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F 686	Continued From page 106 antiseptic that kills most forms of bacteria and viruses (http://www.webmd.com/drugs/2/drug-62261/dakin's-misc/details). *Calmaseptine Ointment to Prevent & Heal Skin Irritations. A moisture barrier that prevents & helps heal skin irritations (https://www.webmd.com/drugs/2/drug-3614/calmoseptine-topical/details). A wound consult was ordered for the wound specialist to evaluate and treat on 2/2/18 per the CWOCN RN on her next visit to the facility. The CWOCN RN recommended the same treatment until evaluation by the wound specialist. The CWOCN RN documented that she re-educated the staff on the importance of packing the wound and re-educated the staff on the use of repositioning tools to offload wound location and prevent further breakdown. The wound care specialist physician evaluated the sacral wound on 2/5/18 and assessed the wound as unstageable necrosis 7.5 cm x 3.5 cm x (depth but not able to measure). The wound bed exhibited 50% black necrotic tissue (eschar) and 40% devitalized necrotic tissue, and 10% skin. the wound was surgically debrided of devitalized and necrotic tissue. The orders were unchanged to the sacral wound and she would re-evaluate on 2/8/18. She added on 2/5/18 to document skin assessments. Starting 2/12/18 skin inspections were placed on the Treatment Administration Records (TAR) and noted to be signed off as completed by the licensed nurse for Resident #18 every 7 days. February 12, 2018 was signed off and not signed	F 686		

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F 686	Continued From page 107 off as completed on 2/19/18. The next skin inspection signed off as completed was dated 2/26/18. The TAR indicated a scheduled skin assessment was not signed off as completed on 4/9/18. The wound was surgically debrided again on the wound care specialist's visits, 2/8/18, 2/15/18, 2/22/18, 3/1/18 (added a *wound vac with the primary wound care three times a week). On 3/15/18, the primary wound bed treatment remained unchanged with continuation of the wound vac. On 3/29/18, the primary wound care was changed to add Bactroban, Santyl and Dakins moistened gauze to the wound bed daily for 14 days covered with a foam dressing. On 4/5/18, the primary wound care was continued as the order of 3/29/18, for 30 days. The wound care specialist evaluated the wound on 4/12/18, 4/19/18, 4/26/18 with surgical debridement. On 5/3/18 the Dakins solution and Bactroban was discontinued and *Calcium Alginate was ordered daily for 30 days and the Santyl remained. On 5/10/18 the primary wound care remained the same with debridement but scheduled to be performed twice a day. The wound VAC was reestablished on 5/24/18 to be changed twice a week and the primary wound care treatment to 1/4 Dakins solution-apply Santyl and Dakins moistened gauze in wound bed, also twice a week with wound VAC change. The primary wound care and wound VAC continued at the next evaluation dated 5/31/18 and 6/7/18. The wound was surgically debrided on 6/14/18 with unchanged primary wound care treatment. On 6/20/18 at 12:15 p.m., the sacral wound care observation was made conducted by the wound specialist physician, assisted by the North 4 Unit	F 686		

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F 686	Continued From page 108	F 686		

Manager RN#1. The wound care specialist stated that she was not going to let the wound go until it was healed. She stated the wound was not accurately assessed from the beginning, wound assessments were not being performed by the nursing staff as they should have been which was one of the reasons she stated she stopped treating residents in the facility. She indicated the condition of Resident #18's wound was avoidable. She stated a certain physician persuaded her to reconsider treating the complicated wounds and Resident #18 was one of the most challenging wounds she took on when coming back to the facility. When asked about the wound care protocols and how effective they were she answered, "The nurses get what they need right at the time, if assessments are appropriate. I am not in agreement with them 100% of the time and probably 85% of them may be followed, but residents are not recipes and one protocol for a wound type does not fit all. After initiation of the protocol, they wound should be assessed every 7 days and the physician informed of improvement or deterioration." She continued to say that Resident #18's wound was clean with no tunneling and the current progress was a "win for us". The wound was observed with a slight odor, but no obvious drainage and measured by the wound care specialist physician as 3.3 cm x 2.8 x 1.2 depth. The treatment observed included 1/4 Dakins solution-apply Santyl and Dakins moistened gauze in wound bed, with wound VAC change (PICO Brand). The UM RN #1 stated the resident was readmitted to the nursing facility on 12/5/17 with an unstageable wound and the wound was never a Stage I at that admission. She stated wound care assessments had been a problem, but they were working on consistency for all licensed nurse in the performance of

