STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET PO BOX 1087 DUBLIN, VA 24084

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/23/18 through 10/25/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 132 certified bed facility was 124 at the time of the survey. The survey sample consisted of 27 current Resident reviews and 4 closed record reviews . An unannounced Medicare/Medicaid standard survey was conducted 10/23/18 through 10/25/18. Three complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 132 certified bed facility was 124 at the time of the survey. The survey sample consisted of 27 current Resident reviews and 4 closed record reviews.	E 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		12/9/18

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

Electronically Signed | 11/23/2018

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, clinical record review and facility document review it was determined the facility staff failed to facilitate voting rights for residents and failed to provide a dignified dining experience for 2 of 31 residents (Residents #82 and #6). Findings:	F 550	Resident #61, #60, #41, #47 and #110 Resident # 82 and #6 Correction: Resident #60, #41 and #47 voted in the 2018 election. Resident #61 received an absentee ballot;	

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F 550	Continued From page 2 The facility staff failed to facilitate voting rights for residents who wanted an absentee ballot. On 10/24/18 at 2:00 PM the Resident Council Group convened for an interview with the surveyors. Nine alert and oriented residents attended the meeting. During this session the residents were asked how the facility made arrangements for them to vote. The residents all said they had not voted since the presidential election in 2016. During that election cycle the residents said the facility provided absentee ballots, but had not received one since. Of the nine residents present, five indicated they would like to vote in the upcoming election on November the 6th, 2018. These residents shall be identified Resident #61, #60, #41, #47 and #110 as per the sample list provided to the facility. Resident #41 indicated he had requested an absentee ballot from an unnamed staff member at the front desk, but had not yet received it. Residents #61, 60, 47, 110 said no one had advised them the facility could or would obtain absentee ballots for them to vote in the upcoming election. On 10/24/18 at 4:00 PM the surveyor informed the administrator, DON and ADON of the resident's concerns. The administrator said the facility social services department was responsible to provide the residents with an absentee ballot if they indicated they wanted to vote and added they had just received the absentee ballots but had yet to distribute them. The administrator said the staff were supposed to	F 550	however, she did not return the completed ballot until 11/07/18, one day after the election. Resident #61 is alert and oriented and declined assistance with completion of the absentee ballot. Resident #110 was not registered to vote for the 2018 election. All current residents were asked if they were registered to vote and if they would like to vote in the 2018 election. Absentee ballot request were delivered to the appropriate county Voter Registration Office. Once the absentee ballots were received and completed by the resident, the absentee ballots were returned by mail. CNAs currently working were inserviced that regardless of assignment, every facility employee is responsible for the care and wellbeing of each resident. Sign stating, TV is turned off when residents are fed was removed. Nursing staff currently working were inserviced that dayrooms will not be used for resident dining unless requested by the resident. Potential Residents: All residents have the potential to be affected	

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F 550	Continued From page 3 determine who wanted to vote by requesting that information from each resident prior to the election. The surveyor requested to see the current list of absentee ballots obtained for 2018 and a list of ballots obtained for residents in the year 2017. The surveyor additionally requested to see the list of resident names reviewed for their voting preference for the 2017 and 2018. On 10/25/18 at 8:20 AM the administrator provided a list of absentee ballots obtained for the residents for 11/06/2018. Resident #41's absentee ballot was observed. The listing of resident reviewed for the the receipt of a 2018 absentee ballot was reviewed. Residents #61, 60, 47, and 110 were not on this list. The administrator said he had spoken to SW I (the assistant social worker) and the entire resident population had not been offered the option of an absentee ballot for 2018, but the ballots could be obtained if they were ordered by 10/30/18. He said SW I was working on swiftly completing a list of current residents wishing to vote so the ballots could be obtained in time for the election. The administrator said there was no documentation the residents had been offered absentee ballots in 2017. On 10/25/18 at 8:40 AM SW I was interviewed. She said prior to the surveyor's request for information, she was not aware of a system in place to canvas the entire population and apply for absentee ballots to facilitate the voting process for the residents. She said the previous social worker in charge had not obtained ballots the previous year and they had failed to offer the	F 550	Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Resident Voting. Social Service staff will be inserviced on the policy and procedure for Resident Voting. At least 60 days prior to an election, a social worker or designee will interview each resident to determine if they are registered to vote, would like to register and if they desire an absentee ballot. Assistance will be provided to ensure each resident exercises their right to vote if desired. The QAA Committee will review and revise as necessary the policy and procedure for Mealtime Procedures. Facility staff will be inserviced on the policy and procedure for Mealtime Procedures. Dayrooms will not be used for resident dining unless requested by the resident. Resident□s choice to dine in a dayroom will be documented in the care plan. Monitoring: The QA Coordinator or designee will review each facility dayroom and conduct a QA audit weekly for 12 weeks using the	

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F 550	Continued From page 4 option to get ballots for all current residents for 2018. The administrator was present at this meeting and said there would be a system in place for the future. No additional information was received prior to the survey team exit. 2. The facility staff failed to provide a dignified dining experience for Resident #82. The resident's clinical record was reviewed on 10/24/18 at 0900. Resident #82 was admitted on 4/19/18. Her diagnoses included Alzheimer's disease. The resident's latest MDS (minimum data set) assessment, dated 9/27/18 coded the resident with severe cognitive impairment. She required the assistance of one staff member to eat. The resident's CCP (comprehensive care plan) reviewed and revised on 4/27/18, indicated the resident was at risk for nutritional imbalance due to inadequate oral intake and cognitive and communication impairments. On 5/22/18 the physician ordered a pureed diet. She was documented with a significant weight loss on 9/7/18. The CCP interventions for these issues included all meals fed by staff and monitoring intake and weights. The staff were to provide her diet as ordered and Resource as ordered. On 10/24/18 at 12:48 PM the surveyor observed Resident #82 being assisted to eat in the small dining room on her unit. She and one other resident were seated at the wall underneath a	F 550	Mealtime Procedure audit tool to identify any resident not receiving needed assistance during meals and any resident dining in a dayroom that has not requested to do so. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the policy and procedure for Mealtime Procedures will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. The QA Coordinator or designee will randomly select 25% of current residents and conduct a QA audit annually for 3 years using the Resident Voting audit tool to identify any resident that was not offered the opportunity to register and submit an absentee ballot. The DON and administrator will receive reports of annual audit. Any staff identified as not following the policy and procedure for Resident Voting will be re-educated and/or counseled as necessary. After the 3-year period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA	

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F 550	Continued From page 5 large screen television mounted on the wall. Each resident was being fed by two separate staff members. At this time seven residents are seated in wheel chairs facing the two residents that are being fed at the wall. Resident #82's CNA (CNA I) says the seven residents have already been to the large dining room and eaten. "They are just waiting for these two to finish up because they cannot watch TV before everyone finishes eating." The sign on the wall below the TV is observed to read, "TV is turned off when residents are fed." All the residents are watching the two residents eat and have nothing else to do but stare at them from their seats until the two staff members finish feeding the two residents unable to feed themselves. By 1:10 PM, two residents were heard to ask them to turn on the TV and a staff nurse (LPN I) stated, "NO, we can't turn the TV back on until they're finished eating." By 1:15 PM nine residents were in the dining room staring at the two residents eating and waiting for the television to be turned back on. Some talk was heard between residents not happy with having to wait for "those people" to finish eating. Their discontent was audible to two surveyors and anyone else in the room, including the residents being fed. The surveyor asked LPN I why nine residents are seated and having to wait to watch TV while two residents are fed in a common area and she stated "I've always been told it has to be off when people are eating". LPN I additionally informed the surveyor the state regulations said the TV	F 550	Committee, DON and Administer.	

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F 550	Continued From page 6	F 550		

can't be on while residents are eating in the room.

On 10/24/18 at 4:15 PM, this observation was discussed with the administrator, the DON, ADON and CCN (corporate compliance nurse). The surveyor asked the staff present if any reasonable person would want to be put in the position of being helpless, dependent and fed by a staff member, while other residents sat nearby watching and complaining about having to wait for them to finish eating so they could watch TV.

There was no additional evidence provided prior to the survey team exit.
3. The facility staff failed to provide a dignified dining experience for Resident # 6.

Resident # 6 was an 86-year-old-male who was originally admitted to the facility on 11/1/15 with a readmission date of 4/18/18.
Diagnoses included but were not limited to: anxiety disorder, dementia, type 2 diabetes mellitus, and hyperlipidemia.

The clinical record for Resident # 6 was reviewed on 10/23/18 at 2:47 pm. The most recent MDS assessment (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/18/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 6 had a BIMS score (brief interview for mental status) of 1 out of 15, which indicated that Resident # 6's cognitive status was severely impaired. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident # 6 required extensive assistance with one person providing physical assistance for eating.

