. for Resident #31.

Resident #31 was admitted to the nursing facility on 11/27/15 with a diagnosis of Diabetes Mellitus, anemia, stroke and high blood pressure.

The Minimum Data Set (MDS) quarterly assessment dated 3/2/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #31 was assessed to have diabetes that required insulin injections.

The care plan dated 3/9/16 identified Resident #31 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the

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interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention. The care plan also identified the resident had high blood pressure and anemia. The goal set for the resident by the staff was that he would have medical conditions managed on a daily basis. Some of the approaches the staff would take to accomplish this goal was that medications would be administered per physician's orders, and to report ineffective medications/concerns to the physician.

Resident #31 had current physician's orders dated 12/15/15 for Finger Stick Blood Sugar (FSBS)/accuchecks before meals four times a day with one of those times at 4:30 p.m. The resident also had physician's orders dated 12/8/15 for *Hydralazine HCL 100 mg (1 tab), *Coreg 25 mg (1 tab) and *Ferrous Sulfate 325 mg (1 tab) to be administered at 5:00 p.m.

*Coreg is used to treat high blood pressure and heart failure (http://www.webmd.com/drugs/2/drug-5574/carvedilol-oral/details).

*Hydralazine is used to treat high blood pressure (http://www.webmd.com/drugs/2/drug-8662/hydralazine-oral/details).

*Ferrous Sulfate is used in the treatment of iron deficiency anemia(www.drugs.com/imprints/-21385.html)

On 03/24/16, at approximately 6:50 p.m. the Unit Secretary/Licensed Practical Nurse (LPN) #6

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stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 and 5:00 p.m.

On 3/24/16, Resident #31's FSBS/accucheck was not obtained before meals at 4:30 p.m. and the resident had already eaten the evening meal. In addition, the oral medications scheduled for 5:00 p.m. were administered 1 hour and 28 minutes late (out of the 1 hour window). There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done and medications were not administered on time, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

8. The facility staff failed to obtain Resident #30's Accucheck at 4:30 p.m. per physician's orders. The blood sugar history records indicated the staff obtained the blood sugar at 6:05 p.m., but recorded a reading of 324 on 3/24/16 in the 4:30

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p.m. box on the Medication Administration Record (MAR). In addition, the 4:30 p.m. scheduled Humalog 2 units before meals was not administered until 6:05 p.m., after the resident consumed the evening meal.

Resident #30 was admitted to the nursing facility on 7/16/15 with a diagnosis of Diabetes Mellitus.

The Minimum Data Set (MDS) assessment dated 1/13/16 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. Resident #30 was assessed to have diabetes that required insulin injections.

The care plan dated 3/23/16 identified Resident #30 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The goal the staff set for the resident was that he would have no effects from hypoglycemia/hyperglycemia. Some of the interventions the staff would implement to accomplish this goal included monitor accuchecks per physician's order and notify the physician as needed. The licensed nurses were the responsible discipline to implement this intervention.

Resident #30 had current physician's orders dated 12/30/15 for Finger Stick Blood Sugar (FSBS)/accuchecks before meals three times a day with one of those times at 4:30 p.m. Humalog 2 units was scheduled to be routinely administered every day at 4:30 p.m. before the evening meal.

On 03/24/16, at approximately 6:50 p.m. the Unit

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Secretary/Licensed Practical Nurse (LPN) #6 stated she was usually scheduled to work from 9:00 a.m. to 5:00 p.m., but when the nurse scheduled was a no call/no show, she stayed over to help pass medication because there was no one assigned to the medication cart for the long hall on Unit 3. She stated most of the evening medications would be either late or not given because of the lack of coverage and said, "I am doing the best I can and moving as fast as I can. I think someone is on their way to relieve me". She stated there were approximately 22 residents on the long hall and many of them had accuchecks and medications due at 4:30 and 5:00 p.m.

On 3/24/16, Resident #30's FSBS/accucheck was not obtained before meals at 4:30 p.m., as well as the routinely scheduled Humalog insulin. The resident had already eaten the evening meal. There were no nurse's notes or entries on the Medication Administration Record (MAR) to indicate the accuchecks were not done on time, nor was there any evidence the physician was called and informed of the same.

The DON stated the physician should have been called and informed of the failure to obtain accuchecks and administer medications, as well as completion of a medication error report and incident report, which was not done.

On 3/29/16 at approximately 4:00 p.m., the Administrator was made aware of all of the aforementioned problems with nursing staff's failure to administer medications per physician orders, along with lack of nursing coverage as the root cause.

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The following additional interviews were conducted regarding staffing shortages:

On 3/28/16 at 6:45 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated, "We know staffing is a problem and we have accepted we have the problem. We have staffing ratios on all units, but we can't always meet our expectations." They stated the Corporation has a staffing resource pool that provides staffing for the hospital and seven nursing facilities, but the facility still cannot maintain sufficient nursing staff and there was not other staffing source. They said the Unit 4 Ventilator Unit required specially trained licensed nurses that often get pulled to cover shortages throughout the building which had to stop. The Administrator stated he posed the problem and made a plea to the Corporation, asking for an immediate solution to the staffing problem. He stated there was a possibility to obtain full time traveling nurses for 3 months until they were able to hire and fill posted open positions, which was a more lengthy process. The DON stated call-ins were a major problem, apart from the open positions, in the facility and sometimes the medication carts were either not assigned or were late being assigned because they are calling and searching for coverage; with the existing staff either working over, working doubles, going to get a nap and coming back early to work. She stated, "We have never had a staffing issue like this before. We have a constant shortage of nursing on a daily basis." The DON also stated she was not only performing the job duties of the DON, but as the acting Unit Manager on Unit 1 and 2 because of the vacancy.

