STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

(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
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 08/28/18 through 08/30/18, was conducted 10/16/18 through 10/18/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Two complaints were investigated during the survey. The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 12 resident reviews.	{F 000}		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the	F 600	F-600 Reporting 1. Resident #115 investigation reviewed utilizing QAPI process post discussion of concerns presented during survey. On October 19, 2018, the Executive Director completed an Initial and Final Facility Reported Incident Report to the Virginia Department of Health regarding the abuse/neglect allegation for Resident #115. 2. Per review of complaints and concerns, no further allegations identified, however a process update was established related to allegations of abuse and neglect whereby the Executive Director/Abuse Coordinator will:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 10/30/18

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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	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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F 600

Continued From page 1

facility staff failed to ensure that one Resident was free from Neglect, (Resident #115) in a survey sample of 12 residents.

For Resident #115, the facility staff failed to provide daily pressure ulcer care for 7 days as ordered by a physician, further, the facility staff failed to report the allegation of neglect to the appropriate agencies after learning of the neglect by staff.

The Findings included:

Resident #115 was admitted to the facility on 3-16-12, and readmitted 9-1-18 with diagnoses including; gastro-esophageal reflux disease, stroke, hypertension, anxiety, hypothyroidism, anemia, and dementia.

Resident #115's most recent Minimum Data Set (MDS) assessment was a significant change assessment with an Assessment Reference Date (ARD) of 10-1-18. Resident #115 was coded with a Brief Interview of Mental Status score of 7, indicating moderate cognitive impairment. Resident #115 was coded as extensive to total dependence on staff for activities of daily living care, such as bed mobility, dressing, and toileting, however, was coded as supervision only for the Resident to feed self, with staff oversight, cueing, or encouragement. The Resident was always incontinent of bowel and bladder. In area M0100 (Skin conditions), the Resident was coded as at risk for, and currently having one stage 3 pressure ulcer. In review of the previous September MDS assessment, the document stated that the Resident did not have a pressure ulcer. This was incorrect, as the pressure ulcer was identified on 7-9-18 as unstageable due to

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a) consult with regional support personnel related to incidents that are potentially reportable in nature
b) interview a minimum of ten (10) other residents related to abuse and neglect any time there is an allegation of abuse

3. On 10/19/18, Regional Director of Clinical Services completed re-education with Executive Director on process of reporting allegations of abuse and neglect.

4. The ED/Abuse Coordinator/DCS will conduct quality improvement monitoring of ten (10) random residents weekly for three (3) months, then monthly for nine (9) months to ensure residents are free from abuse and neglect. Frequency

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F 600

Continued From page 2
100% eschar.

On 10-17-18 the Resident's pressure ulcer on the right ankle was observed with nursing staff. The wound was found to be clean, dry, and healing.

On 10-17-18, review of the July and August 2018 physician's orders, nursing notes, and Medication and treatment administration records (MAR/TAR) revealed the following chronological order of events;

On 7-9-18 the pressure ulcer was identified as unstageable due to 100% eschar, wound edges inflamed and red, per nursing notes.

On 7-11-18, the treatment order was issued for "Santyl Ointment 250 units per gram, apply to right outer ankle topically one time per day for wound care at 9:00 a.m.". No wound cleaning or dressing instructions were given.

It is unknown why no order was issued from the identification of the wound on 7-9-18, for 2 days, until 7-11-18.

On 8-19-18 at 4:30 p.m., the nursing notes documented that the Resident's ankle was assessed by nurses and noted to have "swelling, slough, and pus like drainage with odor to it, and that the surrounding area was warm to the touch. All of these nursing descriptions indicated concern by nursing of an infection of the wound. The note went on to document that the Resident grimaced with pain as the nurse touched the area. The nurse called the doctor at 7:36 p.m., and at 9:22 p.m., after the Resident's daughter voiced concern about the ankle, and questioned what was being done for the ankle wound. The

F 600

of monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly by the Administrator and/or DCS. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action if necessary to maintain substantial compliance and ensure residents are free from abuse and neglect.

5. Allegation of Compliance: October 31, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 600	Continued From page 3	F 600		

nurse documented that the "on call" doctor issued orders for a CBC (complete blood count) laboratory test, and Keflex (antibiotic) 500 milligrams three times per day for 14 days for a possible right ankle infection.

