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	495210	A. BUILDING _____ B. WING _____	C 08/17/2017

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NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/15/17 through 08/17/2017. Corrections are required for compliance with 42 CRF Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two (2) complaints were investigated during this survey. The census in this 180 bed facility was 129 at the time of survey. The survey sample consisted of 22 current Resident reviews (Resident #1 through #20 and Resident #24 and #25) and 3 closed record reviews (Resident #21 through #23).	F 000		
F 166 SS=D	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 166		9/27/17

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

Electronically Signed | 09/08/2017

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grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 166	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review, the facility staff failed to promptly resolve a grievance for 1 of 25 residents (Resident #6), in the survey sample. The facility staff failed to resolve Resident #6's grievance to have his broken lower denture repaired or replaced. The findings included:	F 166	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged	

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F 166	Continued From page 3 Resident #6 was originally admitted to the facility 2/27/17 and has not been discharged from the facility. The current diagnoses included; diabetes, hyperlipidemia, seizure disorder, sleep apnea and schizophrenia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/27/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 2 persons with bed mobility, dressing, toileting, and personal hygiene and total care of two persons with bathing. On 8/16/17 at 10:30 a.m., an interview was conducted with Resident #6. The resident stated his lower denture fell to the floor and a certified nursing assistant stepped on them, causing the dentures to break. Resident #6 further stated he spoke with the Administrator and Unit Manager about having the dentures repaired or replaced but as of 8/17/17 no one had addressed his concern with him. The resident stated not having the dentures does not affect his ability to consume his meals or his speech but he doesn't want people to see him without his teeth, "it's embarrassing". Review of the clinical record revealed a nurse's note dated 3/7/17. The nurse's note stated, Resident #6 returned from having a transfusion at 5:00 p.m., and at approximately 8:15 p.m., the nurse was called to Resident #6 room for he had	F 166	deficiencies cited have been or will be completed by the dates indicated. F166 1. Resident #6 has been notified that the facility will resolve the grievance relating to the broken denture. 2. Current grievances were reviewed to ensure that the grievances have been resolved. 3. Facility administrative staff were educated on the grievance official, receiving a grievance, responding to a grievance, and tracking of grievances. 4. Grievances will be reviewed by the Administrator on a monthly basis to ensure that the grievance has been resolved. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation.	

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fallen from the bed to the floor. Resident #6 states he has a small seizure. The resident then, asked the staff what was that which fell on the floor? The staff identified the object as his bottom denture and told the resident the dentures, were broken. The nurse's note further stated the resident became "irate" and stated one of the staff had broken his denture on purpose.

An interview was conducted with the Unit 3 Manager (U3M) on 8/17/17 at approximately 2:15 p.m. The U3M stated she was on leave when Resident #6's lower dentures were broken but when she returned to the facility she completed a concern form, notifying the Administrator and the Director of Social Work of Resident #6's broken lower dentures. The U3M stated neither notified her to do anything further in regards to the broken lower dentures.

The Administrator, Director of Nursing and Corporate Consultant were informed of Resident #6's concern about repairing or replacing his broken lower denture during the pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The Administrator stated he was aware of the broken dentures and he had explained to the resident the facility would not be paying to have his dentures repaired or replaced. The Administrator stated the resident's sister stated she paid for the dentures and she would pay for some more.

The Administrator provided a progress note written by the Director of Social Work which stated the Director of Social Work met with Resident #6 on 3/23/17 regarding his broken lower denture, reminding him his sister stated she would pay for replacement of the lower dentures.

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F 166	Continued From page 5 The 3/23/17 progress note stated the resident became "loud and irate" and told the Director of Social Work to do as he told her to do, make a dental appointment because he had his own money. The progress note stated the resident refused to talk any further to the Director of Social Work. The facility's policy was not provided but the U3M stated when a resident is identified as needing dental services their name is given to Social Services and the resident is set-up for an appointment. A determination is made regarding payment for services and arranged accordingly. At the time of the survey team's exit the facility staff had not aided Resident #6 to obtain an appointment or coordinate services to replace the broken lower denture.	F 166		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 309		9/27/17

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F 309	Continued From page 6 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review 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 2 of 25 residents in the survey sample (Residents #2 and #6). 1. The facility failed to obtain a Physician Order to cleanse a traumatic wound with Normal Saline and to apply a clean dressing for Resident #2. 2. The facility staff failed to identify two staples remaining in Resident #6's healed surgical sacral suture line. The Findings included:	F 309	F309 1. Resident #2□s treatment order has been revised to include the cleansing agent and dressing. Resident #6 is receiving care and services to promote and maintain the healed sacral surgical site. 2. Residents with wounds were reviewed to ensure that the order includes the cleansing agent and dressing. Residents with surgical sites were reviewed to ensure that staples were removed as ordered. 3. Charge nurses were educated on treatment orders to include a cleansing agent, treatment medication, and dressing as indicated. Charge nurses were educated on assessment of surgical	

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F 309	Continued From page 7 1. Resident #2 was admitted to the facility on 6/22/15 with a readmission on 7/12/16. Diagnoses for Resident #2 included but not limited to Non Alzheimer's Dementia and Traumatic open wound to the Right heel. Resident #2's Annual Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 6/3/17, coded Resident #2 with a BIMS (Brief Interview for Mental Status) of 2 out of 15, indicating a severe cognitive impairment. Resident #2's Physician order of 6/13/17 documented: Silvadene Cream 1%; Apply to Right ankle topically two times a day for open area. The Physician order dated 6/13/17 documented the following: Silvadene Cream 1% Apply to right ankle topically two times a day for open area. The Care Plan Focus revised on 6/20/17 documented the following: Focus: Traumatic wound to right outer ankle Interventions included but are not limited to the following: Devices: wheelchair cushion Keep skin clean and dry Moisture barrier cream as needed for protection of skin No right foot shoe Position resident as needed Weekly skin Assessment On 8/16/17 at approximately 10:15 a.m., LPN #4 (Licensed Practical Nurse) was observed sanitizing the top of the wound cart. The LPN	F 309	wounds and identifying the need for suture removal. 4. A random weekly review of wounds will be completed to ensure that treatment orders are complete and that sutures have been removed as ordered. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation.	