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During a random observation on 3/24/16 at approximately 11:17 a.m. on the back hall Ventilator (Vent) Unit, LPN #3 stated she was still giving 9:00 a.m. scheduled medications because of a shortage. She stated her job was on the desk to read summaries, schedule appointments, transportation and set up dialysis services, but because a nurse left approximately two weeks ago, with no replacement, she was placed on the cart. Additionally, she stated there were supposed to be three licensed nurses on the Unit 4-Vent Unit, but one called out so they gave the unit more Certified Nursing Assistants (CNA). She stated no one, but a special trained Vent nurse can work the Vent Unit and they functioned as primary nurses, providing all care. She stated, "The problem with not having the trained Vent nurse is that the residents prefer a primary nurse that can recognize the critical issues if they should arise during care and the CNA cannot. It is not safe." The person at the desk stated she had never worked the desk and all she could do was answer phone calls. She stated she was the Director of Referral Services and had no clinical knowledge and normally floated to all the nursing centers and assisted living facilities to help with admissions, but when asked what she could do; the DON told her to man the phones due to the nurse staff shortage on Unit 4.

During a random observation on 3/24/16 at 11:43 a.m., on the front hall of Unit 4, which most of the residents had tracheostomies, an interview was conducted with Registered Nurse (RN) #3. She stated she worked at another of the Corporation's nursing center's as the Unit Manager and was in the building for a corporate meeting, when

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approached by the DON around 10:30 a.m., and asked if she could take a medication cart to pass medications because there was a shortage with no coverage. She stated she agreed and was passing 8, 9 and 10 am medications of which all were going to be administered late. She stated she had to leave by 12:45 p.m. and did not know what the DON had planned after that to take over the medication cart.

On 3/24/16 at 2:45 p.m., and interview was conducted with the RN Staff Development Coordinator #6. She stated she did not normally work the medication carts because there was a call out by a nurse who normally worked 12 hours, but was taking over the cart until 7:00 p.m. for the front hall of Unit 4. She stated medications have been administered late because of the shortage, but she was doing the best she could do and may be slower than most because it is not one of her normal job duties. At 7:00 p.m., RN #6 was still trying to administer medications and stated she did not know how long she would be on the cart, but stated she was going to stay until "things get straightened out". The Unit 4 RN Manager joined the conversation and stated they had 4 admissions which took at least 2.5 to 3 hours for each resident to complete and included verification of orders, full nursing assessments and calling pharmacy to get medications sent. The Unit 4 RN Manager stated there was a constant strain on those that come to work to take care of the residents and it was not safe because of the consistent shortages and constant call-ins with no coverage. The Unit 4 RN Manager stated 3/24/16 was just a glimpse into what they have to deal with most days. RN #6 tearfully said, "I will be helping with admissions, as well as

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manning the medication cart for as long as it takes and I have no idea now when I will go home."

The staffing issues regarding individual residents in the survey sample on Unit 3's short and long hall were already addressed within the body of this report, but random reviews of Medication Administration Records and Administration histories on 3/24/16 from 7:00 a.m. to 12:00 midnight, indicated 16 more residents on the long hall were administered multiple medications late or they were omitted, as well as 18 more on the short hall throughout the course of the day. Unit 3's census provided to the survey team for 3/24/16 consisted of 45 residents.

The facility's policy entitled Nursing Staff dated 2/10/15 indicated the following:
Sufficient nursing staff will be employed on a twenty four hour basis to ensure that nursing and related services are provided to enable each resident to attain or maintain his/her highest practicable physical, mental and psychosocial well being, as determined by assessments and individual plans of care. Sufficient nursing staff will be employed to ensure that direct care needs are met and assessments, planning, evaluations and supervision will be provided. Care will be carried out according to the professional practice standards on each shift. Sudden changes in resident health status and emergencies will be properly identified and managed in a timely manner.

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F 385 SS=E	Continued From page 178 483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, clinical record review and facility document review the facility failed to ensure 3 out of 43 resident's in the survey sample medical care was supervised twenty-four hours a day for consultation during a change of condition and need for treatment when called by the facility, Residents #42, 43 and 21. 1. Resident #42 was experiencing a change in condition that required consultation from a physician on 1/26/16. The nursing staff called the on call physician and did not receive a call back. Subsequently, the resident was transferred 911 to the emergency department for evaluation and was admitted. 2. Resident #43 was experiencing a change in condition that required consultation from a physician on 2/26/16. The nursing staff called the on call physician and did not receive a call back.	F 385	F385 1. Residents #21, #42, and #43 no longer reside at this facility. The administrator, DON, and/or corporate representative will meet with the physicians of Resident #21, 42 and #43 to review the findings and to re-educate on the expectation of the physician being available or providing coverage for timely response to resident needs. 2. All residents have the potential to be affected by this deficient practice. Physicians have been informed in writing of the expectations of being available or providing coverage for timely response to resident needs.	

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F 385	Continued From page 179 Subsequently, the resident was transferred 911 to the emergency department and was admitted. 3. Resident #21 was in severe pain. The nursing staff attempted to call the physician for consultation and orders. The physician's mail box was full. The resident did not receive effective pain management until two days later. The findings include: 1. Resident #42 was experiencing a change in condition that required consultation from a physician on 1/26/16. The nursing staff called the on call physician and did not receive a call back. Subsequently, the resident was transferred 911 to the emergency department for evaluation and was admitted. Resident #42 was admitted to the facility on 1/14/16 for altered mental status and HIV (human immunodeficiency virus). The admission MDS (Minimum Data Set) with an assessment reference date of 1/21/16 coded the resident as scoring a 00 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was severely impaired. The resident required extensive assistance of one staff with all activities of daily living. The resident was bed bound. The clinical note dated 1/26/16 for 1:38 a.m., read, in part: Before receiving report from off going nurse, vital signs were taken on resident; blood pressure 167/105 (abnormal/high) heart	F 385	3. Educate physician on certification regulations and facility protocol regarding physician responsiveness Physician will be educated to notify facility if he will be unavailable for a period of time and will name back-up. On-call coverage information will be readily accessible to facility nursing staff. Facility will explore options within the community for additional Medical Director coverage. Nursing staff will be educated on protocol of contacting physicians when needed and what to do if the physician does not respond in a timely manner including calling the Medical Director or designee. Nursing staff will report to DON/designee or administrator any situation in which the licensed nurse feels that the physician has not responded in a timely manner to resident need. The DON/administrator will investigate each situation and maintain a log. Repeated instances will be reported to the Medical Director for additional follow-up and report to the QAPI Committee.	