Nursing notes continued for the next 2 weeks, to document the assessments of the right Ankle wound infection, with a positive diagnosis obtained of right ankle wound infection. The Resident continued the antibiotic, and completed the 14 days of antibiotic therapy for the infection.

The care plan was reviewed and revealed that upon identification 2 of the interventions in that plan were to 1) "Assess, record, monitor, wound healing weekly, and measure length, width, and depth weekly". 2) Administer treatments as ordered, and monitor for effectiveness. Neither of these interventions were instituted and followed as planned.

All "Pressure Ulcer Wound Rounds" weekly assessment documents were requested for the past 6 months, and the facility supplied all documents, which related to a sacrum wound from May 2018, that was healed on 6-6-18, and the right ankle wound documentation. The first formal assessment completed for the right ankle pressure ulcer was dated 9-29-18. In the document, was a full description of the right ankle wound. These documents continued weekly through survey, and the last assessment document received was dated 10-17-18. No documents existed in the clinical record for the ankle wound from 7-9-18 upon identification, until the first documented formal assessment on 9-29-18. The September MDS also did not document a pressure ulcer for this Resident.

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	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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F 600	Continued From page 4	F 600		

The facility policy for wounds was reviewed and revealed the following processes;
Licensed nurse to complete skin evaluation weekly, and document in the medical record.
CNA (Certified Nursing Assistant) to complete skin observations and report changes to licensed nurse.
Monitor response to treatment and modify treatment as indicated.

The facility policy for neglect was reviewed and revealed "Neglect is the failure of the center , it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include; Intentional lack of attention to physical needs including, but not limited to; toileting and bathing, failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed."

The policy mentions "failure to provide services that result in harm to the Resident." A finding of "actual harm" is not necessary for a finding of neglect in regard to the federal regulation. The Administrator was made aware of this during the survey.

The facility investigation of the alleged neglect was requested on 10-17-18 from the facility Administrator, and it was supplied to the surveyors.

The facility investigation described that 4 different nurses treated the Resident's wound from 8-12-18 through 8-19-18. Two of the nurses were facility employees, and two were from a nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 600	Continued From page 5	F 600		

agency who supplied traveling nurses as needed. These nurses were paid to work as needed in facilities who do not have enough facility employed staff at the time, to perform needed care and services for the Resident population. The nurses admitted to not providing wound care on the days of 8-13-18 through 8-19-18 (7 days). Further, all four of the nurses stated they signed the TAR as if the treatments had been provided. The 2 nurses from the facility were disciplined, and the 2 agency nurses were put on the "Do not return" list, and forbidden to return to the facility to provide care to residents.

No facility reported incident (FRI) or allegation of neglect was forwarded to the state agency, (the Virginia Department of Health Office of Licensure and Certification VDH/OLC), nor to Adult Protective Services (APS) as is mandated by state and federal regulation. The allegation of neglect was made on 8-19-18 to the nursing staff by a visitor to Resident #115, as the wound dressing was found on that day (8-19-18) with the date of 8-12-18 written on it, and witnessed by nursing staff that day. The dressing to Resident #115's ankle wound had not been changed in 7 days, and was infected. A report was called in to APS on 8-19-18, by a visitor, and the APS investigation commenced at that point. The facility had still not reported the allegation of neglect to the state agency at the time of survey on 10-16-18.

On 10-17-18 The Administrator, and the Director of Nursing (DON), were interviewed and stated "No harm came to the Resident as a result of not receiving the treatments, so we didn't think we needed to report it."

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	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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F 600	Continued From page 6 The Administrator and Director of Nursing were notified at the end of day meeting on 10-17-18, and 10-18-18 that the staff were negligent in documenting weekly skin assessments, and in withholding pressure ulcer treatment services required by the Resident. They were further informed that they were deficient in reporting this incident. No further information was provided by the facility.	F 600		
{F 645} SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	{F 645}	F-645 PASRR 1. Resident # 162 and # 163's PASRR's have been completed and filed in medical record on 10/19/18. 2. Social Services conducted Quality Review of current residents to determine if PASRR is present for each. Per LTC Supervisor approval, PASRRs completed by facility Social Workers for in-house residents determined to have no PASRR in medical record. 3. BSW provided re- education for facility Social Workers to conduct and complete PASRRs for in-house residents.	