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took needed supplies and placed them on top of the wound cart. The LPN took the clean supplies and went into the Resident's room and placed them on a soiled bedside table.

The Resident was observed to be having Respiratory distress. Vital Signs were obtained (Pulse Oximetry 97%, Blood Pressure 100/59; Pulse 67 and regular, Respirators 17 and irregular). Slight periods of approximately 15-25 seconds of no breathing were observed. The Resident was extremely drowsy. Audible wheezing was heard; the LPN stated the lungs were clear on auscultation. The Doctor was called with an update of Resident's findings as well as the Authorized Representative.

The wound care was delayed until the Resident was feeling better.

On 8/16/17 at approximately 2:15 p.m. wound care was observed. The LPN placed the clean supplies on the edge of the overbed table. The LPN then sanitized the over-bed table portion that did not have supplies. The nurse was heard to say, "I can't clean the rest of the table unless I hold the supplies and I can't do that." After seeing the LPN standing and looking toward the table for several minutes, the surveyor suggested use of a barrier. The LPN stated we don't have them and just stood looking at her supplies. The nurse was asked if she had a clean plastic bag. The LPN left the room and returned with a clean plastic bag and used it as a barrier.

The Resident could be heard audibly wheezing and the LPN stated, I will check to see if he can have another breathing treatment. The LPN was asked if she wanted me to come back. She

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stated she would ask her Director of Nursing what she should do. The LPN left the room and returned. The LPN stated that as the Resident was currently stable, she would proceed with his wound care.

The LPN donned clean gloves and removed the dressing from the Resident's Right ankle area. The LPN was not able to hold the Resident's leg/foot up and do the wound care so she went to the door and asked the Staff Development Coordinator to assist. The Staff Development Coordinator came into the room, donned gloves and explained to the Resident what she was going to do.

The LPN then washed her hands and donned gloves. Wound measurements were taken: Length 0.3 centimeters (cm); Width 0.3 cm; Depth 0
The LPN removed her gloves, and then donned clean gloves. The LPN applied Silvadene Cream 1% to a 4 x 4 dressing and applied it to the wound base. Hypofix tape was used to secure the dressing in place.

The LPN removed her gloves and washed her hands. Supplies were returned to the wound cart and the overbed table was sanitized.

Nurse Consultant #3 on 8/17/17 at approximately 3:15 p.m. stated, "We don't have an order for the wound care."

The Facility Policy titled, "Physicians Orders" with date of 2/1/15 documented the following:
"Medication and treatment orders shall include the following:
Name

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Dose
Route
Reason
Diagnosis"

The facility administration was informed of the findings during a pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.

2. Resident #6 was originally admitted to the facility 2/27/17 and has not been discharged from the facility. The current diagnoses included; diabetes, hyperlipidemia, seizure disorder, sleep apnea and schizophrenia.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/27/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 2 persons with bed mobility, dressing, toileting, and personal hygiene and total care of two persons with bathing.

On 8/17/17 at approximately 11:15 a.m., a skin assessment was conducted of Resident #6's body. As the staff turned the resident, the dressing to the sacral/coccyx site fell off exposing two shiny metal objects in a well healed sacral surgical site. The Licensed Practical Nurse (LPN) accompanying the surveyor stated the metal objects appeared to be staples but she was not certain if they were, nor how long the objects had

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been in the site or if they should be present.

An interview was conducted with the Unit 3 Manager (U3M)on 8/17/17 at approximately 1:30 p.m. The U3M stated she was not aware Resident #6 had shiny metal objects in the sacral surgical site because neither the nurses performing the skin assessments nor the Certified Nursing Assistant (CNA) had reported an observation of metal objects prior to 8/17/17. The U3M further stated the surgeon removed a few staples at a time as the wound healed until all were removed, so they thought. The U3M stated the resident last saw the surgeon on 6/12/17.

The surgeon's progress noted dated 6/12/17 read, "patient seen and examined. Reconstructed sacral ulcer 6 months post operation. Sacral ulcer well healed, no obvious breakdown. Return to office in 3 months. No sitting in wheelchair, may stand with walker."

The current care plan revised 8/4/17, had a problem which read; "Potential for skin impairment/pressure ulcer development related to decreased mobility, history of pressure ulcers to the buttocks/coccyx and noncompliance with turning and repositioning." The goal read; "Resident will have no additional skin breakdown through next review 10/5/17." Some of the interventions were; "weekly skin assessment, keep skin clean and dry."

Review of the weekly skin assessments dated 7/22/17, 7/29/17, 8/5/17 and 8/12/17 did not

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F 309	Continued From page 12 reveal shiny metal objects to the sacral site. The above findings were shared with the Administrator, Director of Nursing and Corporate Consultant during the pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The Director of Nursing stated a review of the skin assessments were reviewed and the staples were not observed by the nursing staff; therefore, the surgeon neither the physician or designee were informed. The Director of Nursing also stated the Physician Assistant assessed the resident on 8/17/17 and identified 2 staples "hidden" in the sacral surgical site. The progress note provided by the Director of Nursing stated: "Physician Assistant removed the staples without difficulty after cleansing the area, dry gauze was applied afterwards due to minimal bleeding, resident tolerated the procedure well".	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with	F 314		9/27/17

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NORFOLK HEALTH AND REHABILITATION CENTER	901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504

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F 314	Continued From page 13 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 observations, resident interview, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to provide care and services to identify new pressure injuries for 1 of 25 residents (Resident #6), in the survey sample. The facility staff failed to identify a new pressure ulcer to the base of Resident #6's neck and a change in the right lateral foot deep tissue injury to a stage 2 pressure injury. The findings included: Resident #6 was originally admitted to the facility 2/27/17 and has not been discharged from the facility. The current diagnoses included; diabetes, hyperlipidemia, seizure disorder, sleep apnea and schizophrenia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/27/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 2 persons with bed mobility, dressing, toileting, and personal hygiene and total care of two persons with bathing.	F 314	F314 1. Resident #6 has been accurately assessed for the presence and status of pressure ulcers. 2. Residents were reviewed to ensure that pressure ulcers have been identified and documented with accurate assessment. 3. CNAs were educated on identifying and documenting an alert for any newly identified area to skin. Charge nurses were educated on identifying, physician notification, documenting newly identified area to skin, and documenting accurate assessment of a wound. 4. A random weekly review of weekly skin assessments will be completed to ensure that areas are identified and assessed appropriately. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation.	