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F 385	Continued From page 180 rate 141 (abnormal/high), temperature 102.3 (abnormal/high); nursing went to assess resident, resident non-verbal; paged doctor (name of on call physician and medical director); no response from either doctor;...called 911 for resident to be evaluated... The hospital emergency room notes dated 1/26/16 read, in part:...comes with fever and worsening lethargy (weakness)...responds to painful stimuli, opens eyes but doesn't follow commands...admitted to ICU (intensive care unit) for further management... During the survey interviews were conducted with various nursing staff to include; licensed practical nurse #2, #3, unit 4 nurse manager and the Director of Nursing. Each of these nursing staff stated there were concerns of the on call physicians accessibility after hours by either the phone mail boxes being full, or the physicians failing to return phone calls. An interview was conducted on 3/24/16 at 4:35 p.m., in attendance was the Administrator, the Director of Nursing (DON) and QM (quality management) Consultant. The Administrator and the DON acknowledged that they were aware of concerns from the nursing staff of the physicians not calling back. The Administrator stated the Vice President of Medical Affairs had also been made aware of this concern recently; within the last couple of weeks. On 3/28/16 at approximately 10:00 a.m., the unit 4 nurse manager was interviewed. She stated the nursing staff have brought it to her attention that they are having difficulty with the on call physician not calling back when consultation is needed for change in condition. She stated, "I have spoken to (name of physician/medical	F 385	4. QA/Designee will audit weekly X **6** weeks 10% chart of residents on each unit with change of condition for physician response. Analysis of audits will be reported to DON and administrator and summary of findings will be reported to QAPI committee for additional oversight Nursing staff will report to DON/designee or administrator any situation in which the licensed nurse feels that the physician has not responded in a timely manner to resident need. The DON/administrator will investigate each situation and maintain a log. Repeated instances will be reported to the Medical Director for additional follow-up and report to the QAPI Committee. 5. Completion: 5/13/16	

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director), I have known him before he completed medical school, I told him that when I call him he needs to call me back..." She further stated that the phone number she calls him on is not the phone number available to the nursing staff.
On 3/28/16 the DON was interviewed. She stated the nursing staff often call her after hours to let her know that the physician has not returned a phone call. She states she will then call/ page the physician. She stated the physician always call her back. The DON was asked if all nursing staff are aware to call her if they don't get a call back from the physician, she stated, "No".
On 3/28/16 at 4:30 p.m., the attending physician for Residents #42, 43 and 21, who is also the Medical Director was interviewed. The nursing staff concerns of no call back from the on call physicians after hours was shared. He stated, " If the situation is critical I expect them to send the resident out 911...my mail box gets full everyday and I do check it everyday...If staff is not able to get in contact with me they should call the DON...the DON has a means of contacting me". The physician/ Medical Director was asked, What is the expected time frame for the on call physician to call back? He stated, "Fifteen to twenty minutes". He further stated, "Most of the time I do call back...I think I am available...usually when I get called I call back..." The Medical Director stated he is aware of concerns with coverage. He stated there have been meetings to discuss coverage, to include hiring additional medical staff such as a nurse practitioner to be in the building daily, and to help with on call after hours. The Medical Director stated he has a full time practice with office hours, and is also the Medical Director at another facility. The second attending physician also has a full time practice outside the facility.

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The Administrator joined the interview at 5:30 p.m., he stated the Vice President of Medical Affairs had been made aware of this concern. The administrator stated the recommendation was to work towards hiring another physician and nurse practitioner/ physician assistant.
The facility policy and procedure titled Notification of Changes in Condition revised 5/14/13 read, in part: The resident, legal representative or family member will be immediately informed and the resident's physician will be consulted when changes defined below occur. 2...a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health...life threatening conditions or clinical complications.) 3...a need to commence a new form of treatment.

2. Resident #43 was experiencing a change in condition that required consultation from a physician on 2/26/16. The nursing staff called the on call physician and did not receive a call back. Subsequently, the resident was transferred 911 to the emergency department and was admitted.

Resident #43 was admitted to the facility on 2/20/16 following a hospitalization for bilateral above the knee amputation due to severe bilateral arterial insufficiency on 2/15/16.

The admission MDS (Minimum Data Set) with an assessment reference date of 2/25/16 had dashes in section C. Cognitive Patterns. The resident was dependent on staff for all activities of daily living. The resident was receiving oxygen and IV (intravenous) therapy.

The clinical note dated 2/25/16 at 6:00 p.m., read, in part:...lethargic, arousable (blood pressure low)

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77/34, MD notified T.O. (telephone order) to give another bolus 250 ml (milliliters) NS 0.9% (normal saline) and after bolus start D 51/2 x 1 L (liter) reassess...at 6:16 p.m.,...still lethargic...

The clinical note 2/25/16 9:20 p.m., read, in part: Received resident in bed with eyes closed, resident seems extremely week and can barely open her eyes when spoken to, resident was experiencing abdominal breathing, lung sounds with crackles, this nurse noticed resident had IV site with D 5 1/2 normal saline infusing; right upper extremity (arm) was cool to touch, edematous (swollen), this nurse stopped fluid and removed IV from right arm...Resident vital signs (blood pressure) 84/46 (low), O2 (oxygen)-97%, contacted (name of attending physician/medical director) regarding residents status, left message to MD on sending resident to emergency department, no call back from MD, Resident was transported by stretcher to (name of hospital).