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F 686	Continued From page 109 wound assessments. On 6/21/18 at 3:54 p.m., an interview was conducted with the Administrator, DON#1, DON #2 and Director of Operations. The above findings were shared with the group regarding failure to correctly assess Resident #18's wound upon readmission 12/5/18 and implement appropriate treatment protocol, thus wound deterioration was the outcome followed by many painful and aggressive treatments. The Administrator and DON #1 were not aware of LPN#6 inaccurate assessment of the sacral wound. It was shared that the inaccuracy led to an inaccurate MDS, as well as an inaccurate care planning. The Administrator stated they did not complete any individual Resident wound investigations, but recognized assessments were not being documented. It was shared with the group that Resident #18 situation was not the result of poor documentation, but the lack of care and services per the facility's wound care protocols, polices and the facility's educational curriculum on prevention and treatment of wounds. The Administrator stated she did identify problems with wounds individually for residents but looked at the problem "as a whole" that weekly skin assessments were not being completed and did not related specifically to care. On 6/25/18 at 12:20 p.m., during an interview with DON #2, who was assisting DON #1 with reviewing issues and locating documents stated she was not able to find any skin assessments completed by the licensed nurses for Resident #18 other than the ones completed by the COWCN when she initiated review of the wound on 1/25/18. She stated she could not locate any of them afterwards, although it was signed off	F 686		

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F 686	Continued From page 110 intermittently that they had been completed by the licensed nurses. The nurse's notes did not reflect skin assessments even after areas had been identified. The most consistent assessments were done by the wound care specialist after she took over care of the wound on 2/5/18. During investigation of the wound with the surveyor, DON #2 stated, "I see where this is going in comparison to the hospital wound care notes on 12/3/18 and I agree there was an inaccurate admission assessment of the wound when he was re-admitted on 12/5/18 with failure to implement appropriate wound care protocol for an advanced stage pressure ulcer." The facility's policy and procedures titled Guidelines for Skin Integrity dated 3/6/17 indicated the following: -Licensed nurse would measure, stage using the National Pressure Ulcer Advisory Panel (NPUAP) guidelines, describe and document all identified impaired skin integrity and surrounding skin areas. -Initiate the Wound Care Protocol for all identified skin impairments. -Complete the Unavoidable Pressure ulcer documentation assessment in Vision on all high-risk residents at time of identification (Clinical Manager and/or DON). -Initiate the Weekly Skin Condition Progress Report (embedded in the initial nursing assessment) for residents with identified skin impairments and will be continued weekly. -Weekly skin assessments to be completed on "ALL" residents through the assessment widget. Residents with skin impairment will have "BOTH" Weekly Skin Inspection Assessment and Weekly Skin Condition Progress reports completed. -All alterations of skin are re-evaluated for healing	F 686		

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F 686	Continued From page 111 progress. If not progressing, notify Clinical Manager/DON and physician for review and recommendations for skin care orders and/or additional treatments. If wound is progressing re-new existing order every 14 days. If wound is not progressing and current treatment continues, discuss with physician and provide documentation to support rational. -Care plans must identify separately existing skin integrity areas and must include their own goals and interventions. -The wound care specialist team will make recommendations regarding wound care, however, the facility is responsible for ongoing care, follow-up, care, notification to the physician, all documentation and referrals as needed. On 6/28/18 at 3:35 p.m., the aforementioned issues were re-shared during a debriefing with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit. *Category/ Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org).	F 686		

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F 686	Continued From page 112 *Category/ Stage I is Pressure Injury: Non-blanchable erythema of intact skin (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). *Category/Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. Bruising indicates deep tissue injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/).. *Category/Stage III: Full thickness skin loss: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/). *DTI (Deep Tissue Injury) - depth unknown	F 686		

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F 686	Continued From page 113 Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). *ABD Pads measure 5" x 9" and feature a soft non-woven outer layer that wicks fluid to a cellulose center that prevents pooling. Often referred to as abdominal pads, ABD pads are also known as trauma pads. The ABD stands for "Army Battle Dressing" and are used when high absorbency is required to handle heavy draining wounds or large wounds. This sterile ABD pad has a thick layer that absorbs and disperses fluids laterally to prevent pooling. The hydrophobic back impedes strike through and all the edges are sealed (http://www.hightidehealth.com/medline-abdominal-abd-pads-5x9-sterile.html#sthash.q0Yr4mtb.dpuf) *Santyl (Collagenase) This product is used to help the healing of burns and skin ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (http://www.webmd.com/drugs/2/drug-9489/santyl-topical/details).	F 686		