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On 8/16/17 at approximately 10:30 a.m., Resident #6 was interviewed in his room. He was observed lying on his back immediately after morning care. The resident had a sheet on from his ankles to his torso and no clothing. A Certified Nursing Assistant (CNA) came in approximately 10:33 a.m., with a gown and put it on the resident. Each foot was observed resting on a pillow and a moderate amount of dark yellow exudate was observed on the right pillow.

Resident #6 was observed again on 8/17/17 at approximately 11:15 a.m., in bed with two CNAs at the bedside. Dressings were observed to bilateral feet. Licensed Practical Nurse (LPN) #51 came in to complete the skin assessment but she had no information concerning the dressings to Resident #6's feet. During the skin assessment Resident #6's feet were observed; there was an open area to the right lateral foot oozing a moderate amount of dark yellow exudate and epithelial tissue. The resident asked if we could observe his neck because it was hurting and at the base of his neck was another open area. It was oozing a small amount of yellow exudate, identified with epithelial tissue and was tender to touch. During the turning of the resident, the coccyx dressing fell off and a healing pressure ulcer with granulation tissue was observed.

An interview was conducted with the Unit 3 Manager (U3M) on 8/17/17 at approximately 1:30 p.m. The U3M stated she was not aware Resident #6 had shiny metal objects in the sacral surgical site because the nurses performing the skin assessments neither the Certified Nursing Assistant (CNA) had reported an observation of

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F 314	Continued From page 15 metal objects prior to 8/17/17. The U3M further stated the surgeon removed a few staples at a time as the wound healed until all were removed so they thought. The U3M stated the resident last saw the surgeon on 6/12/17. The current care plan revised 8/4/17, had a problem which read; "Potential for skin impairment/pressure ulcer development related to decreased mobility, history of pressure ulcers to the buttocks/coccyx and noncompliance with turning and repositioning." The goal read; "Resident will have no additional skin breakdown through next review 10/5/17." Some of the interventions were; "weekly skin assessment, keep skin clean and dry." The above findings were shared with the Administrator, Director of Nursing and Corporate Consultant during the pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The Director of Nursing stated the right lateral foot pressure injury experienced an acute change and the Physician Assistant assessed the open areas and instituted treatments. The progress note read deep tissue injury to the right outer heel is open and with scant drainage, measuring 1.0 x 0.5 centimeters, the wound bed is pink and the treatment was changed to Silverdene. The newly identified pressure injury to the base of his neck measured 1.0 x 0.4 centimeters, Bacitracin ointment was ordered and the resident's gown is not to be tied. The Director of Nursing stated changes and new pressure injuries ideally should be identified during daily care.	F 314		
F 333	RESIDENTS FREE OF SIGNIFICANT MED	F 333		9/27/17

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F 333 SS=E	Continued From page 16 ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility documentation the facility staff failed to administer two (2) significant medications for 1 out of 25 residents in the survey sample, (Resident #20). The facility staff failed to transcribe and administer 3 doses of Clonidine (1) and 7 doses of Methyldopa (2) (Hypertensive medications) as ordered by the cardiologist. The findings included: Resident #20 was admitted to the facility on 06/16/17. Diagnosis for Resident #20 included but not limited to Hypertension (3). The current Minimum Data Set (MDS) a comprehensive assessment with an Assessment Reference Date (ARD) of 06/23/17 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), no cognitive impairment. In addition, the MDS coded Resident #20 for being independent with no assistance required for all ADL's (Activities of Daily Living) except eating requiring set-up help only. Resident was also coded as being continent of bowel and bladder.	F 333	F333 1. Resident #20 has been discharged from the facility. 2. Residents with consult appointments during the past month were reviewed to ensure that any new orders were transcribed and administered in a timely manner. 3. Charge nurses will be educated on review of consult reports to ensure that any new orders are transcribed and administered in a timely manner. 4. A random weekly review of consult appointments will be completed to ensure that any new orders were transcribed and administered in a timely manner. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation.	

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Resident #20's care plan documented resident with actual problem with hypertension. The goal: will remain free of complications related to (r/t) hypertension. The intervention/approaches to manage goal included: medications as ordered.

An interview was conducted with Resident #20 on 08/17/17 at approximately 8:40 a.m.. She stated she made her own medical appointments because she was capable of doing so. Resident #20 also stated at times her medication is not administered on time and sometimes not at all. The resident also stated she went to see her cardiologist (4) on 08/10/17 and returned with new orders but the facility didn't start her medications until 08/15/17. Resident #20 stated, "I just don't understand why I can't get my medication as ordered by the doctor and not receiving my medication makes a great impact on my overall health."

The clinical record revealed on 08/10/17 Resident #20 went to see her cardiologist. According to the clinical record, Resident #20 complained of her blood pressure being high; her blood pressure was taken at her cardiology appointment with a reading of 162/98. New orders were documented on the office note that was faxed to the facility on 08/11/17 at 9:22 a.m., to increase Clonidine 0.1 mg to three times daily and start Methyldopa 250 mg twice daily.

Review of Resident's #20's August 2017 Medication Administration Record (MAR) indicated the medication for Clonidine and Methyldopa wasn't transcribed until 08/14/17.

Review of the resident's clinical record revealed the following blood pressure (BP) readings for

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August 2017 included but not limited to: on 08/14 (141/93), 08/13 (161/86), 08/12 (151/87), 08/11 (160/84), 08/09 (144/88), 08/07 (155/83), 08/04 (162/95), 08/03 (159/88), 08/02 (164/97), 08/01 (173/71) and July 2017 on 07/31 (172/99).