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F 550	Continued From page 7	F 550		

The plan of care for Resident # 6 was reviewed and revised on 10/18/18. The facility staff documented a focus area for Resident # 6 as, "Resident # 6 has potential for dehydration or potential fluid deficit r/t (related to) poor intake, refuses meals and medications, disease process, and has history of sepsis and failure to thrive." Interventions included but were not limited to, "Encourage resident to eat at meals and assist with feeding as needed."

Resident # 6 had current orders that were initiated by the physician on 4/18/18 for "LCS (low concentrated sweets) NAS (no added salt) diet."

On 10/24/18 at 12:37 pm, two surveyors observed Resident # 6 sitting in the lounge on C wing. The surveyors observed two Residents being fed by staff and one Resident was observed feeding herself. The surveyor spoke with Resident # 6 and asked if he had eaten lunch. Resident # 6 stated "No."

On 10/24/18 at 12:42 pm, a facility employee entered the lounge on C wing. Resident # 6 asked the facility employee, "Are you going to feed me?" The facility employee stated, "No I'm not over here today."

On 10/24/18 at 12:52 pm, Resident # 6 yelled out "Can you feed me?" Two surveyors observed that no one addressed Resident # 6's request for feeding assistance.

On 10/24/18 at 12:57 pm, CNA # 1 (certified nursing assistant) stated to the surveyor that the two Residents that were being fed by staff were almost done eating and that she would feed

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F 550	Continued From page 8 Resident # 6 next. On 10/24/18 at 1:00 pm, Resident # 6 yelled out "Hey, Hey, Hey, can you feed me." CNA # 1 stated. "Yeah I will get you." On 10/24/18 at 1:02 pm, CNA # 1 brought Resident # 6's lunch tray into the highland lounge and fed Resident # 6 lunch. On 10/24/18 at 5:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 10/25/18.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interview, and clinical record review it was determined the facility staff failed to ensure 3 of 31 residents received care and treatment in accordance with professional standards of practice (Residents #2, 68, & 112). Resident #2 - staff failed to follow physician's	F 684	Resident #2, #68 and #112 Correction: Resident #2□s medical record was reviewed and physician ordered Ted hose were applied.	12/9/18

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F 684	Continued From page 9 orders for TED hose. Resident #68 - staff failed to follow physician's orders for oxygen administration. Resident #112 - staff failed to follow physician's orders for Aspercreme administration. Findings: 1. Facility staff failed to follow physician's orders to apply TED hose for Resident #2. The resident's clinical record was reviewed on 10/24/18. Resident #2 was admitted on 6/4/14. Her diagnoses included Alzheimer's, seizure disorder, malnutrition and edema, unspecified. The resident's latest MDS (minimum data set) assessment, dated 7/19/18, coded the resident with significant cognitive impairment. The resident was totally dependent on staff members for all the ADLs (activities of daily living). Resident #2's CCP (comprehensive care plan) reviewed and revised on 10/24/18 documented the resident with hypertension and at risk for complications and edema. The interventions to staff included "TED hose on q am (every morning) - off q hs (every night) for edema. The physician's orders, signed and dated 7/27/18, included the order for TED hose to be applied every morning and removed each night. The TED hose were ordered for edema in the resident's lower extremities. The resident's TAR was reviewed for 10/23-24/18. The nurses on the day and evening shifts documented the TED hose were on as ordered.	F 684	Resident #2□s Charge Nurse was inserviced on the importance of accurate and complete documentation of Ted hose use. CNAs currently working were inserviced to apply Ted hose as ordered by the physician. If the resident refuses, the charge nurse must be notified. Resident #68□s medical record was reviewed and oxygen setting was returned to 2 liters per minute as ordered by the physician. The charge nurse for Resident #112, LPN #1, was inserviced on reading/interpreting physician orders and documentation of medication administration. Potential Residents: Each current resident with a physician□s order for Ted hose will be observed for use. Any resident identified as not wearing Ted hose as ordered will be reviewed for documentation and staff identified as not applying Teds as ordered will be educated and/or counseled. Each current resident with a physician□s order for oxygen will be reviewed and observed for proper oxygen delivery rate according to the physician□s order. Any resident identified receiving inaccurate oxygen administration will be immediately reviewed, oxygen re-set as ordered and nurse will be educated and/or counseled.	

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F 684	Continued From page 10 On 10/23/18 at 1:00 PM and 4:00 PM the resident was observed and she did not have on TED hose. On 10/24/18 at 11:28 AM the resident was observed in the dining room with FM I (a family member). FM I checked for the resident TED hose and said they were not in place. FM I told the surveyor that the staff consistently left the TED hose off this resident, despite her repeated requests as to why Resident #2 was not wearing them. The family member said the staff always said they didn't know if she was supposed to have them on and then said they would check the doctor's orders--but nothing ever changed. On 10/24/18 at 4:30 PM these observations were brought to the attention of the administrator, the DON, ADON and CN (corporate nurse). They were also informed the nursing staff had documented the TED hose were on --even when they were not. No additional information was provided prior to the survey team exit. 2. Facility staff failed to follow physician's orders to administer oxygen for Resident #68. The resident's clinical record was reviewed on 10/24/18. Resident #68 was admitted on 1/12/18. Her diagnoses included hypertension, diabetes, Alzheimer's disease, and COPD (chronic obstructive pulmonary disease). The latest MDS assessment, dated 9/20/18, coded the resident with slight cognitive impairment. She required the assistance of	F 684	Any residents with an order for a topical analgesic has the potential to be affected related to the correct administration of the medication. Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Ted Hose Usage, Care and Documentation. Nursing staff will be inserviced on the policy and procedure for Ted Hose Usage, Care and Documentation. An individual resident equipment list will be placed inside each resident□s closet and will indicate if the resident has a physician□s order for Ted Hose. CNAs will immediately report missing or soiled Ted hose to the resident□s Charge Nurse for appropriate action. The resident□s order for Ted Hose will be placed on the CNA Kardex. The QAA Committee will review and revise as necessary the policy and procedure for Oxygen Therapy. Nursing staff will be inserviced on the policy and procedure for Oxygen Therapy. Each nurse will demonstrate competency in setting and reading oxygen concentrator settings. Nurses will be inserviced to check oxygen	

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F 684	Continued From page 11 nursing staff for all the ADLs with the exception of eating (set-up only). Resident #68's CCP, reviewed and revised on 1/31/18, documented the resident was at risk for altered respiratory status from congestive heart failure, hypertension and COPD (chronic obstructive pulmonary disease). The interventions included "O2 via nc (nasal cannula) ....SOB (shortness of breath) as ordered by MD (doctor)." Resident #68's physician orders, electronically reviewed and approved on 10/11/18, included an order for oxygen at 2 liters per minute via nasal cannula every shift. The e-mar (electronic medication administration record) for October 2018 was reviewed. It was documented for oxygen at 2 liters per minute as per the doctor's order. Nurses signed off on the appropriate administration per physician's order 3 x a day for all three shifts. On 10/23/18 at 11:45 AM the resident's oxygen was observed to be administered at 3 1/2 liters per minute. On 10/24/18 at 11:45 AM and 3:15 PM the oxygen was observed to be administered at 3 1/2 liters per minute. On 10/24/18 at 9:45 AM the oxygen was observed to be administered at 3/1/2 liters per minute. These observations were provided to the administrator, DON, ADON and CN (corporate nurse on 10/24/18 at 4:35 PM. They were also informed the nurses had been charting the oxygen at the appropriate rate for two days when it was set at 3 1/2 liters per minute. No additional information was provided prior to	F 684	settings at eye level only to ensure proper setting. This will be documented on the TAR as a reminder. The QAA Committee will review and revise as necessary the policy and procedure for Medication Administration. Nurses will be inserviced on the policy and procedure for Medication Administration. Monitoring: The QA Coordinator or designee will select 50% of current residents with a physician□s order for Ted Hose and conduct a QA audit weekly for 12 weeks using the Ted Hose audit tool to identify any resident not wearing Ted Hose as ordered. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the physician□s order for Ted Hose use will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. The QA Coordinator or designee will select 25% of current residents with a physician□s order for oxygen administration and conduct a QA audit weekly for 12 weeks using the Oxygen Administration audit tool to identify any resident not receiving oxygen as ordered. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the physician□s	

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F 684	Continued From page 12 the survey team exit. 3. The facility staff failed to administer Aspercreme per physician's orders for Resident # 112. Resident # 112 was a 60-year-old-male who was admitted to the facility on 9/29/18. Diagnoses included but were not limited to: anxiety disorder, hypertension, heart failure, and gout. The clinical record for Resident # 112 was reviewed on 10/24/18 at 9:15 am. The most recent MDS assessment (minimum data set) was a 14-day scheduled assessment with an ARD (assessment reference date) of 10/12/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 112 had a BIMS score (brief interview for mental status) of 13 out of 15 which indicated that Resident # 112 was cognitively intact. The current plan of care for Resident # 112 was reviewed and revised on 10/17/18. The facility staff documented a focus area for Resident # 112 as, "Resident #112 is at risk for injuries from falls d/t (due to) limited mobility r/t (related to) stroke, general weakness, has CHF (congestive heart failure) anxiety, DDD (degenerative disc disease), gout, blindness in right eye and takes medications that increase risk for falls." Interventions included but were not limited to, "Give medications as ordered (see MAR) (medication administration record) and evaluate for effectiveness." Resident # 112 had current orders that were signed by the physician on 10/11/18. Orders included but were not limited to, "Aspercreme w (with)/Lidocaine 4% Apply to knees bilaterally	F 684	order for oxygen administration will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. The QA Coordinator or designee will select 25% of current residents with a physician□s order for routine topical analgesic medication administration and conduct a QA audit weekly for 12 weeks using the Topical Medication Administration audit tool to identify any resident not receiving topical analgesic medications as ordered. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the physician□s order for topical analgesic medication use will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer.	