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F 686	Continued From page 114 *Mesalt Sodium Chloride Impregnated Gauze helps stimulate the cleansing of moist necrosis (slough) in draining infected wounds. Upon contact with wound moisture, sodium chloride is released (https://www.woundsource.com/product/mesalt-sodium-chloride-impregnated-gauze). *Alleyvn adhesive, with its unique triple layer formation, has been designed to achieve this combination to ensure optimal fluid handling to support moist wound healing1. Alleyvn adhesive is an economically-efficient2 dressing specifically designed to manage chronic or acute exuding wounds (http://www.smith-nephew.com/key-products/advanced-wound-management/allevyn/allevyn-adhesive/). *Wound V.A.C. therapy for wounds promotes wound healing through Negative Pressure Wound Therapy (NPWT). By delivering negative pressure (a vacuum) at the wound site through a patented dressing, this helps draw wound edges together, remove infectious materials and actively promote granulation (http://www.kci1.com/KCI1/vactherapy) *Calcium Alginate dressings are used primarily for the granulating phase of wound repair. They are made from alginate, a derivative of seaweed (https://www.sciencedirect.com/topics/agricultural-and-biological-sciences/calcium-alginate). 3. For Resident #72, the staff failed to identify a wound on the plantar surface of the left foot until it was 45% eschar (hard black dead tissue) and found by surveyors during wound care	F 686		

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F 686	Continued From page 115 observations, due to observed exudate on the foot of the bed. The wound doctor was present, and unable to stage the wound. Resident #72 was admitted to the facility on 7-17-15. Diagnoses for Resident #72 included but were not limited to; Traumatic Brain Injury and quadriplegia. Resident #72's most recent Minimum Data Set (an assessment protocol) was a quarterly assessment, with an Assessment Reference Date of 5-3-18. The MDS coded Resident #72 as alert, oriented to person, place, time and situation, with no cognitive impairment. The Minimum Data Set further coded Resident #72 as being totally dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was coded as at risk for skin breakdown, and having currently, 2 acquired wounds, while in the facility. They were; (1) unstageable deep tissue injury on the right buttock, and (2) a stage 3 wound on the lower right leg shin. On initial tour of the facility on 6-19-18 at approximately 11:30 a.m. Resident #72 was interviewed and observed. The Resident was laying in a "Clinitron Bed" which is a specialty skin pressure removal bed used for individuals with skin breakdown from pressure. The bed is constantly filled with blowing air which moves tiny soft beads inside the mattress creating a floating sensation for the user, and no steady pressure point on the body of a user. The Resident's feet were uncovered and were noted to be propped on a pillow. The mattress was covered with 2 sheets, and had a border around it which resembled the bumper rail around a billiards or pool table, which set up above the mattress	F 686		

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approximately 4-6 inches. With the Resident's calves elevated on the pillow, it allowed the Resident's heels to lie directly on the bumper which was harder than the mattress, and forced the soles of the Resident's feet against the hard plastic foot board of the bed. Brown yellow and tan spots of creamy drainage were noted on the bumper of the mattress in the foot area. On the floor, against the wall at the foot of the bed was a pile of 2-3 foam wedges, and 2-3 pillows, which the Resident stated were to position him with while he was in bed. These positioning devices were also stained with the same color drainage observed to be on the bumper at the foot of the bed. The Resident was asked if he was comfortable with his feet pushed against the foot board, and he responded that he slid down in the bed often, and had to wait for nurses to pull him up. He stated he loved the bed, however, needed to be pulled up to get his feet "right" "every couple hours".

A review of Resident #72's clinical record was conducted during the survey. The review revealed documents titled "Skin". The Director of Nursing (DON) provided these records and stated "these are the May and June 2018 weekly skin checks, these are all we have". The documents revealed skin assessments completed by nursing staff on May 1, 7, 14, 21, 28, and 6-18-18. No skin checks were completed from 5-28-18 through 6-18-18. The documents revealed the following;

5-1-18 - 2 different wounds right lower leg, no open lesions on the foot. No preventative, or protective foot care.
5-7-18 - DTI (deep tissue injury) right buttock, 3 areas right lower leg, no open lesions on the foot.

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F 686	Continued From page 117 No preventative, or protective foot care. 5-14-18 - DTI (deep tissue injury) right buttock, 3 areas right lower leg, no open lesions on the foot. No preventative, or protective foot care. 5-21-18 - DTI (deep tissue injury) right buttock, 2 areas right lower leg, no open lesions on the foot. No preventative, or protective foot care. 5-28-18 - DTI right buttock, and right lower leg, no open lesions on the foot. No preventative, or protective foot care. 6-18-18 - Blister right elbow, right lower leg wound. No preventative, or protective foot care. Nursing progress notes were reviewed and revealed no wound had been identified on the bottom (sole) or plantar surface of the left foot. A nutrition assessment was ordered on 5-24-18 to be completed by the Registered Dietician. The nutrition assessments were reviewed, and the most recent assessment was completed March 2018. The DON was asked to produce the May nutrition assessment, she stated "there was none." The current care plan "starting 5-8-18" was reviewed and revealed an intervention which read "(Resident name) has a Clinitron Air Mattress, ensure air mattress is inflated and operating appropriately." "Goal date 7-31-18." No instruction was given in the care plan as to how the bed should be used, what settings should be maintained, what linens could be used, if any, and if other positioning devices should be used with the bed. No direction was given as to use of the bed. Interventions for "Floating of legs and heels remained on the care plan, and had not been removed/revised when the Clinitron bed was installed. No foot wound was documented in the	F 686		