An interview as conducted with the Director of Nursing (DON) on 08/17/17 at approximately 12:45 p.m., who was informed by the surveyor that after the review of Resident #20's clinical record it indicated that resident went to her cardiology appointment on 08/10/17; the office notes were faxed over on 08/11/17 but the orders for Clonidine and Methyldopa were never transcribed until 08/14/17. The DON stated, "The nurses placed the office note from the cardiology appointment into the Physician Assistant (PA) box for review. The surveyor asked what are your expectations of the nurses when a resident returns from a doctor's appointment with a progress note or a progress note is faxed over and that progress note contains new orders, she replied "I expect for the nurse to notify the physician of the new orders and take them off."

The facility's Administrator, DON and nurse consultant were informed of the findings during a briefing on 08/17/17 at approximately 3:30 p.m. The surveyor asked the nurse consultant for the facility's policy on transcribing and administering medications. The same day at 3:40 p.m., the nurse consultant gave the surveyor a policy titled: "History and Physical" with #5 highlighted in yellow. The facility did not present any further information about the findings.

Policy name: "History and Physical (Effective date): 02/01/15
Procedure:

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F 333	Continued From page 19 5. All verbal orders shall be immediately recorded and signed by the individual receiving them and shall be countersigned by the prescribing physicians." 1). Clonidine is used alone or in combination with other medications to treat high blood pressure (https://medlineplus.gov/ency/article/007365.htm). 2). Methyldopa is used to treat high blood pressure(https://medlineplus.gov/ency/article/007365.htm). 3). Hypertension is when your blood pressure, the force of your blood pushing against the walls of your blood vessels, is consistently too high (https://medlineplus.gov/ency/article/007365.htm). 4). Cardiologist is a physician who specializes in the diagnosis and treatment of disorders of the heart (Mosby's Dictionary of Medicine, Nursing and Health Professions, 7th Edition). This is a complaint deficiency.	F 333		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 371		9/27/17

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F 371	Continued From page 20 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to maintain the proper food temperature at one of 3 nursing units. The facility staff failed to maintain the proper temperature for hot foods at 135 degrees Fahrenheit (F) or above at one of the nursing units, Unit 2. The findings included: During a Group Interview conducted on 08/16/17 at 10:00 AM with 11 cognitive residents, 6 residents out of the group stated the hot food was never hot because the food carts will sit on the floor about 15-20 minutes, if not longer, before the CNAs (Certified Nurse Aide) come to pass out the trays. Three (3) of the residents stated, "I come from the 3rd unit and they won't even take the time to use the steam tables."	F 371	F371 1. Unit 2 is served food at a temperature of 135 degrees Fahrenheit or above. 2. Food temperatures are maintained at 135 degrees Fahrenheit or above on all nursing units. 3. Dietary staff will be educated on maintenance of food temperatures at 135 degrees Fahrenheit or above at time of serving, reheating of hot-holding food if found to be below 135 degrees Fahrenheit to a temperature of 165 degrees within 2 hours or discarding the food as indicated. 4. A random review of food temperatures at time of service will be completed by the Food Service Director to ensure that food temperatures are acceptable. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation.	

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F 371	Continued From page 21 On 8/16/17 at 11:50 AM, food temperatures were checked when the food arrived on Unit 2 after they were placed on the steam table. The temperature of the hot foods that were served was as follows: baked ziti was 110 degrees F and the broccoli was 130 degrees F. On 8/17/17 at approximately 4:20 PM, the Director of Food Services was interviewed in regards to the food temperature findings on Unit 2 and he stated that it should have been maintained at 135 degrees F. He also stated that if the food temperature was 135 degrees F or below, the staff must reheat the food. The Director of Food Services provided a copy of the facility policy and procedure titled, "Safe Food Temperatures" with an effective date of 4/27/16, stated, in part, "Policy: Food will be prepared and maintained at proper temperature to ensure food safety and palatability. Temperatures shall be recorded for all types of perishable hot or cold menu items offered at each meal; Procedure: ...9. If at any time food item is not at an acceptable temperature, corrective actions will be taken, For hot-holding foods found to be below 135 degrees F, the food will be reheated to 165 degrees F within 2 hours or discarded..." The Director of Food Services did not provide any further information.	F 371		
F 411 SS=E	ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS CFR(s): 483.55(a)(1)(2)(4) (a) Skilled Nursing Facilities A facility-	F 411		9/27/17

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F 411	Continued From page 22 (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and clinical record review, the facility staff failed to assist 1 of 25 residents (Resident #6), in the survey sample to arrange dental services. The facility staff failed to assist Resident #6 to have his broken lower denture repaired or replaced. The findings included: Resident #6 was originally admitted to the facility 2/27/17 and has not been discharged from the facility. The current diagnoses included; diabetes, hyperlipidemia, seizure disorder, sleep apnea and schizophrenia. The quarterly Minimum Data Set (MDS)	F 411	F411 1. Resident #6 is scheduled for follow-up replacement of the dentures. 2. Residents were reviewed to ensure that the need for dental services has been addressed. 3. Charge nurses were educated on communicating the need for dental services to the Unit Manager to ensure that needed services are addressed. 4. A random review of residents triggering for dental concerns on their MDS will be done weekly to ensure that dental needs are addressed. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation.	

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assessment with an assessment reference date (ARD) of 6/27/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 2 persons with bed mobility, dressing, toileting, and personal hygiene and total care of two persons with bathing.

On 8/16/17 at 10:30 a.m., an interview was conducted with Resident #6. The resident stated his lower denture fell to the floor and a certified nursing assistant stepped on them, causing the dentures to break. Resident #6 further stated he spoke with the Administrator and Unit Manager about having the dentures repaired or replaced but as of 8/17/17 no one had addressed his concern with him. The resident stated not having the dentures does not affect his ability to consume his meals or his speech but he doesn't want people to see him without his teeth, "it's embarrassing".

Review of the clinical record revealed a nurse's note dated 3/7/17. The nurse's note stated, Resident #6 returned from having a transfusion at 5:00 p.m., and at approximately 8:15 p.m., the nurse was called to Resident #6 room for he had fallen from the bed to the floor. Resident #6 states he has a small seizure. The resident then, asked the staff what was that which fell on the floor? The staff identified the object as his bottom denture and told the resident the dentures, were broken. The nurse's note further stated the resident became "irate" and stated one of the staff had broken his denture on purpose.