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F 684	Continued From page 13 topically three times a day for gen OA (osteoarthritis)/pain. On 10/24/18 at 8:41 am, the surveyor conducted a medication pass observation. The surveyor observed LPN # 1 (licensed practical nurse) administer Apercreme with Lidocaine 4% to Resident # 112's right knee. Resident # 112 stated, "They usually put it on both knees." LPN # 1 stated to Resident # 112, "Well mine says one knee so we will put it on one knee for now." On 10/24/18 at 9:15 am, the surveyor reviewed Resident # 112's MAR for October 2018. The surveyor observed that LPN # 1 had documented that Aspercreme with Lidocaine 4 % had been applied to "knees bilaterally" for the 9:00 am dose on 10/24/18 when in fact the Aspercreme with Lidocaine 4% had only been applied to Resident # 112's right knee. On 10/24/18 at 5:00 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 10/25/18.	F 684		
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	F 686		12/9/18

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F 686	Continued From page 14 (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 document review, clinical record review and in the course of a complaint investigation the facility staff failed to assess, monitor and provide treatment for the prevention of pressure ulcers for 3 of 31 Residents, #21, #91 and #30. 1. Facility staff failed to provide physician ordered heel protection for Resident #21. The resident's record was reviewed on 10/24/18. Resident #21 was admitted on 4/17/17. Her diagnoses included hypertension, Alzheimer's disease, anorexia and adult failure to thrive. Resident #21's MDS (minimum data set) dated 8/9/18 coded the resident with moderately impaired cognitive ability. The resident was totally dependent on staff assistance for the ADLs (activities of daily living). Resident #21's CCP (comprehensive care plan) reviewed and revised 3/15/18, included the issue of potential/actual skin integrity impairment. The interventions to staff included "float heels" and "Per MD order on 6/13/18: Heel protectors to be worn at all times for heel protection (see TAR)." The resident's physician orders signed and dated electronically on 9/27/18, included an order for heel protectors to be worn at all times. On 10/25/18 at 8:00 AM the resident's TAR	F 686	Resident #21, #91 and #30 Correction: Resident #21 and #30□s heel protectors were applied as ordered. Resident #91□s treatment was performed and dressing applied as ordered. Potential Residents: Each current resident with a physician□s order and/or care planned for the use of a protective skin device will be observed for use. Any resident identified without their protective skin device in place will be reviewed for documentation and staff identified as not applying the protective skin device(s) will be educated and/or counseled. No additional residents were identified without a treatment dressing in place as ordered. Systematic Changes: Each resident will have an Adaptive Equipment list placed inside their closest which will include any required protective skin equipment.	

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F 686	Continued From page 15 (treatment administration record) for 10/1/18 through 10/24/18 was observed to be documented every day by nursing staff on all three shifts that the heel protection was provided. On 10/23/16 during the initial tour of the facility at 12:00 noon and at 3:30 PM the resident was observed to be in a geri-chair without heel protection. On 10/24/18 at 11:30 AM the resident was again observed up in a geri-chair without heel protection. On 10/24/18 at 4:30 PM the administrator, DON, ADON and CN (corporate nurse) were informed the of the aforementioned observations. They were also informed the nurse were signing off on the TAR that the resident was wearing them on those dates. No additional information was provided prior to the survey team exit. 2. The facility staff failed to ensure that dressing was in place to Resident # 91's right and left buttocks as ordered by the physician. Resident # 91 was an 82-year-old-male who was admitted to the facility on 11/12/09, with a readmission date of 9/27/16. Diagnoses included but were not limited to: hypertension, benign prostatic hyperplasia, anemia, and anxiety disorder. The clinical record for Resident # 91 was reviewed on 10/23/18 at 1:40 pm. The most recent MDS assessment (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/4/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that	F 686	Protective skin devices will be included in the resident□s individual Kardex. Resident□s protective skin device usage will be documented on the resident□s task/ADL Record. Any resident dressing that is ordered to remain in place greater than 1 day, will be visually checked every shift and documented on the TAR. CNAs will be inserviced to notify the Charge Nurse when a resident dressing is not in place. Monitoring: The QA Coordinator or designee will select 25% of current residents care planned for the use of protective skin equipment and conduct a QA audit weekly for 12 weeks using the Protective Skin Equipment Observation audit tool to identify any resident who may not have protective skin equipment in place as indicated. The DON and administrator will receive reports of weekly audit. Any staff identified as not ensuring the resident□s protective skin device(s) are in place as indicated will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. The Treatment Nurse or designee will select 10% of current residents with a physician□s order for a treatment	

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F 686	Continued From page 16 Resident # 91's cognitive status was moderately impaired. Section M of the MDS assesses skin conditions. In Section M1200, the facility staff documented that Resident # 91 had nonsurgical dressings applied during the lookback period for the 10/4/18 ARD. The current plan of care for Resident # 91 was reviewed and revised on 10/23/18. The facility staff documented a focus area for Resident # 91 as, "The resident has potential for impairment to skin integrity r/t (related to) limited mobility, incontinence of bowel, has HTN (hypertension), depression history and Alzheimer's dementia with impaired cognition-is incontinent of bowel-is dependent on staff for mobility and toileting." Interventions included but were not limited to, "10/23/18-Treatment change to bilateral buttocks as ordered." The physician signed current orders for Resident # 91 on 10/11/18. Orders included but were not limited to, "Cleanse areas of blancehable excoriation to residents right and left buttocks with NS (normal saline), pat dry and cover with replicare Q (every) 3days and Prn (as needed)." On 10/25/18 at 10:28 am, the surveyor was in Resident # 91's room along with the wound nurse RN # 1 (registered nurse) and CNA # 2 (certified nursing assistant). Resident # 91 was turned onto his left side by CNA # 2. Upon being turned onto his left side, the surveyor observed excoriated areas to Resident # 91's right and left buttocks that were uncovered. On 10/25/18 at 10:30 am, the surveyor spoke with the wound nurse RN # 1 about Resident # 91's right and left buttocks being uncovered. The	F 686	dressing and conduct a QA audit weekly for 12 weeks using the Treatment Dressing Observation audit tool to identify any resident who may not have the physician ordered treatment dressing in place as indicated. The DON and administrator will receive reports of weekly audit. Any staff identified as not ensuring the resident□s treatment dressing is in place as indicated will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer.	

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F 686	Continued From page 17	F 686		

wound nurse RN # 1 stated that Resident # 91's wound should have been covered. The surveyor asked the wound nurse if CNA staff was allowed to remove dressings. The wound nurse RN # 1 stated that the CNAs are not supposed to remove the dressings and if the dressings become dislodged during ADL (activities of daily living) care, the CNA was to immediately notify the nurse to make her aware to replace the dressing.

On 10/25/18 at 10:35 am, the surveyor interviewed CNA # 2. The surveyor asked CNA # 2 if she had given Resident # 91 a bath on the morning of 10/25/18. CNA # 2 stated that she bathed Resident # 91 around 8:30 am on the morning of 10/25/18. The surveyor asked CNA # 2 if there was a dressing in place when she bathed Resident # 91 on the morning of 10/25/18. CNA # 2 replied "No." CNA # 2 stated to the surveyor that she did not inform the nurse that Resident # 91's wound was uncovered because she had spoken to the wound nurse RN # 1 earlier that morning and she made her aware that she needed assistance with turning while doing the dressing change for Resident # 91 and she figured the wound would be covered during the dressing change.