The hospital emergency room notes dated 2/25/16 at 10:56 p.m., read, in part:"...sent from NH (nursing home) with AMS (altered mental status) and SOB (shortness of breath). Per EMS (emergency medical services) patients sats were in mid 80's on their arrival (normal oxygen saturations are 100%). The resident received a work up to include a chest x-ray which was positive for congestive heart failure (CHF) and lab work. The resident had elevated white blood cells and was started on IV antibiotics, IV Lasix (a diuretic) and IV fluids, aspirin and a steroid. The residents blood pressure began to drop and the resident received albumin 25 gm IV. The resident was admitted to the hospital for acute care and discharged to another long term care facility on 3/8/16.

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SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

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Albumin (Human) 20% is indicated in the emergency treatment of hypovolemia (low blood volume) with or without shock. Its effectiveness in reversing hypovolemia depends largely upon its ability to draw interstitial fluid (tissue fluid) into the circulation. It is most effective in patients who are well hydrated.

3. Resident #21 was experiencing severe pain. The nursing staff attempted to call the physician for consultation and orders. The physician's mail box was full. The resident did not receive effective pain management until two days later.

Resident #21 was admitted to the facility at 8:00 p.m., Sunday 1/24/16 following a hospitalization for surgical incision and drainage (I&D) with resection of a toe due to a diabetic foot ulcer related to osteomyelitis (a bone infection) on 1/19/16; with subsequent left foot skin graft on 3/15/16. The resident was admitted for IV (intravenous) antibiotics, wound care, physical and occupational therapy.

The admission MDS (Minimum Data Set) with an assessment reference date of 1/31/16 evidenced the resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Section J. Health Conditions Pain Assessment Interview evidenced the resident had experienced occasional pain, with intensity of severe, that limited day-to-day activity.

On 3/23/16 at 5:30 p.m., the resident was observed in a wheelchair sitting outside the residents room doorway. The resident requested to speak to an inspector. At this time an interview

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was conducted with the resident. The resident expressed concerns over the lack of care and services provided since admission and her safety due to the care. Resident #21 stated the facility did not provide effective pain management for the first two days following admission to the facility. She stated, "...I was not able to get any sleep at all due to my pain...I had surgery and they removed two bones and ligaments, my bone was infected...I kept saying the Tramadol was not working for two days...they would not give me anything stronger than Ibuprofen...I was in pain, I kept saying what do I have to do to get you all to understand...at first the nurse said my birth date was wrong and that is why pharmacy would not fill the prescription...then they said I was allergic to hydrocodone...which I am not, it makes me itch and at the hospital they gave it to me with an antihistamine...by the morning I was livid...that's when (name of unit 3 manager), the administrator and (name of the director of nursing) came into my room and apologized...after that they (the unit 3 nurse manager) gave me a dose of liquid morphine around 9:00 a.m., it knocked me out, I slept until 6:00 p.m.,... my pain came back and I asked for some more morphine and they told me it had not come in from the pharmacy, they gave me Tylenol."

Resident #21 was asked what her pain goal level was, and stated, "I can handle a lot of pain...my goal would be to have a five to five and a half on a scale of one to ten...for those two days my pain was a ten out of a ten...It made me feel depressed, like nobody was listening to me...I was yelling at the nurse...I couldn't sleep well, I was literally trembling...I wasn't eating much".

The clinical record notes were reviewed, the

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nurse documented the following, in part: 1/27/16 at 1:48 a.m.,"...client c/o(complains of) pain/discomfort attempted to administer Tramadol client refused: client stated "Tramadol does not work". at this time I called pharmacy spoke with the pharmacist she stated, "I need clarification for the prescription (Percocet)"...called (name of attending physician) @ 0126 am message box full. Redirected client and she took two Tramadol...called (name of attending physician) @ 0147 am message box full..."

Clinical record notes dated 1/27/16 at 9:27 a.m., documented by the unit 3 nurse manager, read, in part: Resident complaint of left leg pain. She has orders for Tramadol and she has been refusing stating it is not strong enough for her pain. MD gave orders for Percocet on 1/26/16. The order was discontinued {sic} allergy to Hydrocodone. The night nurse called MD and received orders for Morphine (right before she left her shift). This nurse called the MD and received orders to give morphine sulfate liquid now and morphine tablet as needed. Pharmacy notified of the new orders to send the medications. Morphine sulfate liquid now order pulled from emedstart.

On 3/23/16 at 7:40 p.m., the unit 3 manager was interviewed. The unit manager was asked about the resident's pain and stated, "She (the resident) was in severe pain, she said the Tramadol was not effective...the night nurse called the doctor his mail box was full...she was able to get an order right before she left in the morning. I called the doctor that morning and got an order for the Morphine liquid and gave it to her right away." The unit manager stated she was aware of the nursing staffs concern with on call physicians not

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F 385	Continued From page 187 returning phone calls.	F 385		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 1. Licensed nursing staff will be re-educated on the facility policy of handwashing and cleaning glucometers for monitoring blood sugars between residents. 2. All residents have the potential to be affected. Licensed nursing staff will be re-educated on the facility policy of handwashing and cleaning glucometers for monitoring blood sugars between residents. 3. Licensed staff will be educated on facility policy for sanitizing glucometers using to monitor blood sugars and hand washing	

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review the facility staff failed to implement proper and effective hand hygiene and infection control practices between resident contact during a medication pass and pour observation task.

The nurse failed to implement effective hand washing according to acceptable infection control practices during a medication pass and pour observation; and failed to sanitize a glucometer between resident use.

The findings include:

A medication pass and pour observation was conducted on 3/22/16 at 4:45 p.m., with licensed practical nurse #5. The nurse was observed washing her hands for a count of 10 seconds on three occasions during the medication pass and pour. Two of the occasions were after removal of gloves after obtaining blood sugars between residents, and one occasion between resident medication administration.

The nurse also failed to sanitize the glucometer between use for two residents.

After the medication pass and pour was completed the nurse was interviewed. The handwashing observations was shared. She was asked, How long should you have washed your hands? She stated, "That is a good question...I am not sure...is it 30 seconds?" The observation

4. QA/designee will audit 5 nurses 3 times weekly on all shifts for compliance with infection control procedure while performing AccuChecks. This will be done X 6 weeks. If variances are observed, staff will be re-educated.