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An interview was conducted with the Unit 3 Manager (U3M) on 8/17/17 at approximately 2:15 p.m. The U3M stated she was on leave when Resident #6's lower dentures were broken but when she returned to the facility she completed a concern form, notifying the Administrator and the Director of Social Work of Resident #6's broken lower dentures. The U3M stated neither notified her to do anything further in regards to the broken lower dentures.

The Administrator, Director of Nursing and Corporate Consultant were informed of Resident #6's concern about repairing or replacing his broken lower denture during the pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The Administrator stated he was aware of the broken dentures and he had explained to the resident the facility would not be paying to have his dentures repaired or replaced. The Administrator stated the resident's sister stated she paid for the dentures and she would pay for some more.

The Administrator provided a progress note written by the Director of Social Work which stated the Director of Social Work met with Resident #6 on 3/23/17 regarding his broken lower denture, reminding him his sister stated she would pay for replacement of the lower dentures. The 3/23/17 progress note stated the resident became "loud and irate" and told the Director of Social Work to do as he told her to do, make a dental appointment because he had his own money. The progress note stated the resident refused to talk any further to the Director of Social Work.

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F 411	Continued From page 25 The facility's policy was not provided but the U3M stated when resident is identified as needing dental services their name is given to Social Services and the resident is set-up for an appointment. A determination is made regarding payment for services and arranged accordingly. At the time of the survey team's exit the facility staff had not aided Resident #6 to obtain an appointment or coordinate services to replace the broken lower denture.	F 411		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and	F 431		9/27/17

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F 431	Continued From page 26 that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review the facility staff failed to discard medication prior to the expiration date in 1 of three Medication Storage Rooms (Unit 2). The findings included: On 8/15/17 at approximately 2:30 p.m. the Medication Room on Unit 2, a bottle of Magic	F 431	F431 1. The expired bottle of Magic Mouthwash was discarded on 8/15/17. 2. Storage of medications was reviewed in the medication rooms and medication carts to ensure that medications were stored appropriately and were not expired. 3. Charge nurses were educated on proper storage of expired medications.	

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F 431	Continued From page 27 Mouthwash with an expiration date of 8/13/17 was observed. in the Refrigerator. LPN #3 stated on 8/15/17 at approximately 2:30 p.m., "Yes, it's expired. I will get rid of it." The Mayo Clinic documents: Magic Mouthwash is the term given to a solution used to treat mouth sores (oral mucositis) caused by some forms of chemotherapy and radiation therapy. Oral mucositis can be extremely painful and can result in an inability to eat, speak or swallow. Magic mouthwash provides some relief. The Facility Policy and Procedure revised 10/31/16, titled, "Policy: 4.1 Physician/Prescriber Authorization and Communication of Orders to Pharmacy" did not document information related to disposal of expired medications. The facility administration was informed of the findings during a pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.	F 431	4. A random weekly review of medications located in the medication rooms and medication carts will be completed to ensure that expired medications are stored appropriately. Issues noted during the review will be referred to the QA committee for review and recommendation.	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		9/27/17

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communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 441	Continued From page 29 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review the facility failed to ensure infection control practices were maintained to prevent the potential development and transmission of infection during wound care for three of 25 Residents in the survey sample, Resident #1, #2, and #14. 1. For Resident #1 staff failed to ensure proper handwashing and provide a clean barrier field for supplies during wound care. 2. For Resident #2 staff failed to ensure proper handwashing and provide a clean barrier field for supplies during wound care. 3. For Resident #14 staff failed to ensure proper handwashing, maintain clean barrier field and prevent contamination of supplies during wound care.	F 441	F441 1. Residents #1, #2, and #14 are receiving wound care following infection control practices to prevent the potential development and transmission of infection during wound care. 2. Charge nurses completed a treatment observation to ensure that the treatment was done in a manner that prevents the spread of infection during wound care. 3. Charge nurses were educated on proper infection control practices during wound care. 4. Random weekly treatment observations will be completed to ensure that proper infection control practices are used during wound care. Issues noted during the review will be referred to the QA committee for review and recommendation.	

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The findings included:

1. Resident #1 was admitted to the facility on 10/31/16. Diagnoses for Resident #1 included but are not limited to Healing Stage IV Community Acquired Pressure Ulcer (1).

Resident #1's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 5/29/17, coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 12 out of 15, indicating moderate cognitive impairment.

Resident #1's 7/17/17 Physician order documented the following wound care:
"Sacral Pressure Ulcer: Clean wound with Normal Saline. Apply Santyl Ointment to wound bed then lightly pack wound with 4 x 4 (4 inch by 4 inch) gauze soaked with normal saline. Cover with ABD (abdominal) pad, secure with Allevyn as needed."

Resident #1's revised 8/8/17 Care Plan documented the following:
"Focus: Resident has a pressure ulcer of the sacrum
Interventions: included but not limited to:
Apply ordered medication to area for healing of wound."

A Wound Record dated 8/9/17 documented the following:
Stage IV Pressure Ulcer Stage
Measurements: Length 1 centimeter (cm); Width 1 cm; Depth 0.1 cm

On 8/16/17 at approximately 1:55 p.m. Resident

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#1's wound care was observed. The wound care was performed by the Unit Manager LPN (Licensed Practical Nurse) #4.
LPN #4 was observed sanitizing the top of the wound care cart. The nurse then washed her hands and took paper towels to dry the sanitizer from the table. The LPN then placed paper towels on the overbed table for her barrier. The supplies were moved from the Plastic Drawer and set onto the overbed table. The LPN then washed her hands and donned gloves to remove the soiled dressing. The gloves were taken off, reapplied gloves then the LPN cleansed the wound with normal saline and took her gloves off. Clean gloves were donned and Santyl ointment applied to a normal saline wet gauze and lightly packed into the wound bed. LPN #4 then removed her gloves and retrieved a brief for the Resident. The LPN donned gloves and remove the brief, then took her gloves off and pulled a roll of tape and pen from her pocket. The LPN dated a piece of tape and applied it on top of the Allevyn dressing. The LPN pulled the soiled brief from under then Resident and placed a clean brief under the Resident. The LPN took off her gloves and then put on another pair of gloves and took supplies to the wound cart. Upon re-entering the room, the LPN washed her hands and sanitized the overbed table.