On 10/25/18 at 11:50 am, the surveyor spoke with the director of nursing and made her aware of the findings as stated above. When the surveyor informed the director of nursing that CNA # 2 stated that the wound nurse RN # 1 had spoken to her about assisting with turning during the dressing change and this was the reason that she did not report that the dressing was not in place, the director of nursing stated, "That's no excuse, she still should have reported it to the nurse."

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F 686	Continued From page 18	F 686		

The facility policy on "Wound/Pressure Ulcer Treatment" contained documentation that included but was not limited to,
..."Purpose
To prevent further deterioration of skin and ulcer development as appropriate for each individual resident. The objectives will be to cover and protect the area

Procedure
10. Apply treatment and dressing-follow proper technique for dressing change." ...

On 10/25/18 at 5:00 pm, the administrative team was made aware of the findings as stated above.

No further information was provided to the survey team regarding this issue prior to the exit conference on 10/25/18.

3. The facility failed to ensure heel protectors were in place at all times for protection for Resident #30.

Resident # 30 is a 77-year-old-female who was originally admitted to the facility on 03/02/18 with a readmission date of 09/26/18. Diagnoses included but were not limited to: cerebral infarction, dysphagia, hemiplegia, and depression.

The clinical record for Resident # 30 was reviewed on 10/24/18. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/16/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #30 had a BIMS (brief interview for mental status)

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F 686	Continued From page 19 score of 09 out of 15. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident # 30 requires extensive assistance of two or more persons for bed mobility. Resident #30's CCP (comprehensive care plan) was reviewed on 10/24/18. The CCP contained a focus area for "Resident has potential for impairment skin integrity related to limited mobility ...Resident readmitted with stage three pressure ulcer to left heel ...," has interventions that included but were not limited to "Heel protectors at all times." The physician signed the current orders for Resident # 30 on 10/11/18. The physician's orders included but were not limited to: "Heel protectors at all times, every shift for protection." On 10/25/18 at 12:16 pm, the surveyor observed Resident #30 lying in bed on her back. Resident #30 was agitated at this time yelling for assistance. The surveyor observed no heel protectors on Resident #30's heels. The heel protectors could not be visibly located in the Resident's room at the time of this observation. On 10/25/18 at 4:38 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 10/25/18.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		12/9/18

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F 690	Continued From page 20 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide services to prevent urinary tract infections for 1 of 31 Residents in the survey sample, Resident #	F 690	Resident #91 Correction:	

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F 690	Continued From page 21 91. The findings included: The facility staff failed to ensure that the Foley catheter for Resident # 91 was secured. Resident # 91 was an 82-year-old-male who was admitted to the facility on 11/12/09, with a readmission date of 9/27/16. Diagnoses included but were not limited to: hypertension, benign prostatic hyperplasia, anemia, and anxiety disorder. The clinical record for Resident # 91 was reviewed on 10/23/18 at 1:40 pm. The most recent MDS assessment (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/4/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 91's cognitive status was moderately impaired. Section H of the MDS assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 91 had an indwelling catheter during the lookback period for the 10/4/18 ARD. The current plan of care for Resident # 91 was reviewed and revised on 10/23/18. The facility staff documented a focus area for Resident # 91 as, "The resident has indwelling catheter d/t (due to) urinary retention, BPH (benign prostatic hyperplasia) and urethral outlet obstruction and is at risk for complications and urinary tract infections. Interventions included but were not limited to, "Check tubing for kinks each shift." The physician signed current orders for Resident	F 690	Resident #91□s catheter was anchored to the thigh using a catheter strap. Potential Residents: All current residents with a physician□s order for a urinary catheter will be observed for the presence of a catheter strap. Any resident identified without a catheter strap in place will be reviewed and a catheter strap will be placed as indicated. Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Urinary Catheters. Nursing staff will be inserviced will on the policy and procedure for Urinary Catheters. Resident use of a urinary catheter strap will be documented by the CNA each shift on the Task/ADL Record of Care. Nurse will check the placement of catheter straps each shift and signify this on the resident□s TAR. Monitoring: The QA Coordinator or designee will select 50% of current residents with a physician□s order for a urinary catheter and conduct a QA audit weekly for 12 weeks using the Urinary Catheter Strap	

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F 690	Continued From page 22 # 91 on 10/11/18. Orders included but were not limited to, "Foley catheter: 18F (French) Coude catheter Balloon size 10 ml (milliliter) for urinary outlet obstruction due to BPH every shift for cath care." On 10/25/18 at 10:21 am, the surveyor was in Resident # 91's room along with wound nurse RN (registered nurse) # 1 and CNA # 2 (certified nursing assistant) to observe Resident # 91's Foley catheter. Wound nurse RN # 1 showed the surveyor Resident # 91's Foley catheter. The surveyor observed that Resident # 91's catheter was unanchored and positioned over Resident # 91's right thigh. The surveyor spoke with the wound nurse RN # 1 and asked if Resident # 91's Foley catheter should be anchored. The wound nurse RN # 1 stated, "Yes." On 10/25/18 at 5:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 10/25/18.	F 690	Observation audit tool to identify any resident who may not have a catheter strap in place as directed. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the policy and procedure for urinary catheter strap usage will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed	F 697	Resident #112	12/9/18

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F 697	Continued From page 23 to utilize non-pharmacological interventions prior to the use of pain medication for 1 of 31 residents (Resident #112). The findings included: The facility staff failed to use non-pharmacological interventions prior to the use of pain medications for Resident #112. The clinical record of Resident #112 was reviewed 10/23/18 through 10/25/18. Resident #112 was admitted to the facility 9/29/18 with diagnoses, that included but not limited, to cerebral infarction, depressive episodes, anxiety disorder, hypertension, gastroesophageal reflux disease (GERD), muscle weakness, difficulty in walking, chronic obstructive pulmonary disease, heart failure, gout and atrial fibrillation. Resident #112's 14-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/12/18 assessed the resident with a BIMS (brief interview for mental status) of 13 out of 15. Section J Health Conditions was reviewed for the pain assessment. Resident #112 was assessed to have pain occasionally and current pain assessment was 4 out of 10. Resident #112's current comprehensive care plan had a focus area that the resident had potential for acute/chronic pain r/t (related to) GERD, DDD (degenerative disc disease), gout, disease process flank pain/abdominal pressure/urinary frequency, he states that he had pain occasionally, he states that his pain medication is effective and that his current pain management is good Date initiated: 10/9/2018 Revision on: 10/17/2018. Interventions: Observe/record/report to nurse resident	F 697	Correction: Resident #112 was discharged home on 10/24/18. Potential Residents: The medical records of all current residents who received a PRN narcotic analgesic will be reviewed for documentation of a non-pharmacological intervention prior to administration. Any nurse identified as not offering a non-pharmacological intervention prior to administration of the narcotic analgesic will be inserviced and or counseled as indicated. Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Pain Management. Nurses will be inserviced on the policy and procedure for Pain Management. Nurse will offer non-pharmacological interventions for pain relief prior to administering a PRN pain medication. Nurse will document the intervention(s) offered, the resident□s response and effectiveness. Nurses will be inserviced on types of available non-pharm pain relief interventions.	

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F 697	Continued From page 24 complaints of pain or requests for pain treatment. Encourage Resident #112 to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, music, etc. Resident #112's September 2018 and October 2018 physician's orders were reviewed and included an order for Ultram 50 mg (milligrams) by mouth every 8 hours as needed for pain. The surveyor reviewed the October 2018 electronic medication records (eMARs). Resident #112 received Ultram 50 mg twenty-eight times (28) with the pain level from 0-8. On 10/11/18, Resident #112 received Ultram 50 mg when the pain level was 0 (zero). The surveyor requested the October 2018 progress notes. The was no evidence the resident was encouraged or offered non-pharmacological interventions prior to the administration of any of the pain medication Ultram. The surveyor informed the administrative staff of the above issue on 10/25/18 at 4:25 p.m. and requested the facility policy on pain management. The surveyor reviewed the facility policy titled "Pain Management." "9. Various strategies and modalities may be utilized to assist the resident in achieving optimal comfort. Such strategies and modalities may include, but are not limited to: a) Non-pharmacological interventions may be appropriate alone or in conjunction with medications." No further information was provided prior to the exit conference on 10/25/18.	F 697	Monitoring: The QA Coordinator or designee will select 25% of current residents who received a PRN analgesic and conduct a QA audit weekly for 12 weeks using the PRN Analgesic audit tool to identify any resident who may have received a PRN narcotic medication prior to a non-pharmacological intervention. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the policy and procedure for Pain Management will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer.	