   Analysis of audits will be reported to DON and administrator and summary of findings will be reported to QAPI committee for additional oversight.

   QA/Designee will complete at least 5 medication administration observations 3 times weekly on all shifts for compliance with hand hygiene during the medication pass. This will be done X 6 weeks. If variances are observed, staff will be re-educated. Analysis of audits will be reported to DON and administrator and summary of findings will be reported to QAPI committee for additional oversight.

5. Completion: 5/13/16

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of the nurse failing to sanitize the glucometer between resident use was shared. She stated, "I should have wiped the glucometer between residents...I did not have any wipes (sanitizing wipes) on my cart".

The above observations was shared with the Administrator, the Director of Nursing and the QM (quality management) Consultant during a pre-exit meeting conducted on 3/24/16 at 4:35 p.m.

The facility's policy and procedures titled Infection Control with revision date of 6/12/15 read, in part:
Purpose: Guidelines are provided for proper and effective hand washing hygiene to prevent transmission of infection.
Lather hands with soap and rub together vigorously using friction to all surfaces or 20 seconds under running water at comfortable temperature...

The facility's policy and procedures titled Infection Control with revision date of 6/12/15 and Glucose Monitoring revised 12/10/13 read, in part:
Clean and disinfect blood glucose meter after every use with Sani-wipe.

The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration.

CDC is alerting all persons who assist others with blood glucose monitoring and/ or insulin administration of the following infection control

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F 441	Continued From page 190 requirements: 1. Finger stick devices should never be used for more than one person. 2. Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. www.cdc.gov/injection safety/blood-glucose monitoring	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation the facility staff failed to ensure preventative maintenance was completed on a feeding pump for one resident (Resident #4) of a forty-three (43) resident survey sample. The findings included: Resident #4 is a 91 year old who was originally admitted to the facility 03/09/2011 and her most recent readmission was 12/14/2015. Diagnoses included but were not limited to PVS (persistent vegetative state) s/p (after) a CVA (stroke) in 2008, CHF (congestive heart failure), Diabetes Mellitus, Hypertension, Respiratory Failure	F 456	F456 1. Feeding pump on resident #4 was removed and replaced with pump in compliance. 2. All residents using feeding pumps have the potential to be affected by this deficient practice. Feeding pumps have all been cleaned and inspected for functionality. 3. Separate rooms will be designated for equipment ready for use and equipment to be sent for repair or inspection. Procedure for sending out equipment for repair will be developed and nursing staff educated to procedure. Nursing staff will be educated on checking date on equipment to ascertain compliance. 4. QA/Designee will audit feeding pumps in use weekly X 6 weeks for appropriate dating and cleanliness. Results of weekly audits will be reported to DON and administrator and summary of findings will be reported to QAPI committee for additional oversight. 5. Completion: 5/13/2016	

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requiring a tracheostomy and continuous oxygen, PEG placement (surgically inserted tube into the stomach for nutrition and fluid needs), Contractures of multiple joints, Chronic Renal Insufficiency, history of Decubitus Ulcers, history of a Right Above the Knee Amputation in 2014, Urinary Retention, a history of DVT (deep vein thrombosis and multiple infections resulting in MDRO (multiple drug resistant organisms) resistance established in 2011.

Review of the resident's clinical record revealed a Quarterly MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 12/21/15. The resident was coded as having unclear speech, rarely made decisions and had short and long-term memory problems. Further review revealed the resident was totally dependent on one to two staff members for all of her ADLs (activities of daily living), had a continuous feeding tube, had a Foley catheter for urine elimination and was incontinent of bowel.

An observation of the resident was made on 03/22/16 at approximately 3:07 p.m. The resident had a Contact Isolation set up outside of her room. After gowning, entry was made and the resident was observed to be sleeping in her bed on her left side. It was observed that the resident had a trach and was receiving continuous humidified oxygen via a blue colored cupped tubing from a concentrator, a Foley catheter draining yellow urine and an enteral feeding (via a PEG tube). On the top area of the pump by a built in handle was a sticker which stated: "Preventative Maintenance due 06/2015".

An interview was conducted on 03/24/16 at

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approximately 9:15 a.m., with the Administrator and the DON (director of nursing). During the interview the administrator and DON were informed of the observation made of the enteral feeding pump which had an expired Preventative Maintenance sticker dated 06/2015. The DON stated: "One of the nurses noticed that yesterday and it was traded out."

On 03/24/16 at approximately 10:09 a.m., an observation was made of the enteral feeding pump which was delivering Resident #4's physician's ordered continuous feeding. The pump that was being used had a Preventative Maintenance sticker which had a different color and it was observed to read: "Preventative Maintenance 06/16."

An interview was conducted on 03/24/16 at approximately 12:05 p.m., with LPN (licensed practical nurse) #3 on Unit 400. When asked if she knew anything about the switched out enteral pump for Resident #4 she stated: "Yes. I noticed that the sticker was expired and so I got a different pump that had a current sticker and put the expired pump into a red bio-hazard bag (indicates contaminated equipment requiring special handling) and put it in the dirty utility room designated for used equipment that came out of an isolation room." LPN #3 was then asked to locate the red bagged pump. LPN #3 obtained the keys to the locked bio-hazard room which was located inside the dirty utility room. No red bagged enteral pump could be located. When LPN #3 was asked what happened to the bagged pump she stated: "Other #10 (name) periodically picks up the soiled equipment for cleaning and he also repairs anything that has a repair tag on it." She was then asked if there had been a problem

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with the pump and had it ever malfunctioned she stated: "No. If the pump wasn't working right we would have traded it out for repair. The pump was working fine. It's running all day and night due to Resident #4's (name) need for continued enteral feeding and water hydration."