After the completion of wound care, LPN #4 was asked what should be done when removing gloves. The LPN stated, "Wash hands?" The LPN was asked why she sanitized the overbed table and not the Plastic Drawer set that she placed her clean supplies on. The LPN stated that she should not have placed the clean supplies on the plastic drawer as it could spread infection. The LPN was asked why she used

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paper towels and she replied, "to act as a barrier". The LPN was asked if a paper towel was a barrier if it became wet. The LPN shook her head from right to left indicating no.

A Facility Policy and Procedure with an effective date of 4/17/17 and titled, "Handwashing Requirements" documented the following:
The following is a list of some situations that require hand hygiene:
After removing gloves or aprons
After handling soiled equipment or utensils
Before and after changing a dressing

The Germicidal Disposable Wipe had this statement written on the packet: "To Disinfect: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three minutes."

The facility administration was informed of the findings during a pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.

Definitions:

1.) IV Pressure Ulcer: The National Pressure Ulcer Advisory Panel documented: Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or

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eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

2. Resident #2 was admitted to the facility on 6/22/15 with a readmission on 7/12/16. Diagnoses for Resident #2 included but are not limited to Non Alzheimer's Dementia and Traumatic open wound to the Right heel.

Resident #2's Annual Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 6/3/17, coded Resident #2 with a BIMS (Brief Interview for Mental Status) of 2 out of 15, indicating a severe cognitive impairment.

Resident #2's Physician order of 6/13/17 documented: Silvadene Cream 1%; Apply to Right ankle topically two times a day for open area.

The Physician order dated 6/13/17 documented the following: Silvadene Cream 1% Apply to right ankle topically two times a day for open area

The Care Plan Focus revised on 6/20/17 documented the following:
"Focus: Traumatic wound to right outer ankle
Interventions included but are not limited to the following:
Devices: wheelchair cushion
Keep skin clean and dry
Moisture barrier cream as needed for protection of skin
No right foot shoe
Position resident as needed
Weekly skin Assessment"

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On 8/16/17 at approximately 10:15 a.m., LPN #4 (Licensed Practical Nurse) was observed sanitizing the top of the wound cart. The LPN took needed supplies and placed them on top of the wound cart. The LPN took the clean supplies and went into the Resident's room and placed them on a soiled bed-side table.

The Resident was observed to be having Respiratory distress. Vital Signs were obtained (Pulse Oximetry 97%[oxygen saturation in blood], Blood Pressure 100/59; Pulse 67 and regular, Respirators 17 and irregular). Slight periods of approximately 15-25 seconds of no breathing were observed. The Resident was extremely drowsy. Audible wheezing was heard; the LPN stated the Lungs were clear on auscultation. The Doctor was called with an update of Resident's findings as well as the Authorized Representative.

The wound care was delayed until the Resident was feeling better.

On 8/16/17 at approximately 2:15 p.m. wound care was observed. LPN #4 placed the clean supplies on the edge of the overbed table. The LPN then sanitized the overbed table portion that did not have supplies. The nurse was heard to say, "I can't clean the rest of the table unless I hold the supplies and I can't do that." After seeing the LPN standing and looking toward the table for several minutes, the surveyor suggested use of a barrier. The LPN stated we don't have them and just stood looking at her supplies. The nurse was asked if she had a clean plastic bag. The LPN left the room and returned with a clean plastic bag and used it as a barrier.

The Resident could be heard audibly wheezing

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and LPN #4 stated, "I will check to see if he can have another breathing treatment." The LPN was asked if she wanted me to come back. She stated she would ask her Director of Nursing what she should do. The LPN left the room and returned. The LPN stated that as the Resident was currently stable, she would proceed with his wound care.

LPN #4 donned clean gloves and removed the dressing from the Resident's right ankle area. The LPN was not able to hold the Resident's leg/foot up and do the wound care so she went to the door and asked the Staff Development Coordinator to assist. The Staff Development Coordinator came into the room, donned gloves and explained to the Resident what she was going to do.

The LPN then washed her hands and donned gloves. Wound measurements were taken: Length 0.3 centimeters (cm); Width 0.3 cm; Depth 0
The LPN removed her gloves, and then donned clean gloves. The LPN applied Silvadene Cream 1% to a 4 x 4 dressing and applied it to the wound base. Hypofix tape was used to secure the dressing in place.

The LPN removed her gloves and washed her hands. Supplies were returned to the wound cart and the overbed table was sanitized.

After the first attempt of LPN #4 to perform wound care she was asked why she sanitized the top of the wound cart and then placed clean supplies on the nonsanitized over-bed table. She stated, "I've messed up." LPN #4 was asked the importance of placing clean supplies on a

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sanitized table with a barrier. She stated to reduce transmission of infection. When she was asked about handwashing after removing her gloves, the LPN just shook her head back and forth and closed her eyes. The LPN later confirmed she should wash her hands after removing gloves.

A Facility Policy and Procedure with an effective date of 4/17/17 and titled, "Handwashing Requirements" documented the following:
"The following is a list of some situations that require hand hygiene:
After removing gloves or aprons
After handling soiled equipment or utensils
Before and after changing a dressing"

The Germicidal Disposable Wipe had this statement written on the packet, "To Disinfect: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three minutes."

The facility administration was informed of the findings during a pre-exit briefing on 8/17/17 at approximately 3:30 p.m. The facility did not present any further information about the findings.

3. Resident #14 was admitted to the facility on 6/10/17. Diagnoses for Resident #14 included but not limited to, dementia (1), diabetes mellitus (2) and high blood pressure.

The most recent Minimum Data Set with an assessment reference date of 6/20/17, coded Resident #14 with a score of 99 on the Brief Interview for Mental Status (BIMS), indicating the

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resident was unable to complete the interview and had severe impairment in cognitive skills for daily decision-making. Resident #14 was assessed as having pressure ulcers.