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	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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{F 645}	Continued From page 7 and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	{F 645}	4. Quality Improvement Monitoring was completed to confirm that PASRRs are complete and filed for current in-house residents. Admissions Director to continue Quality Improvement Monitoring 5x/week x 8 weeks, weekly x 4 weeks, then monthly as needed thereafter. Findings to be reviewed at monthly QAPI Committee meetings. Quality Monitoring schedule to be modified based on findings. 5. Allegation of Compliance: October 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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{F 645}	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review the facility failed to have PASARR Level 1 Screenings completed for two Residents (#162 and #163) in a survey sample of 12 Residents. 1 . For Resident #162 the facility failed to have a PASARR Level I screening completed prior to admission. 2. For Resident #163 the facility failed to have a PASARR Level I screening completed. The findings include: 1 . For Resident #162 the facility failed to have a PASARR Level I screening completed. Resident #162, a 76 year old woman was admitted to the facility on 07/25/2018 with diagnoses of but not limited to Generalized Anxiety Disorder, Insomnia, Restlessness and Agitation, Unspecified Psychosis not due to a substance or known physiological condition, Major Depressive Disorder, Diabetes and Dementia without behavioral disturbance. On 10/17/2018 during clinical record review it was noted that the clinical record for Resident #162 did not contain a PASARR Level I Screening. On 10/17/2018 1:45 PM an interview was conducted with (Social Worker) Employee C who stated that Resident #162 did not have a PASARR on admission and the facility tried to get it done once she was admitted.	{F 645}		

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	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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{F 645}	Continued From page 9 Employee C then submitted an undated letter to (Other A) an employee at the local health department, requesting PASARR Screenings for Residents #162 and #163. She also submitted an undated email to the same employee at the local health department requesting PASARR Screenings for Resident #162 and #163. On 10/17/2018 at 2:15 PM a phone interview was conducted with (Other A) an employee at the local health department who stated that she did indeed have contact with the facility about PASARR Level I. She went on to say that she had informed the facility that the local health department only did screenings for people who were "Not yet admitted to a facility". She further elaborated that "Once they are admitted to a facility the health department does not go in to facilities to do screenings." Surveyor A conducted an interview with the Administrator and Director of Nursing on 10/17/2018 at 2:35 p.m. The Administrator stated there was no PASARR obtained prior to admission for Residents # 162 and # 163 and there was still no PASARR completed. The Administrator stated that the facility was trying to find someone to complete the PASARR but was having difficulty since Residents # 162 and # 163 were already residing in the facility. The Director of Nursing agreed that there was no PASARR in the medical record. No further information was provided. 2) For Resident #163 the facility failed to have a PASARR Level I screening completed.	{F 645}		

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{F 645}	Continued From page 10	{F 645}		

Resident #163 a 65 year old woman was admitted to the facility on 01/26/2017 with diagnoses of but not limited to Bipolar Disorder, Insomnia, Unspecified Psychosis not due to a substance or known physiological condition, Major Depressive Disorder, Diabetes and Vascular Dementia with behavioral disturbance.

On 10/17/2018 during clinical record review it was noted that the record for Resident #163 did not contain a PASARR Level I Screening.

.On 10/17/2018 2:15 PM an interview was conducted with (Social Worker) Employee C who stated that Resident #163 did not have a PASARR on admission and the facility tried to get it done once she was admitted.

Employee C then submitted an undated letter to (Other A) an employee at the local health department, requesting PASARR Screenings for Residents #162 and #163. She also submitted an undated email to the same employee at the local health department requesting PASARR Screenings for Resident #162 and #163.

On 10/17/2018 at 2:15 PM a phone interview was conducted with (Other A) an employee at the local health department who stated that she did indeed have contact with the facility about PASARR Level I. She went on to say that she had informed the facility that the local health department only did screenings for people who were "Not yet admitted to a facility". She further elaborated that "Once they are admitted to a facility the health department does not go in to facilities to do screenings."