On 03/24/16 at approximately 2:24 p.m., Other #10 was located and asked if he had done anything with the enteral pump that had been in a red bag in the bio-hazard room inside of the dirty utility room on Unit 400. He stated: "I cleaned the pump and returned it to the maintenance office because the preventative maintenance was overdue. I can show you the pump if you would follow me to the maintenance office."

When Other #10 and I arrived at the maintenance area the Maintenance Director was present. Other #10 showed me the pump in question and it had been cleaned. An interview was then conducted at approximately 3:07 p.m., with the Maintenance Director and Other #11, another maintenance worker. The Maintenance Director was informed of the observation I had on 03/22/16, and also what the DON and LPN #3 shared with the surveyor. He was then asked what the facility process was for Preventative Maintenance checks. He stated: "We don't do the PM (preventative maintenance) here. It is sent to Bio Med, it's a department of our facility's company that picks up the equipment due for PM." When asked if the facility Maintenance Department gathered the equipment within the facility he stated: "No. The schedule we have is, I make a call to Bio Med about April to be placed on the list. The system that has been established is that our equipment is done in the month of

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June of each year." He continued: "I then inform the Unit Managers of each unit-100, 200, 300 and 400 to start collecting and trading out any equipment that needs to be checked and it is picked up by one of the maintenance men to prepare for the Bio Med pick up. We've never had a problem exchanging out equipment before." The facility policy and procedure for equipment maintenance was requested.

Review of the facility's policy entitled "Clinical Engineering Medical Equipment Inventory and Support" with a revision date of 12/2013 noted the following:

Purpose: To establish Clinical Engineering Department responsibilities for: 1. Inventory inclusion and priority; 2. Scheduled maintenance plans for equipment in inventory; 3. Corrective maintenance process.

Definitions: Medical Equipment-refers to that equipment that is designated to aid in the diagnosis, monitoring or treatment of medical conditions.

Procedure: 2. Assess Medical Equipment included in the inventory to create a scheduled maintenance plan regardless of ownership. 3. Base Planned maintenance schedules on manufacturer recommendations, risk assessments and experience with approval from the Physical Environment & Safety Committee. Equipment inventory has been assessed and a group designated as :Life Support". 4. Contact the Clinical Engineering Department for any equipment that needs corrective maintenance performed on it. It was further noted for #4. Performed By Managers/Designees. During

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F 456	Continued From page 195 normal business hours requests are made by calling the CD (clinical engineering) Department or placing an electronic request. For (specific name) serviced sites-after hours requests are made through CE dispatch at (specific phone number). For Non-(specific name) serviced sites shall follow their hospital's procedure. After hours on call technicians will call the requesting department to determine emergent need or schedule for service. The Administrator and DON were informed of the findings on 03/25/16. No additional information was submitted for review. This is a COMPLAINT DEFICIENCY.	F 456		
F 501 SS=E	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy the medical director failed to provide clinical guidance and oversight regarding implementation of resident care policies and coordinate of medical care in the facility. The medical director did not collaborate with the facility leadership, staff, and other practitioners and consultants to help develop, implement and	F 501	F501 1. The corporate Vice President of Medical Affairs and Director of Operations have met with the Medical Director to review the certification regulations and facility expectations for oversight by the Medical Director standards of care and quality improvement projects. An agreement with a new Medical Director has been presented to a local Gerontologist. 2. All residents may have potentially been impacted. Medical Director will review QI areas identified as needing improvement and work with facility staff in developing a plan of correction.	

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F 501	Continued From page 196 evaluate resident care policies and procedures that reflect current standards of practice for pressure ulcers and ensuring the facility maintained sufficient nursing staff. The findings included: On 3/26/16 at 11:35 a.m., the QA&A (Quality Assessment and Assurance) interview was conducted with the Administrator and Director of Nursing (DON). The Administrator stated the Quality Assurance QA&A committee meets monthly and was composed of himself, the DON, Medical Director, Director of Social Services, Food Service Director (FSM), Director of Maintenance, Staff Development Coordinator, Activities Director, Rehabilitation Manager, Pharmacist, the Clinical Managers and the Administrative Assistant who records the minutes. The Administrator stated each month all participate except the Pharmacist, may miss some meetings. The Administrator stated any member of the QA&A committee as well as other facility employees, residents and staff can submit concerns to be addressed by the QA&A committee and the QA&A committee can develop a plan to resolve any concern affecting the facility's operation. The Medical Director's agreement with the facility stated the Medical Director is to provide medical leadership to the facility, establishing standards of care and practice. This leadership includes initiating and managing planned and systematic process of performance improvement in the facility including data collection, analysis, problem resolution, evaluation and communication.	F 501	3. An agreement with a new Medical Director will be initiated Medical Director will review QAPI meeting agenda with Administrator, opportunities for improvement, and analysis of data and will be an active participant in the QAPI Committee. The QAPI Committee meeting documentation will include identification of new opportunities for improvement, status of developed action plans, analysis of data, and recommendations for additional oversight or changes to promote improvement 4. Representatives from corporate quality management support services will participate in forming of the monthly agenda and will attend the QAPI meetings to ensure the Medical Director is collaborating with facility leadership, staff and other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice. 5. Completion: 5/13/2016	

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F 501	Continued From page 197	F 501		

The Administrator stated pressure ulcers had been a concern and they now had them under control. He stated pressure ulcers are all green (where they wanted them to be). He looked at the Quality Measure Report/Casper Report and pointed to new/worse pressure ulcer quality measure; it was now in the 62 percentile compared with the Group National Percentile. The Administrator stated they now had a wound care physician in the facility weekly and a successful system in place to prevent wounds and to identify skin problems early. The wound care program began with the certified nursing assistants reporting any areas of concern to the charge nurse, the charge nurse was to initiate treatment and document the skin concern for follow-up by the Clinical Manager. Other interventions included weekly skin assessments by the charge nurses, completion of the skin risk assessment at intervals as specified, consulting the wound care physician upon recommendations of the primary care physician and accurate coding on the Minimum Data Set assessment (MDS) hence, the Casper report would provide accurate information.