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review the facility failed to ensure medications were available for administration for 2 of 31 Resident, #268 and	F 755	Resident #268 and #86 Correction:	12/9/18

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F 755	Continued From page 26 #86. The findings included : 1. For Resident #268 the facility staff failed to ensure the medication Levaquin was available for administration. Resident #268 was admitted to the facility on 05/17/18. Diagnoses included but not limited to urinary tract infection, bronchopneumonia, anemia, thrombocytopenia, depression hypertension, hypotension, gastroesophageal reflux disease, dermatitis, adult failure to thrive, anxiety and hyperkalemia. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 05/24/18 coded the Resident as 10 out of 15 in Section C, cognitive patterns. This is an admission MDS. Resident #268's CCP (comprehensive care plan) was reviewed and contained a care plan for "...has right lung pneumonia". Interventions for this care plan included "Per MD orders on 5/25/18 Levaquin 500 mg po (by mouth) qd (every day) x 7 days". Resident #268's clinical record was reviewed on . It contained a physician's order summary for the month of May which read in part "Levaquin Tablet 500 mg (levofloxacin) Give 1 tablet by mouth one time a day for RL (right lower) lung pneumonia for 7 days". This order was dated 05/25/18. Resident #268's eMAR's (electronic medication administration record) were reviewed and contained an entry which read in part, "Levaquin Tablet 500 mg (levofloxacin) Give 1	F 755	Resident #268 was discharged from the facility on 6/15/18. Resident #86 was discharged from the facility on 10/24/18. Potential Residents: The medical records of all current residents will be reviewed for the past 4 week to identify any medications that were not administered due to unavailability. Physician and responsible party notifications and interventions will be made as indicated. Systematic Changes: QAA Committee will review and revise as necessary the policy and procedure for Unavailable Medications. Nursing staff will be inserviced on the policy and procedure for Unavailable Medications. A reference list of medications available in the facility□s First Dose medication storage system will be placed at each Nurse□s Station. If a medication is unavailable in the med cart and the FirstDose system, the nurse will immediately notify pharmacy for further instructions. If a medication remains unavailable after contacting the pharmacy, the nurse must contact the physician for additional	

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F 755	Continued From page 27 tablet by mouth one time a day for RL (right lower) lung pneumonia for 7 days". The time for this administration was 9 pm, with a start date on 05/25/18. This entry was coded as "9" on 05/29/18, which is the equivalent of "other/see progress notes". Resident #268's progress notes were reviewed and contained progress notes dated 05/30/18 which read in part, "05/30/18 00:35 Levaquin Tablet 500 mg Give 1 tablet by mouth one time a day for RL lung pneumonia for 7 days Did not receive meds from pharmacy and none in the one dose machine" and "05/30/18 06:47 NP (nurse practitioner) notified that rsd (Resident) did not receive 2100 dose on 05/29/18. New order received to give dose this morning and change to morning for the remainder of course. RP (responsible party) to be notified". The surveyor requested and was provided a copy of a policy entitled "Medication Ordering and Receiving From Pharmacy IC5: Emergency Pharmacy Service and Emergency Kits" which read in part, "Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency supply or by special order from the provider pharmacy. The provider pharmacy supplies emergency medication including emergency drugs, antibiotics, controlled substances, products for infusion in limited quantities in portable, sealed containers, automated dispensing systems in compliance with applicable state regulations". The surveyor spoke with the ADON on 10/25/18 at approximately 1000 regarding Resident #268's medication not being available. ADON stated that the medication should have been available in the "one-dose machine", but there was no way of	F 755	direction. After contacting the physician, the nurse must report to Nurse Administration. Monitoring: The QA Coordinator or designee will select 50% of current residents with MAR documentation of 5=Hold/See Progress Notes and conduct a QA audit weekly for 12 weeks using the Held Medication audit tool to identify any resident who may not have received medications as ordered. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the policy and procedure for Unavailable Medications will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer	

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F 755	Continued From page 28	F 755		

knowing if it had been used and not replaced by the pharmacy.

The concern of the medications not being available for administration was discussed with the administrative team during a meeting on 10/25/18 at approximately 1645.

No further information was provided prior to exit.
2. The facility staff failed to ensure medications were available for administration for Resident #86.

Resident #86 was admitted to the facility 9/12/18 with diagnoses that included but not limited to left fractured humerus, glaucoma, chronic obstructive pulmonary disease, Sicca syndrome, muscle weakness, fibromyalgia, left hip fracture, hypertension, anemia, gastroesophageal reflux disease, urinary tract infection, hypothyroidism, age related osteoporosis, anxiety and depressive episodes.

Resident #86's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/10/18 assessed the resident with a BIMS (brief interview for mental status) as 15 out of 15.

Resident #86's October 2018 physician orders included an order for Elavil 10 mg (milligrams) by mouth at bedtime for depression.
The surveyor reviewed the October 2018 electronic medication administration records (eMARs). On 10/23/18 at 2100 (9:00 p.m.), Elavil 10 mg was marked with a "9" in the box. The legend read "9=Other/See Progress Notes."

The 10/23/18 23:26 (11:26 p.m.) progress note

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F 755	Continued From page 29 read "PAC (physician's assistant certified) called re: Elavil not available from pharmacy, not in first dose, given order to hold until available." Elavil 10 mg was not available to be given to Resident #86 on 10/23/18 at 9:00 p.m. The surveyor informed the assistant director of nursing on 10/25/18 at 2:09 p.m. The ADON reviewed the first dose list of medications and stated Elavil was not in the box. The surveyor requested the facility policy on obtaining medications. The surveyor informed the administrative staff of Resident #86's medication on 10/23/18 not available to administer during the end of the day meeting on 10/25/18 at 4:25 p.m. The surveyor reviewed the facility policy titled "Medication Ordering and Receiving from Pharmacy." The policy read in part "C. The dispensing pharmacy is called if an emergency arises requiring immediate pharmacist consultation concerning appropriateness of therapy, drug information, etc. If the required information is unavailable from the dispensing pharmacy, the pharmacy will determine the appropriate method for obtaining it, including speaking with the facility's consulting pharmacist." No further information was provided prior to the exit conference on 10/25/18.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		12/9/18

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F 760	Continued From page 30 medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 31 Residents were free of significant medication errors. Residents #67. Findings include: For Resident #67 the facility staff failed to administer insulin as ordered by the physician. Resident #67 is a 74-year-old-male who was originally admitted to the facility on 11/18/15 with a readmission date of 01/14/18. Diagnoses included but were not limited to: vascular dementia, type 2 diabetes mellitus, lymphedema, and peripheral vascular disease. The clinical record for Resident #67 was reviewed on 10/24/18. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 09/20/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #67 had a BIMS (brief interview for mental status) score of 11 out of 15. Resident #67's CCP (comprehensive care plan) was reviewed and contained a focus area for "Resident has Diabetes Mellitus and is at risk for complications -requires oral medications and insulin injections," has interventions that included but were not limited to, "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness ...."	F 760	Resident #67 Correction The nurse is no longer employed with HRRC. Resident #67 did not experience any adverse effects of the insulin omission on 10/03/18; the physician and responsible party were notified. Potential Residents The medical records of all current residents with a physician□s order for insulin will be reviewed for the previous 4 weeks for appropriate insulin administration. Any nurse identified as not administering insulin as ordered will be inserviced and/or counseled as indicated. Physician and responsible party notifications will be made as indicated. Systematic Changes: The QAA Committee will review and revise as necessary the policy and procedure for Insulin Administration Nurses will be inserviced on the policy and procedure for Insulin Administration. Nurses will be inserviced on reading,	

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F 760	Continued From page 31 Resident #67's clinical record was reviewed on 10/24/18. It contained a physician's order which read in part: "HumaLOG Solution 100 unit/ML (milliliter) (Insulin Lispro) Inject as per sliding scale: if 0-200=0; 201-500= 8 units; 501 + notify MD (medical doctor), subcutaneously with meals for DM (diabetes mellitus)". Resident #67's eMAR (electronic medication administration record) for the month of October 2018 were reviewed and contained an entry which read in part, "HumaLOG Solution 100 unit/ML (milliliter) (Insulin Lispro) Inject as per sliding scale: if 0-200=0; 201-500= 8 units; 501 + notify MD, subcutaneously with meals for DM". This entry was coded "15" on 10/03/18 at 1700, which is the equivalent of "see progress notes". Resident #67's progress notes were reviewed and contained an administration note for: 10/03/18 at 1636, which read in part " ... bs (blood sugar) 221 no insulin given ..." Resident#67's blood sugar at bedtime (2100) on 10/03/18 was 198 per Resident #67's eMAR. The surveyor spoke with the administrative team on 10/24/18 at approximately 4:47pm regarding Resident #67's insulin not being administered as ordered by physician. No further information was provided prior to exit on 10/25/18.	F 760	interpreting and following physician orders. Monitoring: The QA Coordinator or designee will select 50% of current residents with a physician□s order for insulin and conduct a QA audit weekly for 12 weeks using the Insulin Administration audit tool to identify any resident who may not received as ordered. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the physician□s order for insulin administration will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		12/9/18