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{F 645}	Continued From page 11 Surveyor A conducted an interview with the Administrator and Director of Nursing on 10/17/2018 at 2:35 p.m. The Administrator stated there was no PASARR obtained prior to admission for Residents # 162 and # 163 and there was still no PASARR completed. The Administrator stated that the facility was trying to find someone to complete the PASARR but was having difficulty since Residents # 162 and # 163 were already residing in the facility. The Director of Nursing agreed that there was no PASARR in the medical record. No further information was provided.	{F 645}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure that one Resident	{F 686}	F 686 Wounds 1. Resident # 162 was assessed by physician on 10-23 and wound care interventions reviewed. The right buttock wound has been identified as resolved by the physician on 10-23 and Responsible party member notified of resident's current skin integrity status. The care plan for resident # 162 has been updated by the interdisciplinary team (IDT) to reflect resident(s) current plan of care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 686}	Continued From page 12 was free from pressure ulcers, (Resident #162) in a survey sample of 12 residents. 1. For Resident #162, the facility staff failed to provide preventive care, and weekly skin assessments prior to the development of a stage 2 pressure ulcer on 10-12-18. The Findings included: 1. For Resident #162, the facility staff failed to provide preventive care, and weekly skin assessments prior to the development of a stage 2 pressure ulcer on 10-12-18. Resident #162 was admitted to the facility on 7-25-18 from a sister facility, with diagnoses including; stroke, seizures, per endoscopic gastrostomy tube (PEG) in the abdomen for feeding, hypertension, chronic kidney disease, heart failure, anxiety, and type 2 diabetes. Resident #162's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 8-29-18. Resident #162 was coded with a Brief Interview of Mental Status score of unable to complete, indicating severe cognitive impairment. Resident #162 was coded as totally dependant on staff for activities of daily living care, such as bed mobility, dressing, and toileting. The Resident was always incontinent of bowel and bladder. In the MDS section M0100 (Skin conditions), the Resident was coded as at risk for pressure ulcer formation. The Resident currently had no pressure ulcers during the assessment at section (M0900). In review of section M1200, skin and ulcer treatments (preventive measures), only	{F 686}	2. Current facility residents have had a skin assessment completed on 10-22-18 by a licensed nurse and any newly identified skin integrity issues, a physician was consulted for treatments. Residents identified with a Braden scale at high risk plans of care have been reviewed by the IDT to include preventative skin care interventions and care plans updated accordingly. 3. Licensed nursing staff has been re educated by DON or ADON on obtaining physician orders for residents identified with new wounds or a change in wound condition and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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{F 686} Continued From page 13
"pressure reducing device for chair, and pressure reducing device for bed" were coded.

The Resident received a cushion for her wheel chair, and had the same bed that every resident in the facility was supplied with upon admission. That mattress was classified by the manufacturer as a "pressure reducing mattress" according to the Corporate Registered nurse. No applications of ointments was coded in the MDS. This Resident had a history of pressure ulcers, had no wounds, and was receiving no individualized preventative treatments at the time of the assessment.

A "Functional Maintenance program" form was developed by the therapy department after Resident #162's admission dated 8-7-18, and described Resident #162 as dependent for all; dressing, bathing, toileting, grooming, bed mobility and transferring. The Resident was NPO (nothing by mouth).

A chronological order of the development of Resident#162's stage 2 pressure ulcer findings were as follows;

The Admission assessment and nursing notes indicated that on 7-25-18, Resident #162 was admitted from a sister facility with a history of pressure ulcers and resultant scar tissue of the buttocks. The sister transferring facility sent with the Resident the current treatment orders which included the following 3 preventative orders;

1. "moisture barrier ointment apply to buttocks topically every shift for protection after incontinent episodes, ordered (11-9-15)".

{F 686}

4. The Director of Nursing/ Assistant Director of Nursing / licensed nurse designee will complete a quality measure tool to randomly assess residents with a high risk Braden score for application of skin prevention interventions ordered by a physician 5x week for 1month, 3x week for month , then weekly for one month with results reported to the QAPI Committee. Monitoring schedule modified based on findings.
completing at risk tool for skin integrity issues on admission, quarterly and significant change in condition. The licensed nurse will notify the nursing administrative nurses (DON, ADON, and Unit Manager) to review newly identified skin findings related to alteration in resident's skin integrity.
5. Allegation of Compliance: October 31, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 686}	Continued From page 14	{F 686}		

2. "Coccyx cleanse with normal saline, pat dry, cover with foam dressing, on Monday, Wednesday, Friday (day shift) for prevention, ordered (7-25-18)."