The QA&A committee failed to address the Hi-risk Pressure Ulcer quality measure for long stay residents. The facility scored 96 percentile compared with the national percentile on the Casper Report and had 20 residents with hi-risk. All four residents identified in F314 (Resident #s 17, 11, 10 and 9) were listed on the Caspers as within the 96% for high risk for pressure ulcers. The Administrator stated he only reviewed the new/worse quality measure not the Hi-risk quality measure.

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F 501	Continued From page 198	F 501		

During the survey four (4) compliant residents were recognized with pressure ulcer not identified by the staff until they were at an advance stage (stage 3 or more). An MDS was coded with granulation tissue but classified as a stage 2. The MDS manual and National Pressure Ulcer Advisory Panel specifically states a stage 2 pressure ulcer cannot have granulation tissue therefore; the MDS was not coded correctly. (CMS's RAI Version 3.0 Manual, page M-24). The MDS coordinator stated this was the information provided by the Clinical Manager who assessed the wound.
Other non-functioning components pertinent to having an effective wound care program were many weekly skin assessments, skin risk assessments and nurse admission assessments were not completed. Only 1 of 4 units had a full-time Clinical Manager. The Clinical Manager is the individual responsible to follow-up on identified skin conditions and ensures the program on their respective unit was operational.

The facility's Nurse Staffing was also addressed during the QA&A interview. The Administrator and DON stated the QA&A process can address nurse staffing. They both stated staffing looked good on paper but the lack of staff is a result of many call outs. The DON stated a program was instituted 8 weeks ago where current staff could sign up for additional shifts. Another effort to address staffing was they had participated in several job fairs to recruit staff and conducted an onsite job fair. The mentorship was changed because there were mentors who discouraged newly hired employees.

The Administrator and DON were asked to share information regarding the staffing on the evening

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F 501	Continued From page 199	F 501		

of 3/24/16. One unit was identified by the surveyors as not having licensed nurses to relieve the licensed nurse leaving from the previous shift. This resulted in only 1 licensed nurse caring for the entire unit. A resident experiencing pain was unable to obtain medication, 8 residents receive their dinner meal prior to have ordered finger stick blood sugars obtained and family members were complaining because a resident needed assistance with toileting hygiene. The DON simply said people did not show up.

The survey team conducted an interview with the Medical Director on 3/28/16 at approximately 5:00 p.m. The Medical Director stated he attends all QA&A meetings and all policies are discussed at some point in the meetings. The Medical Directors was asked to share what had care policies had he implemented regarding pressure ulcer prevention and management. The Medical Director stated they had obtained a consulting wound care physician but other than that no one had presented any pressure ulcer concerns to the QA&A committee. The Medical Director stated it is his expectation for someone to bring up systemic resident care concerns in the QA&A meetings.

The Medical Director was also asked during the 3/28/16 interview at approximately 5:00 p.m. to share with the survey team what the QA&A committee had concluded would be a means of resolving the nurse staffing problem the facility was experiencing. The Medical stated he was not aware there was a nurse staffing problem. The Medical Director continued by stating he was not aware he had the power to make decisions regarding facility systems, if he had he would have executed the authority where needed.

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F 501	Continued From page 200 The above findings were shared with the Medical Director, Administrator, and Director of Nursing on 3/28/16 at approximately 5:50 p.m.. The Administrator stated he did not know why the Medical Director was unaware of the nurse staffing problems, although it had not addressed in the QA&A meetings, "we have staffing problems". The Director of Nursing stated they had not created an action plan to address pressure ulcers nor nurse staffing.	F 501		
F 514 SS=D	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 clinical record review, staff interview and facility documentation, the facility staff failed to ensure that physician admission notes were in the Resident's chart for 1 of 43 residents (Resident #40) in the survey sample. The facility staff failed to ensure that the	F 514	F514 1. Resident #40 no longer resides at this facility. 2. All residents admitted in last 30 days will have record checked for presence of physician admission notes. 3. Physicians will be educated on the need to have admission notes and orders signed within 48 hours of admission. Physicians will be education on the 48 hour requirement of completed physician notes being in the EMR. 4. QA/Designee will audit weekly X 8 weeks all charts for new admits for placement of physician notes within 48 hours Analysis of weekly audits will be reported to DON and administrator and summary of audit findings will be reported to QAPI committee for additional oversight. 5. Completion: 5/13/2016	

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Physician's 3/14/16 admission note was in Resident #40's chart prior to 3/28/16 5:00 p.m.

The findings include:

Resident #40 was admitted to the facility on 3/12/16 from a local hospital to the Skilled Nursing Facility for rehabilitation services. The resident's diagnoses per hospital discharge summary included but are not limited to: Acute and chronic respiratory failure secondary to Chronic Obstructive Pulmonary Disease (COPD - a lung disease that makes it hard to breathe), with acute exacerbation (worsening) in the setting of possible HCAP (hospital acquired aspiration pneumonia).

The current MDS (Minimum Data Set) an admission with an assessment reference date of 3/19/16 coded the resident as scoring a 10 out of 15 on the Brief interview for Mental Status, indicating the resident had moderately impaired cognition. The resident was coded as having shortness of breath. In addition, the resident was coded requiring extensive assistance with the assistance of one staff person for bed mobility, hygiene, and bathing.