On 8/16/17 at 9:30 AM, an observation of wound dressing change performed by LPN (Licensed Practical Nurse) #1, Nurse Manager, was conducted. Resident #14 was on contact precautions at the time for a urinary tract infection. LPN #1 failed to: 1. Properly sanitize the overbed table that was used for wound dressing supplies by not following the proper dwell time (contact time) of the germicidal wipe for 3 minutes; 2. Place barrier on the bedside stand; 3. Wash hands after removing gloves; 4. Have a separate clean and dirty area; 5. Take needed supplies only to the isolation room; 6. Prevent contamination of supplies by placing them in her uniform pockets.

LPN #1 performed the following wound dressing change procedure, as observed:
1. Prepared wound dressing supplies outside the room. Placed a packet of germicidal disposable wipe, a bag of wound measuring sticks (approximately 25 sticks), and a marker in her pocket.
2. Put on isolation gown and gloves before entering the room.
3. Cleaned the overbed table with the germicidal wipe and did not allow it to dry for 3 minutes prior to placing the supplies on the overbed table. The Germicidal Disposable Wipe had this statement written on the packet, "...To Disinfect: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three (3) minutes."
4. Positioned the resident to her right side.

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5. Removed the soiled dressing from the sacrum (3) wound and rolled it into the disposable briefs.
6. Removed gloves. Put on a new pair of gloves without washing her hands.
7. Cleansed the wound with moistened gauze, unfolded the small red bag and placed the soiled gauze in the red bag. Placed the red bag on the overbed table beside the clean supplies. LPN #1 was reminded to have a separate clean and dirty area, so she placed the red bag in the trash can beside the bed.
8. Removed gloves without washing her hands. Put on a new pair of gloves. Reached into her pocket underneath the isolation gown and took one wound measuring stick.
9. Measured the wound and discarded the measuring stick.
10. LPN #1 forgot to bring in packets of 4x4 gauze to dress the wound. She asked another nurse outside the room to get them.
11. Soaked the 4x4 gauze in normal saline solution and Santyl Ointment (4) and placed this on the wound.
9. Removed gloves. Put on a new pair of gloves without washing her hands.
10. Took a marker from her pocket and labeled the 2 sets dressing with date and her initials.
11. Applied the labeled dressings to the wound.
12. Without removing gloves and washing her hands, LPN #1 proceeded to remove the dressing on the second wound on the right heel.
13. Removed gloves. Put on one glove without washing hands. LPN #1 ran out of gloves at this point.
14. Applied the ointment on a 4x4 gauze and applied on the wound using one gloved hand. When she started to apply the gauze bandage roll around the foot and ankle, she needed to use both hands, so she asked a nurse outside the

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room for more gloves.
15. Removed the glove from one hand. Put on a new pair of gloves without washing her hands.
16. Proceeded to apply the gauze bandage.
17. Labeled the tape and applied it on the dressing.
18. Repositioned the resident and lowered the bed.
19. Removed gloves and gown. Washed hands with soap and water.
20. The bag of measuring sticks remained in LPN #1's pocket after leaving the room.

On 8/16/17 at 2:40 PM, LPN #1 was interviewed and was asked when her last wound dressing change training was and she stated that it was during orientation. When asked what how she thought she did during the wound dressing change observation, she stated, "There was a lot of cross contamination and I need to improve on infection control". She stated that she did not place a barrier on the overbed table, did not wash hands in between changing gloves, and I did so many mistakes."

On 8/17/17 at 8:40 AM, an interview with the DON (Director of Nursing) was conducted and discussed the wound dressing change observation. She had expected the nurse to "Take only what you need to the room; don't take everything to the room; wash hands with every glove change; keep away clean from dirty; no supplies in pocket; barrier for supplies; and don't compromise your personal protective equipment".

Resident #14's Physician Order Sheet indicated:
1. Cleanse sacrum wound with Dakins (5) 1/4 strength solution, rinse with sterile water, use gauze moistened with normal saline and

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embedded with Santyl to pack undermining and cover with (brand name) dressing two times a day for wound healing. Start date: 8/16/17.
2. Clean R (right) heel with normal saline pat dry apply Silvadene (6) with gauze and apply foam heel protectors every evening shift for wound healing. Start date: 8/16/17.

Resident #14's Comprehensive Resident Centered Plan of Care stated, in part, "Focus: The resident has pressure-related skin breakdown; Goal: The resident's pressure ulcer will show signs of healing and remain free form infection by/through review date; Interventions: Administer treatments as ordered and monitor for effectiveness..."

On 8/16/17, the facility provided a copy of the requested facility policies and procedures, as follows:

The policy and procedure titled, "Wound Care" with and effective date of 2/1/15, stated, in part, "Procedure: ...4. Remove and reapply dressings as ordered and/or indicated; 5. Licensed nurses will follow recognized standards of practice regarding dressing change (s), including date and initials on dressing; 6. Licensed nurse will follow manufacturer's guideline specific to the products used when providing wound care/dressing change (s)..."

The policy and procedure titled, "Handwashing Requirements" with an effective date of 4/13/17, stated, in part, "Policy: All staff are trained in proper technique upon hire, annually, and PRN (as needed), and are monitored for proper handwashing practices. Employees will wash hands at appropriate times to reduce the risk of

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transmission and acquisition of infections; Procedure: 1. Hand hygiene can consist of handwashing with soap and water or use of an alcohol based hand rub; A. Hand Hygiene: 1. the following is a list of some situations that require hand hygiene: ...j. before and after changing a dressing...r. After removing gloves or aprons...D. Gloves: ...3. Change gloves during patient care if moving from a contaminated body site to a clean body site."

The policy and procedure titled, "Isolation Practice - General Practice" with and effective date of 11/11/16, stated, in part, " Procedure: ...19 e (7). Perform hand hygiene after gloves are removed...29. When changing dressings or administering skin treatments: ...b. Take only those materials required for dressing change or treatment into the room and complete prescribed treatment according to procedures..."

The Administrator, DON and Corporate Nurse Consultant were made aware of these findings on 8/17/17 at approximately 3:20 PM. No further information was provided.