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F 761	Continued From page 32 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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, clinical record review, and facility document review, the facility staff failed to label and store medications appropriately on 2 of 7 medication carts. The findings included: 1. A medication cart on D wing 400 hall had an opened package of Ipratropium Bromide and Albuterol Sulfate Inhalation solution that was undated. 2. A medication cart on the A100 had had an opened package of Ipratropium Bromide and	F 761	Correction: The open, undated packages of Ipratopium and Albuterol Sulfate inhalation solution were removed from the A Wing and D Wing med carts. The plastic bag with medications was removed from the A Wing med cart and returned to the resident□s family. Potential Residents: All facility med carts were checked for any	

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F 761	Continued From page 33 Albuterol sulfate Inhalation solution that was undated and several medications that were brought from home that were not labeled and the resident had no current orders for use. On 10/25/18 at 10:50 am, the surveyor reviewed the medication cart on A100 hall. The surveyor observed a package of Ipratropium Bromide 0.5 mg (milligram) and Albuterol Sulfate 3 mg that was opened not dated. Instructions were documented on the package included but was not limited to, "Once removed from the foil pouch, the individual vials should be used within one week. " The surveyor also observed a plastic bag with medications in the bottom drawer of the cart. The medications were as follows: Equate Clear Lax Walgreens stool softener Docusate Sodium 100 mg Walgreens Sulfameth/TMP 800/160 mg TB 9/13/18 date filled-prescribed to Resident # 119 Therapeutic mineral Ice pain relieving gel Ocean Saline Nasal Spray Artificial Tears First Aid antibiotic + pain relief Vicks Vapo Rub Walgreens Amoxicillin 500 mg tab date filled 2/20/18- prescribed to Resident # 119 Spring Valley Magnesium 400 mg Acetaminophen Extra Strength caplets 500 mg 500 caplets. On 10/25/18 10:53 am, the surveyor spoke with the director of nursing regarding bag of medications found in the bottom drawer of the cart on A100 hall. The director of nursing stated that the facility policy was that medications from home can be used as long as there is an active	F 761	opened and undated inhalation solutions and no additional packages were found. All facility med carts were checked for any unlabeled medications brought in by a resident/family and no additional unlabeled medications were found. Systematic Changes: QAA Committee will review and revise as necessary the policy and procedure for Medication Storage in the Facility. Nurses will be inserviced on the policy and procedure for Medication Storage in the Facility. QAA Committee will review and revise as necessary the policy and procedure for Medications Brought to the Facility by Physician□s or Residents/Family Members. Nurses will be inserviced on the policy and procedure for Medications Brought to the Facility by Physician□s or Residents/Family Members. The Unit Manager or designee will check each med cart at least weekly for any open, undated medications and/or unlabeled medications. Monitoring: The QA Coordinator or designee will select 50% of facility med carts and conduct a QA audit weekly for 12 weeks	

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F 761	Continued From page 34 order and there is an appropriate label on the medication. The director of nursing stated normally the nursing staff would store the medications in the medication room and then send the medications home. The director of nursing stated Resident # 119's medications had been supplied by the facility pharmacy and that the medications found on the cart on A100 hall should have been sent home. The facility policy on "Medications brought to the facility by physician's or residents/family members" contained documentation that included but was not limited to: ... "D. Medications from home 1) In order to safeguard the quality and stability of medications used within the facility, medications brought to the facility by other than the designated pharmacist or agent can be accepted only if there is current order for use, the medication container is properly labeled, in proper container, has not expired and has been positively identified by the Physician or Pharmacist prior to use. Facility will have documentation that the identification has been made." ... On 10/25/18 at 11:00 am, the surveyor reviewed the medication cart on the 400 hall D wing. The surveyor observed a package of Ipratropium Bromide 0.5 mg (milligram) and Albuterol Sulfate 3 mg that was opened not dated. Instructions were documented on the package included but was not limited to, "Once removed from the foil pouch, the individual vials should be used within one week. " On 10/25/18 at 5:00 pm, the administrative team	F 761	using the Med Cart Observation audit tool to identify any opened, undated medications and/or unlabeled medications. The DON and administrator will receive reports of weekly audit. Any staff identified as not dating medications when opened and/or placing unlabeled medications in the med cart will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer.	

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F 761	Continued From page 35 was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/25/18.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		12/9/18

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F 842	Continued From page 36 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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 staff interview and clinical record review and in the course of a complaint investigation, the facility staff failed to ensure a complete and accurate clinical record for 2 of 31	F 842	Resident #268 and #94 Correction:	

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F 842	Continued From page 37 Residents. #268 and #94. The findings included: 1. For Resident #268 the faciltiy staff failed to accurately document wounds. Resident #268 was admitted to the facility on 05/17 /18. Diagnoses included but not limited to urinary tract infection, bronchopneumonia, anemia, thrombocytopenia, depression hypertension, hypotension, gastroesophageal reflux disease, dermatitis, adult failure to thrive, anxiety and hypokalemia. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 05/24/18 coded the Resident as 10 out of 15 in Section C, cognitive patterns. Section G, functional status, coded the Resident as needing extensive assistance with two person physical assist in the areas of bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. Section M, skin conditions, coded the Resident as being at risk for developing pressure ulcers, but not having any unhealed pressure ulcers. Subsection M1040, other ulcers, wounds and skin problems coded the Resident as having no other skin problems. This is an admission MDS. Section M of the 14-day MDS with an ARD of 05/30/18 coded the Resident as being at risk for developing pressure ulcers, but not having any unhealed pressure ulcers. Subsection M1040, other ulcers, wound and skin problems coded the Resident as having no other skin problems. Section M of the 30-day MDS with an ARD of 06/14/18 coded the Resident as being at risk for	F 842	Resident #268 was discharged from the facility on 6/15/18. Resident #94□s medical record was reviewed and the nurses responsible for inaccurate documentation of the tube feeding and water flushes have been re-educated. Potential Residents: All residents have the potential to be affected related to skin assessment documentation. The medical records of all current residents with a physician□s order for tube feeding will be reviewed for the previous 4 weeks for accurate documentation of tube feeding and water flushes. Systematic Changes: Nurses will be inserviced on proper documentation of Weekly Skin Assessments and subsequent follow up. Nurses and CNAs will be inserviced on appropriate documentation and follow up of bath skin assessments. Nurses will be inserviced on identification of wound changes, communication of observations of wounds and appropriate documentation. CNAs will be inserviced to notify the Charge Nurse immediately of	

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F 842	Continued From page 38 developing pressure ulcers and having one or more unhealed pressure ulcers at a stage 1 or higher. Subsection M0300G, current number of unhealed pressure ulcers at each stage, unstageable-deep tissue injury, coded the Resident as having two unstageable pressure ulcers with suspected deep tissue injury in evolution. According the National Pressure Ulcer Advisory Panel a suspected Deep Tissue Pressure Injury is one with persistent non-blanchable deep red, maroon or purple discoloration, intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Resident #268's CCP (comprehensive care plan) was reviewed and contained a care plan for "...has potential/actual impairment to skin integrity r/t limited mobility d/t (due to) general weakness....-skin tear to right lower arm". Interventions for this care plan included "observe skin daily during ADL (activities of daily living) care for redness, irritation or skin breakdown, skin management: peri wash, moisture and barrier cream to cleanse, moisturize and protect prn (as needed), monitor fluid filled area to LLE (left lower extremity) until healed, treatment back of right calf as ordered, treatment to skin tear to right lower arm as ordered, treatment to top of left buttock/hip as ordered". Resident #268's clinical record contained "Weekly Skin Assessment by Licensed Nurse" forms dated 05/23/18, 05/25/18, 05/30/18, 06/06/18, and 06/13/18. These forms read in part "05/23/18: 1. Observations: (nothing	F 842	changes/worsening of skin areas. Nurses will be inserviced on accuracy of MAR documentation for tube feeding and water flushes. Monitoring: The QA Coordinator or designee will select 10% of current residents and conduct a QA audit weekly for 12 weeks using the Skin Assessment audit tool to identify any resident without appropriate and complete documentation of bath assessments and weekly skin assessments. The DON and administrator will receive reports of weekly audit. Any staff identified as not appropriately documenting skin assessments and any subsequent follow up will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. The QA Coordinator or designee will select 50% of current residents with a physician□s order for tube feeding and water flushes and conduct a QA audit weekly for 12 weeks using the Tube Feeding audit tool to identify any resident who may have received tube feeding and/or water flushed as ordered. The DON and administrator will receive reports of weekly audit. Any staff identified as not following the physician□s order for tube feeding and water flushes will be re-educated and/or counseled as	