3. "Weekly skin checks every Tuesday, ordered (12-2-16)".

Review of the September, and October 2018 physician's orders, and Medication and Treatment Administration Records (MARs/TARs), revealed that none of the three preventive orders were continued as active orders in the receiving facility prior to, or at the time, of the stage 2 pressure ulcer development on Resident #162's right buttock on 10-12-18.

On 8-29-18 the quarterly MDS assessment documented no preventive care except the wheel chair cushion, and facility routine mattress.

Review of all nursing notes and all of the "Weekly skin integrity review" documents from admission was conducted and revealed skin assessments were completed on 8/1/18, 8/27/18, 9/2/18, 10/3/18, 10/10/18, and on 10/12/18, when the ulcer was identified as a stage 2 pressure sore, equaling 5 skin assessments in 12 weeks.

On 10-12-18, Resident #162 was identified by nursing in the nursing notes to have an "area to lower right side of buttocks, (measuring) 2.2 (centimeters) x 1 (centimeter)." This first identification of the wound was the last nursing note in the clinical record. No depth of the wound was recorded.

On 10-15-18, "pressure ulcer wound rounds" were documented on the facility assessment form

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{F 686}	Continued From page 15 as a stage 2 pressure ulcer measuring 2.2 cm long x 1 cm wide by the ADON. No depth of the wound was recorded. On 10-15-18 at 3:00 p.m., an order was obtained for "Barrier cream to right buttocks to be applied by nurse every shift for stage 2." The ADON (Assistant Director of Nursing) was asked why no barrier cream was ordered for 3 days after the identification of the wound, she stated "I will have to check on that." No answer was ever given. Note: It is unknown why no order was issued from the identification of the wound on 10-12-18, for 3 days, until 10-15-18. On 10-17-18, Resident #162's wound observation was conducted with the ADON who completed the 10-15-18 assessment, and the current DON (Director of Nursing), who were both interviewed. The ADON stated that the wound "had not changed at the 10-15-18 assessment, from the original identification of the stage 2 wound on 10-12-18." The pressure ulcer was noted by surveyors to be a stage 2 pressure ulcer located in the tissue of the lower right buttock covering the ischial tuberosity. The wound was open into the dermis, beefy red tissue was noted in the wound bed, the edges of the wound were slightly rolled, and the center had white ointment imbedded in the wound, obscuring the depth of the wound bed. The DON stated "I can't remove it all (ointment) or I could further injure the wound." The wound bed was not able to be fully visualized. The ADON, and DON stated the wound was healing. The DON and ADON were asked when pressure areas should be identified, and the answer was "at a stage 1". On 10-17-18, during another resident's wound	{F 686}		

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	495190	A. BUILDING ______ B. WING ______	R-C 10/18/2018

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{F 686}	Continued From page 16	{F 686}		

observation, LPN B, the treatment nurse on Resident #162's unit, was asked what the purpose of the TAR was. The reply was "that tells us what the doctor's orders are, so we can complete them, and shows they are completed when we sign them off." LPN B was asked who performed peri care, and incontinence care on the residents, she stated "the CNA's."

On 10-17-18, facility staff provided copies of Resident #162's September and October TARs. The moisture barrier order had not been applied to either TAR for nurse direction to treat, and to document that treatment as completed.

On 10-18-18, The DON, Corporate Regional nurse, and ADON requested that surveyors view the wound again. Three surveyors observed the wound, and the facility nurses measured the wound to be 0.9 cm x 1.0 cm. The wound bed still contained white ointment in crevices, and the depth of the wound could not be fully visualized.

The Resident's care plans were reviewed, and the original care plan dated 8-3-18 was found to have 3 identical versions. All 3 documents were date initiated on 8-3-18, and revised on 8-9-18, with no other revisions to the interventions. The care plans listed moisture barrier to be applied as one of the interventions, however, there was no physician's order for the moisture barrier ointment, the 8-29-18 MDS denied the use of ointments, and the TAR did not list it as a treatment for nursing to follow, and document the completion of that treatment.