Definition:

(1) Dementia - is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. (Source: NIH U.S. National Library of Medicine : Medline Plus)

(2) Diabetes Mellitus - is a disease in which your blood glucose, or blood sugar, levels are too high. (Source: NIH U.S. National Library of Medicine : Medline Plus)

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F 441	Continued From page 42 (3) Sacrum - The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. (Source: medlineplus.gov > Medical Encyclopedia) (4) Santyl ointment - is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process. (Source: antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts. (5) Dakins solution - is used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. It is also used before and after surgery to prevent surgical wound infections. Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation. (Source: healthcentral.com/skin-care/medications/dakin-misc-62261/uses) (6) Silvadene® - ...Silver sulfadiazine, a sulfa drug, is used to prevent and treat infections of second- and third-degree burns. ... Silver sulfadiazine comes in a cream. (Source: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=silvadene&_ga)	F 441		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5)	F 514		9/27/17

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F 514	Continued From page 43 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to maintain an accurate medical record for 1 of 25 residents in the survey sample, Resident #14.	F 514	F514 1. Resident #14□s order for the Cranberry tablet was revised to indicate the correct route of administration.	

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F 514	Continued From page 44 The facility staff failed to accurately document a physician order of Cranberry capsule for Resident #14. It was ordered to be administered per gastronomy tube (G Tube) (1) but it was transcribed by the nurse to be administered by mouth. The findings included: Resident #14 was admitted to the facility on 6/10/17. Diagnoses for Resident #14 included but not limited to, dementia (2), diabetes mellitus (3) and high blood pressure. The most recent Minimum Data Set with an assessment reference date of 6/20/17, coded Resident #14 with a score of 99 on the Brief Interview for Mental Status (BIMS), indicating the resident was unable to complete the interview and had severe impairment in cognitive skills for daily decision-making. Resident #14 was assessed as having a G Tube in place. On 8/16/17, a review of Resident #14's medication orders revealed that all medications were ordered to be administered per G Tube, except for the Cranberry capsule which was ordered by the physician as follows: "Cranberry Capsule. Give 425 mg. orally (by mouth) one time a day for UTI (urinary tract infection) prophylaxis (prevention); Start date 7/27/17." The Medication Administration Record (MAR) indicated, "Cranberry Capsule. Give 425 orally one time a day for UTI prophylaxis; Start date: 7/27/17." The MAR showed that the Cranberry Capsules were given daily at 9:00 AM by the nurses on 8/1/17 through the survey date of	F 514	2. Residents with a G tube were reviewed to ensure that the route of administration is correct. 3. Charge nurses were educated to ensure that the route of medication administration for residents with a g-tube is correct. 4. A random weekly review of residents with a g-tube will be completed to ensure that the route of medication administration is correct. Issues noted during the review will be presented to the QA committee for review and recommendation.	

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8/16/17.

On 8/17/17 at 8:20 AM, LPN #2 was interviewed and was asked how she was administering the Cranberry capsule and stated that she was giving it per G Tube since the resident was NPO (nothing by mouth). She read the order and it indicated to administer orally; she stated that she would change the order to be administered per G Tube as soon as possible. She stated that a nurse may give it by mouth, as ordered.

On 8/17/17 at 8:45 AM, an interview was conducted with the Director of Nursing (DON). She stated that she expected the nurses to have clarified the order and corrected it. She was asked of possible outcomes if the Cranberry capsule is given orally and she stated. "A nurse may give it orally, as ordered, and may result to "choking, aspiration or pneumonia."

On 8/17/17 at 9:55 AM, LPN #1 was interviewed and she stated, "She (Resident #14) doesn't take any medications by mouth. It should have been verified with the doctor; it might have been a verbal order. I know they won't give it by mouth."

On 8/17/17 at 11:25 AM, the DON shared the information from the investigation in regards to the written order for Cranberry capsule. She stated that the order was dictated to her by the Physician Assistant to be given via G Tube. She then called LPN #1, Nurse Manager, and gave her the order per G Tube. LPN #1, Nurse Manager, entered the information in the electronic medical record as PO (by mouth). The DON stated, "It was a transcription error." She stated that the order was corrected on the same date, 8/17/17 to give the Cranberry capsule per G

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Tube.

The Comprehensive Resident Centered Plan of Care care plan created on 6/10/17 and revised on 8/9/17, documented, in part: "Focus: Resident is NPO secondary to dysphagia (4) and dependent on enteral (5) feedings to meet nutrient needs; Goals: The resident will remain free of side effects or complications related to tube feedings through review date... The resident will be free of aspiration through the review date; Interventions: The resident needs the HOB (head of bed) elevated 30-45 degrees during and 30 minutes after tube feed... Check for tube placement... Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of: Aspiration..."

On 8/17/17, a copy of the facility policy and procedure addressing verbal orders was requested. The Corporate Nurse Consultant provided a copy of the policy titled, "History and Physical" with an effective date of 2/1/15 and it stated, in part, "Policy: a Physician's Admission Medical Care Plan (History and Physical" must be provided at the time of admission, or within 48 hours after admission. The admission medical plan of care is to be prescribed and signed by the attending physician; Procedure: ...5. All verbal orders shall be immediately recorded and signed by the individual receiving them and shall be countersigned by the prescribing physician." The Corporate Nurse Consultant stated that this is the only policy that addressed verbal orders.

The Administrator, DON and the Corporate Nurse Consultant were made aware of these findings on 8/10/17 at approximately 3:20 PM. No further information was provided.

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Definition:

(1) Gastrostomy Tube (G Tube) - A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach.
(Source: https://medlineplus.gov/ency/article/002937.htm)

(2) Dementia - is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior.
(Source: NIH U.S. National Library of Medicine : Medline Plus)

(3) Diabetes Mellitus - is a disease in which your blood glucose, or blood sugar, levels are too high.
(Source: NIH U.S. National Library of Medicine : Medline Plus)

(4) Dysphagia - People with dysphagia have difficulty swallowing and may even experience pain while swallowing (odynophagia). Some people may be completely unable to swallow or may have trouble safely swallowing liquids, foods, or saliva.
(Source: https://www.nidcd.nih.gov/health/dysphagia#1)

(5) Enteral - of, relating to, or affecting the intestines
(Source: http://c.merriam-webster.com/medlineplus/enteric)