An interview was conducted with the Medical Director also the Physician of Resident #40 by the team on 3/28/16 at approximately 5:00 p.m. The Director of Nurses was present during this meeting. When the Medical Director was asked how he gets his notes into the Resident's chart, he stated: "For the most part I'm able to put my notes into the system here in 10 days to 2 weeks." The Medical Director proceeded to state: "I'm guilty of not getting them in. The vision system is inadequate. I don't think it's

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F 514	Continued From page 202 going to work. I write in my own computer so that if I get a call, I can see notes on the patient." The Policy and Procedure entitled: "Physician Visits - Delegation" was reviewed and documented the following: At each required visit, physicians will review the resident's total program of care, including medications and treatments: will write, sign and date progress notes; and will sign and date all orders. The Director of Nursing was notified of the findings during the meeting with the Medical Director on 3/28/16 at approximately 5:00 p.m. A copy of the 3/14/16 physician admission note was hand delivered to the surveyor on 3/28/16 at approximately 5:30 p.m.	F 514		
F 520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520	F520 1. The facility leadership team will be educated by an external long term care consultant on developing timely and focused action plans. 2. All residents may have potentially been impacted. Staff will be educated on each individual's ability to notify QAPI Committee on possible deficient practices that may need analyzing and corrective action implemented	

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F 520	Continued From page 203 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and review of facility policies, it was determined the facility failed to adequately identify, keep systems functioning properly as well as implement necessary action plans to assure the provisions of quality care for the residents. The Quality Assessment and Assurance (QA&A) committee failed to identify quality deficiencies in the areas of Pressure Sores F314 and Sufficient Nurse Staffing F353. The findings included: On 3/26/16 at 11:35 a.m., the QA&A interview was conducted with the Administrator and Director of Nursing (DON). The Administrator stated the Quality Assurance QA&A committee meets monthly and was composed of himself, the DON, Medical Director, Director of Social Services, Food Service Director (FSM), Director of Maintenance, Staff Development Coordinator, Activities Director, Rehabilitation Manager, Pharmacist, the Clinical Managers and the Administrative Assistant who records the minutes. The Administrator stated each month all participate except the Pharmacist, may miss	F 520	3. The QAPA Committee will be revamped with more emphasis placed on identified risks, data analysis, POC development and implementation. QAPA Committee members will be educated on the function of the committee to identify deficient practices and develop and implement corrective action plans. Staff will be educated on each individual's ability to notify QAPI Committee on possible deficient practices that may need analyzing and corrective action implemented. 4. Periodic attendance at QAPI meetings by corporate quality staff to monitor problem identification through data analysis and development of action plans will be performed X 6 months 5. Completion: 5/13/2016	

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F 520	Continued From page 204	F 520		

some meetings.

The Administrator further stated during the interview that it was the company's way of operation to have the QA&A committee meeting monthly instead of quarterly and he felt it was a good idea because it encouraged them to take a good look at various indicators and act upon them expeditiously. He stated any of the above mentioned personnel as well as other facility employees, residents and staff can submit concerns to be addressed by the QA&A committee and the QA&A committee can develop a plan to resolve any concern affecting the facility's operation.

The Administrator stated pressure ulcers had been a concern and they now had them under control. He stated pressure ulcers are all green (where they wanted them to be). He looked at the Quality Measure Report/Casper Report and pointed to new/worse pressure ulcer quality measure; it was now in the 62 percentile compared with the Group National Percentile. The Administrator stated they now had a wound care physician in the facility weekly and a successful system in place to prevent wounds and to identify skin problems early. The wound care program began with the certified nursing assistants reporting any areas of concern to the charge nurse, the charge nurse was to initiate treatment and document the skin concern for follow-up by the Clinical Manager. Other interventions included weekly skin assessments by the charge nurses, completion of the skin risk assessment at intervals as specified, consulting the wound care physician upon recommendations of the primary care physician and accurate coding on the Minimum Data Set assessment hence, the

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Casper report would provide accurate information. All four residents in F314 (Resident #s 17, 11, 10 and 9) were listed on the Caspers as within the 96% for high risk for pressure ulcers.

The QA&A committee failed to address the Hi-risk Pressure Ulcer quality measure for long stay residents. The facility scored 96 percentile compared with the national percentile on the Casper Report and had 20 residents with hi-risk. The Administrator stated he only reviewed the new/worse quality measure not the Hi-risk quality measure.

During the survey four (4) compliant residents were recognized with pressure ulcer not identified by the staff until they were at an advance stage (stage 3 or more). An MDS was coded with granulation tissue but classified as a stage 2. The MDS manual and National Pressure Ulcer Advisory Panel specifically states a stage 2 pressure ulcer cannot have granulation tissue therefore; the MDS was not coded correctly. (CMS's RAI Version 3.0Manual, page M-24). The MDS coordinator stated this was the information provided by the Clinical Manager who assessed the wound.

Other non-functioning components pertinent to having an effective wound care program were many weekly skin assessments, skin risk assessments and nurse admission assessments were not completed. Only 1 of 4 units had a fulltime Clinical Manager. The Clinical Manager is the individual responsible to follow-up on identified skin conditions and ensures the program on their respective unit was operational.

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F 520	Continued From page 206	F 520		

The facility's Nurse Staffing was also addressed during the QA&A interview. The Administrator and DON stated the QA&A process can address nurse staffing. They both stated staffing looked good on paper but the lack of staff is a result of many call outs. The DON stated a program was instituted 8 weeks ago where current staff could sign up for additional shifts. Another effort to address staffing was they had participated in several job fairs to recruit staff and conducted an onsite job fair. The mentorship was changed because there were mentors who discouraged newly hired employees.

The Administrator and DON were asked to share information regarding the staffing on the evening of 3/24/16. One unit was identified by the surveyors as not having licensed nurses to relieve the licensed nurse leaving from the previous shift. This resulted in only 1 licensed nurse caring for the entire unit. A resident experiencing pain was unable to obtain medication, 8 residents received their dinner meal prior to have ordered finger stick blood sugars obtained and family members were complaining because a resident needed assistance with toileting hygiene. The DON simply said people did not show up.

The Administrator shared with the survey team on 3/26/16 at approximately 11:00 a.m. that authorization for interim staff had been received and he expected the individuals to begin working within 14 days. The Administrator stated it can take up to 3 months to get newly hired staff on board to work.

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At the conclusion of the QA&A interview with the Administrator and DON on 3/26/16 at approximately 11:35 a.m., they both stated they

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F 520	Continued From page 207 had access to the above information and neither had presented it to the QA&A committee or had initiated action plans to address pressure ulcers or nurse staffing.	F 520		

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