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F 842	Continued From page 39 documented) 2. Notes: Skin warm and dry. No new areas observed", "05/25/18: 1. Observations: Site: 12) Chest-R chest, fent patch (fentanyl pain patch), 42) Left lower leg (front) fluid filled area, Other (specify)-bilat (both) knees, existing discoloration, pt (Patient) states from fall at home, Other (specify)-existing multiple discolorations to bilat arms, pt states from fall at home & venipuncture sites, Other (specify)-L (left) posterior arm existing scab, Other (specify) R (right) 4th toe, existing scab, pt states from previous ill fitting shoes, Other (specify) R posterior arm, skin tear, states from venipuncture". 2. Notes: Skin warm, dry.", "05/30/18: 1. Observation: (nothing documented), 2. Notes: lower legs swollen and weeping, no other skin issues noted, instructed to keep legs elevated. will continue to monitor.", "06/06/18: 1. Observations: (nothing documented), 2. Notes: Skin warm and dry. No new areas present. Will continue to monitor.", and "06/13/18: 1. Observations: Other (specify) BLE (both lower extremities), existing areas, tx (treatments) in place. Other (specify) buttocks, existing areas, txs in place. 2. Notes: Skin warm, dry". Resident #268's clinical record contained a "Weekly Wound Assessment" form dated 06/05/18, which read in part "A. COMMUNICATION: 1a. Date MD/Alternate Notified/Last Updated: 06/05/18, B. OBSERVATIONS/DATA: 1. Location: left heel, 2a. Indicate whether this site was acquired during the Resident stay or whether it was present on admission: acquired, 2b. Date acquired: 06/05/18, 3a. Type: pressure, 3b. Specify Other: SDTI (suspected deep tissue injury), 4. PRESSURE INJURY STAGE: 4a. Original:	F 842	necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed quarterly by the Medical Director, QAA Committee, DON and Administer.	

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DTPI. Deep Tissue Pressure Injury, 5. VISIBLE TISSUE: 5a. First Observation, no reference, 5c1. Describe the extent (%) of granulation tissue present: Deep purple, closed, blanchable around wound, 5g. dry, 6. DRAINAGE: 6a. Type: none, 7. ODOR: 7a. Odor Present: no, 8. WOUND MEASUREMENTS: 8a. Length (cm [centimeters]): 2.5, 8b. Width (cm): 2.5, 9. PERI-WOUND TISSUE: 9a. Description of peri-wound tissue: fragile, blanchable, 9b. Describe wound edges and shape (e.g. well-defined, rolled, calloused, irregular etc.): irregular." The Resident's clinical record also contained a "Weekly Wound Assessment" for dated 06/05/18 with the same information as previously stated for the right heel, with the exception of wound measurements, which were 2 cm in length and 1.5 cm in width. The surveyor could not locate any wound assessments related to areas on the Resident's buttocks or legs.

The Resident's clinical record contained "Bath Skin Assessment (To be completed by CNA [certified nurse's aide] at each bath time of Resident)" forms, dated 05/26/18, 05/30/18, 06/06/18, 06/07/18, and 06/13/18. The form for 05/26/18 read in part, "Mark location with X of any skin problems found during skin check Skin Problem found: (check all that apply): Existing Area". The form was marked as existing area to Resident's buttocks, and notation was made that area was red. The form for 05/30/18 indicated that the Resident refused. The form for 06/06/18 was marked as Resident having existing red areas to buttocks. The form for 06/07/18 was marked as Resident having areas to front of left leg and both heels with treatment in place. The form dated 06/13/18 was marked as Resident having existing areas to front of left leg, back of

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right leg and buttocks.

Resident #268's clinical record contained daily "Skilled Charting" forms that had been completed for each shift (3). The surveyor reviewed all the skilled charting forms from 05/18/18-06/15/18. Section G, Skin/Wound, subsection G1a, Skin integrity, read, "no new changes to skin integrity noted" to all forms reviewed by surveyor. Subsection G2a, "Resident has treatable wounds", was marked on the forms dated 06/08/18 at 02:23, 06/09/18 at 19:41, 06/10/18 at 18:38, 06/11/18 at 00:32, 06/12/18 at 02:04, and 06/14/18 at 18:25. Type and location of wound was documented as "open area to right calf" on the forms dated 06/11/18 at 00:32 and 06/12/18 at 02:04. No other documentation related to wounds was observed on the "Skilled Charting" forms.

Resident #268's nurse's progress notes were reviewed on 10/24/18. The surveyor could only locate one nurse's note that refers to an area on the Resident's buttocks. This note read in part, "05/30/18 11:45 Nurses Note: area to left upper buttock/hip area observed, new treatment to this area ordered."

Resident's physician progress notes for the dates of 05/18/18, 05/21/18, 05/29/18, 06/01/18, 06/04/18, 06/06/18, 06/08/18, 06/11/18, and 06/15/18 were reviewed. The surveyor could not locate any documentation in the physician's progress notes related to area on Resident's buttocks.

Resident #268's clinical record contained a nurse's note dated 06/15/18, which read in part, "06/15/18 08:08 rsd (Resident) sent to hospital for

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eval for shortness of breath, cyanosis, c/o chilling, she is confused and was unable to sign bed hold due to weakness".

Resident #268's hospital record contained an admission history and physical from.... (name omitted) hospital dated 06/16/18 which read in part, "Skin: cool, pale, no rash, previous IO (intraosseous) noted to right humerus was been removed in the ED (emergency department). Dressing over site is noted, multiple decubitus noted to body 1. left buttocks 9 x 5 cm eschar 2. distal below eschar area 3 x 3 cm stage 2 decubitus. 3. right buttocks 3 x 2 cm stage 2 decubitus 4. right calf 3.x1 stage 2 ulcer 5. left anterior left (sic) lower extremity 0.5 x 0.5 ulcer. A & P (assessment and plan) Sepsis-initiated Vancomycin due to multiple ulcerations, largest being right buttocks 9 x 5 cm with eschar and drainage. Multiple ulcerations to sacral area and legs-see pictures on chart for details."

The National Pressure Ulcer Advisory Panel (NPUAP) defines "eschar" as dead tissue found in a full-thickness wound. The NPAUP defines a stage 2 pressure ulcer as partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. The NPAUP defines a stage 3 pressure ulcer as full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible.

Surveyor spoke with RN #2 on 10/25/18 at

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approximately 0830. RN #2 stated that Resident was very sickly, had fragile skin and was non-compliant with turning and floating her heels. She developed deep tissue injuries on her heels and had an area on her right buttock. RN #2 stated that an investigation was done on area to right buttock when it was first noticed and she wrote a statement regarding her observations at that time. RN #2 stated that Resident had taken herself to the bathroom when the area on her buttock was discovered. RN #2 stated that she assisted Resident to bathroom "a few days later" and the bandage was "peeling off and I caught a glimpse of it and it had bruising around the area and some brown scabbing". Surveyor asked RN #2 if she had documented this and she stated that she had not.

Surveyor spoke with CNA #2 on 10/25/18 at approximately 0920 regarding Resident #268. CNA #2 stated that Resident would sometimes take herself to bathroom. CNA #2 stated "She (Resident #268) rang her bell while in the bathroom. ...(name omitted) was getting her up and called me to come look at area. It was low on her (Resident's) butt check and looked like bleeding under the skin, no open area. I went and got the nurse (LPN #2). Area was not fresh looking, about the size of a 50 cent piece. It looked like she had hit something". CNA #2 stated that she did not work with Resident for a while, but when she saw the area again it was "bigger than a 50 cent, and black looking". CNA #2 also stated at this time she observed "another place, smaller blister area, dime-sized, not intact, and even smaller area on right, blister intact. CNA #2 stated that she did not know if these areas were documented or if an incident report was completed. CNA #2 stated "...(name omitted) said

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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 842	Continued From page 44 she was going to call ...(name omitted, wound care nurse), due to it being an existing area". The concern of staff not documenting Resident wounds was discussed with the administrative team during a meeting on 10/25/18 at approximately 1625. Surveyor asked the administrative team if the areas on Resident #268's buttocks should have been documented on the weekly skin assessment sheets, and the DON stated, "Yes it should". Surveyor also asked if areas should have been documented on the wound assessment sheet and DON stated, "We didn't do a pressure ulcer assessment because it came from a cut from the toilet paper holder and we didn't consider it to be a pressure ulcer". No further information was provided prior to exit. Complaint Deficiency 2. For Resident #94 the facility staff failed to accurately document tube feeding and flush amounts. Resident #94 was admitted to the facility on 06/23/13. Diagnoses included but not limited to.hypertension, gastroesophageal reflux disorder, diabetes mellitus, hypothyroidism, anxiety, depression and Parkinson's disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/14/18 coded the Resident as 15 of 15 in section C, cognitive status. This is an annual MDS. Resident #94's clinical record was reviewed on 10/ /18. It contained a signed physician's order summary for the month of September 2018 which	F 842		