The only difference in the three 8-3-18 care plans was 3 different target dates. The three different target dates were 10-24-18, 10-25-18, and

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{F 686}	Continued From page 17 11-27-17. None of them indicated an actual pressure ulcer, and the only change was on the 11-27-18 target date which changed "Float heels", to "Float heels as tolerated." No other intervention changes were made to the 3 documents. A new care plan was initiated on 10-15-18, three days after identification of the pressure ulcer injury. The new care plan had a target date of 11-27-18, and denoted the pressure ulcer. The only new intervention after identification of the pressure ulcer injury on 10-12-18, was to "assess/record/monitor wound healing weekly: Measure length, width and depth where possible." Depth had never been described or recorded, up until the time of survey. The care plan moisture barrier ointment intervention stated "Apply barrier cream after peri care". In this facility, CNA's (certified nursing assistants) provided peri care, and incontinence care. The doctor's order specifically stated, "Apply the barrier cream every shift by the nurse". CNA's are not permitted, according to their scope of practice, to treat wounds. As the nursing care plan stated moisture barrier cream after peri care, which is a CNA job duty, and the moisture barrier cream did not appear on the TAR for nurses to complete, it is unknown if the treatment was being completed by nurses. The Corporate Registered Nurse was asked to provide surveyors with all facility policies related to skin assessments, skin care, and pressure ulcer identification and treatment. She returned with one policy entitled "Clinical Guideline Skin & Wound". The document was reviewed, and revealed the following;	{F 686}		

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{F 686}	Continued From page 18 "Overview" - "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing, and decrease worsening of/prevention of pressure injury. "Process" - "Licensed nurse to complete skin evaluation weekly and prior to transfer or discharge and document in the medical record."...... On 10-16-18 the CMS (Centers for Medicare & Medicaid services) form 802 matrix was requested from the facility, and an initial working copy was received. The document did not list Resident #162 as having a pressure ulcer. On 10-17-18 the final 802 form which had been updated and corrected was supplied to surveyors, and it revealed no pressure ulcer documented for Resident #162 during survey. Resident #162 was at risk, and had a history of developing pressure ulcers upon admission. The facility failed to implement their policy to complete weekly skin assessments. The staff failed to continue preventive care upon admission, and failed to obtain treatment orders for 3 days after the Resident developed a stage 2 pressure ulcer on 10-12-18 (10 days after the AOC date). It is unknown who was completing the physician ordered moisture barrier cream application, and the staff failed to identify a pressure injury before it became a stage 2 pressure ulcer. The Administrator and Director of Nursing were notified at the end of day meeting on 10-17-18, and 10-18-18 that the staff were deficient in pressure ulcer prevention care and services, which were required by the Resident. No further information was provided by the facility.	{F 686}		

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F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide in-house RN (Registered Nurse) staffing for eight hours per day. Findings include: A review of the facility's staffing for 9/22/2018 through 9/30/2018 was conducted. On 9/22/2018 and 9/23 2018, the facility records show no Registered Nurse (RN) on site. On 10/18/2019, an interview was conducted with Employee B (the Director of Nursing). When asked to show which employee on the schedule was an RN, Employee B replied "there wasn't one, there was no RN that weekend." No other information was provided prior to exit.	F 727	F 727 RN Coverage 1. The facility nursing staff coordinator and DON has reviewed daily the nursing schedule to ensure RN coverage for eight hours a day. The facility RN coverage has been maintained since surveyors exit on 10-18-18. 2. The current nursing schedule has been reviewed by DON and /or ED for RN coverage eight hours a day per daily labor management meeting. 3. The nursing staff coordinator has been re educated by Director of Clinical Services on 10/19/18 related to reviewing and monitoring to ensure there is eight hours of RN coverage daily to meet state and federal regulation.	

4. Quality Improvement Monitoring to be completed daily by nursing staff coordinator or DON to monitor RN coverage of eight hours in the facility. ED/DON to verify RN coverage via labor management meeting 5x/week x 12 weeks, weekly x 6 weeks, monthly x 3 and as needed. The results of the quality monitor will be reported to the QAPI Committee. Monitoring schedule modified based on findings.
5. Allegation of Compliance: October 31, 2018