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F 842	Continued From page 45 read in part, "Enteral Feed Order every 4 hours Glucerna 1.5: _175 mL bolus feed Q4H (every four hours)" and "Enteral Feed Order every 4 hours Free Water Flush: _200 mL before and after each feeding". Resident #94's eMAR (electronic medication adminstration record for the month of September 2018 was reviewed and contained an entry which read in part "Enteral Feed Order every 4 hours Formula Glucerna 1.5: 175 ml". This entry had been initialed as 200 ml administered on 09/02/18 at 9p, 09/03/18 at 12a, 4a, 8a and 12p. Resident #94's eMAR also contained an entry which read in part "Enteral Feed Order every 4 hours Water flush: 100 ml before and after each feeding for a totoal of 200 ml with each feeding". This entry had been initialed as 175 ml administered on 09/02/18 at 9p, 09/03/18 at 12a, 4a, 8a and 12p. The surveyor spoke with the ADON (assistant director of nursing) 10/25/18 at approximately . ADON stated that it looked like someone just got the orders reversed and documented the amounts in the wrong place. The concern of not accurately documenting Resident's tube feeding and water flushes was discussed with the administrative team during a meeting on 10/25/18 at approximately 1625. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		12/9/18

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F 880	Continued From page 46	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and 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;

§483.80(a)(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

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F 880	Continued From page 47 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 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines for 2 of 31, Residents #96 and #30. Findings include: 1. For Resident #96, facility staff failed to change gloves and wash hands after having contact with fecal matter per facility policy. Resident #96 is a 76 year-old-male admitted to the facility on 09/07/2018. Diagnoses included, but were not limited to, bacterial infection, rectal fistula, sepsis, and type 2 diabetes mellitus.	F 880	Resident #96 and #30 Correction: Resident #96's buttocks was cleansed and treatment reapplied. Resident #30's room was sanitized. LPN #1 and #2 were re-educated on appropriate hand hygiene procedures. Nursing staff present in the facility were inserviced to wash hands and change gloves between providing personal care and touching items in the resident□s	

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F 880	Continued From page 48 The clinical record for Resident # 96 was reviewed on 10/24/18. The most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 09/14/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #96 had a BIMS (brief interview for mental status) score of 12 out of 15. Resident #96's CCP (comprehensive care plan) was reviewed on 10/24/18. The CCP contained a focus area for "Resident has questionable C-diff (bacterial infection-clostridium difficile)," has interventions that included but were not limited to "Contact isolation until ABT (antibiotic) completed." Physician's orders included a physician order dated 10/17/18 for Resident # 96 that read in part: "Contact isolation for diagnosis of C-Diff until antibiotic completed." On 10/24/18 at 10:00 am, the surveyor observed Resident #96 receiving treatment. LPN (licensed practical nurse) #1 took a damp wash cloth and wiped Resident #96's rectum prior to applying treatment. LPN #1 placed soiled wash cloth in barrel marked linen. LPN#1 obtained prescribed cream from bedside table and proceeded to apply prescribed cream to buttocks without washing hands or changing gloves. LPN#1 placed dry dressing over left buttock without washing hands or changing gloves. The surveyor did not observe LPN #1 washing hands or changing gloves prior to initially donning gloves when entering the Resident's room and washing hands upon exiting Resident's room after treatment was completed.	F 880	room. Nurses present in the facility were inserviced to remove gloves, wash hands and reapply gloves between peri-care and treatment administration. Potential Residents: All residents have the potential to be affected related to hand hygiene. Systematic Changes: QA Committee will review and revise as necessary the policy and procedure for Hand Hygiene. Facility staff will be inserviced on the policy and procedure for Hand Hygiene. QA Committee will review and revise as necessary the policy and procedure for Contact Precautions. Facility staff will be inserviced on the policy and procedure for Contact Precautions. Nursing staff will be inserviced on performing proper hand hygiene following ADL care and prior to performing additional task in the resident□s environment. Monitoring: The Infection Preventionist or designee will select at least 4 residents and conduct	

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F 880	Continued From page 49 On 10/24/18 at 4:47 pm the surveyor spoke to administrative team regarding the issue stated above. DON (director of nursing) was asked by surveyor if facility staff was expected to wash hands and change gloves after coming in contact with fecal matter while performing treatment. DON stated "yes". The surveyor requested facility policy for infection control at this time. On 10/25/18 the DON provided the surveyor with a copy of a policy/procedure titled "Contact Precautions". Page 1 of this document read under Procedure: section 3.b "(During the course of caring for the Resident, change gloves and wash hands after having contact with infective material that may contain high concentrations of microorganisms (fecal material, sputum, or respiratory secretions and wound drainage)." The DON notified surveyor during the end of the day meeting on 10/25/18 at 4:38 pm that an educational in-service was completed on the evening of 10/24/18 and the morning of 10/25/18 for all facility staff on all shifts regarding the above issue. 2. For Resident #30, facility staff failed to change gloves and wash hands after performing mouth care per facility policy. Resident #30 is a 77-year-old-female who was originally admitted to the facility on 03/02/18 with a readmission date of 09/26/18. Diagnoses included but were not limited to: cerebral infarction, dysphagia, hemiplegia, and depression. The clinical record for Resident #30 was reviewed on 10/24/18. The most recent MDS (minimum	F 880	a QA audit weekly for 12 weeks using Hand Hygiene Observation audit tool to identify any staff member not following proper hand hygiene and/or contact precautions during resident care. The DON and administrator will receive reports of weekly audit. Any staff identified as not following proper hand hygiene and/or contact precautions will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. The Wound Care Nurse or designee will select at least 2 residents with a physician□s order for wound care and conduct a QA audit weekly for 12 weeks using the Treatment Observation audit tool to identify any nurse not following proper hand hygiene during treatment administration. The DON and administrator will receive reports of weekly audit. Any staff identified as not following proper hand hygiene will be re-educated and/or counseled as necessary. After the 3-month period, the QAA Committee will re-evaluate the frequency of the audit. DON and Administrator will review an aggregate analysis of the QA Audit Reports and report monthly findings to the QAA Committee. QAA Committee will monitor reports monthly for patterns and trends and recommend adjustments accordingly. Recommendations will be reviewed	

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F 880	Continued From page 50 data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/16/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #30 had a BIMS (brief interview for mental status) score of 09 out of 15. Resident #30's CCP (comprehensive care plan) was reviewed on 10/24/18. The CCP contained a focus area for "Resident has infection (MDRO (multi-drug resistant organism) CRE (carbapenem-resistant enterobacteriaceae infection) urine)." has interventions that included but were not limited to "Per MD (medical doctor) order on 10/10/18: Contact isolation." The physician signed the current orders for Resident #30 on 10/11/18. The physician's orders included but were not limited to: "Contact isolation for MDRO CRE in urine." On 10/24/18 at 10:30 am, the surveyor observed Resident #30 receiving mouth care. LPN (licensed practical nurse) #2 took moistened toothettes (disposable oral care sponge) and cleansed the inside of Resident #30's mouth. LPN #2 placed waste in biohazard barrel designated for infectious waste. LPN#2 proceeded to tidy up the Resident's room and reposition Resident in bed without washing hands or changing gloves. The surveyor did not observe LPN #2 washing hands or changing gloves prior to initially donning gloves when entering the Resident's room and washing hands upon exiting Resident's room. On 10/24/18 at 4:47 pm the surveyor spoke to administrative team regarding the issue stated	F 880	quarterly by the Medical Director, QAA Committee, DON and Administer.	

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F 880	Continued From page 51 above. DON (director of nursing) was asked by surveyor if facility staff was expected to wash hands and change gloves after coming in contact with saliva and/or sputum while performing mouth care. DON stated "yes". The surveyor requested facility policy for infection control at this time. On 10/25/18 the DON provided the surveyor with a copy of a policy/procedure titled "Contact Precautions". Page 1 of this document read under Procedure: section 3.b "(During the course of caring for the Resident, change gloves and wash hands after having contact with infective material that may contain high concentrations of microorganisms (fecal material, sputum, or respiratory secretions and wound drainage)." The DON notified surveyor during the end of the day meeting on 10/25/18 at 4:38 pm that an educational in-service was completed on the evening of 10/24/18 and the morning of 10/25/18 for all facility staff on all shifts regarding the above issue.	F 880		