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F 686	Continued From page 118 care plan. The treatment nurse and Wound doctor were asked if they had been trained on the use of the bed, and they both stated no, however, they stated that the Hill ROM representative came and set up the bed, and if they had a problem the representative would come out and fix it. They were asked what the representatives response time to their call for help would be, and they stated they were unsure. The treatment nurse, and Administrator were asked for the manufacturers instructions guide for use of the bed. The Administrator delivered a 2 page flyer printed from the Hill ROM computer site on 6-21-18, and stated "this is all we have." The flyer did not explain how to use the bed. Research of the Clinitron bed was conducted by the surveyor online, on the Hill ROM eLearning site and revealed that only one bed sheet should be used, not 2, and all other support devices such as pillows under feet defeat the therapeutic results of the bed, as they create pressure points, and barriers between the patient, and the bed, which is designed to relieve pressure by coming into contact with the Resident's skin. The sitefurther stated the "air wall" (bumper) is firm and not fluidized with beads (would create pressure points). The directions for use were detailed and required added education necessary to learn the manipulation of the bed controls, and therapeutic use of the bed. The device was not self explanatory. On 6-21-18 at 9:45 a.m., a wound care observation was conducted with the South unit nursing manager and the wound doctor (other #5). Resident #72 was laying in bed and the	F 686		

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F 686	Continued From page 119	F 686		

doctor and wound nurse were asked why the Resident had drainage on the air wall of the bed. They lifted the Resident's foot and revealed a new wound measuring 1.5 centimeters x 1.8 centimeters circular wound which was 45% necrotic according to the wound doctor.
An interview was conducted at that time, and the wound doctor and the wound nurse both stated that pressure ulcers should not be found at necrotic eschar.

The wound was not identified nor prevented prior to eschar formation and thus found at "unstageable". The wound was further encouraged to form by pressure on the plantar surface of the foot caused by the inappropriate placing of pillows in the bed under both feet for "floating" purposes which pushed the feet on top of the bumper/air wall surrounding the mattress, and pressing them onto the foot board of the bed causing pressure.

The the "SOC Quality Assurance & Performance Improvement" (QAPI) facility form for wounds was reviewed and revealed the facility Administration was only aware of the "right lower leg stage 2 wound, and the unstageable right buttock wound for Resident #72. The form stated that both wounds were avoidable, and facility acquired.

It is notable to mention that the Resident had 3 other wounds, 1) Resident's left ankle, lateral left Achilles tendon, and top of left foot at the ankle juncture which had all begun as blisters. These wounds were not mentioned in the QAPI report, nor on the care plan.

The facility administration was informed of the

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F 686	Continued From page 120 findings during an end of day briefing on 6-21-18 at approximately 4:00 p.m. The facility did not present any further information about the findings up to the time of exit on 6-27-18. COMPLAINT DEFICIENCY 4. Resident #576 was discharged from the facility, and so the clinical documents were reviewed as a closed record. Resident #576 was admitted to the facility on 10-17-17, and was discharged to the hospital 11-23-17. The Resident did not return. Diagnoses for Resident #576 included but were not limited to; Traumatic spinal cord injury, quadriplegia, dialysis, anemia, and insulin dependant diabetes mellitus. Review of the facility Admission assessment dated 10-17-17, revealed no wounds on admission, and the Resident was assessed as "at risk" of skin breakdown due to immobility. Resident #576's most comprehensive Minimum Data Set (an assessment protocol) was a 14 day assessment, with an Assessment Reference Date of 11-7-17. The MDS coded Resident #576 with no cognitive impairment. The Minimum Data Set further coded Resident #576 as being totally dependent, on 1 staff member for all Activities of Daily Living care (ADL's). The Resident was coded as at risk for skin breakdown, and having currently, 9 acquired wounds, while in the facility. They were; (5) unstageable deep tissue injury areas, and (4) unstageable due to slough or eschar. The Resident was coded as no	F 686		

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F 686	Continued From page 121 behaviors, and no refusals of care. Nursing notes were reviewed and revealed that the 9 wounds were all first identified and found at the same time on 11-6-17 by the wound nurse when the Resident's TED hose (compression stockings were removed. The progress notes document the wound measurements, stages, treatments ordered, and results of one Albumin blood test which was 3.5. The nursing notes documented no refusals of care. The short descriptions of those 9 wounds are as follows; 1. Right lateral heel DTI (deep tissue injury) 6.5 cm (centimeters) x 7.0 cm. 2. Right plantar DTI 4.5 cm x 4.5 cm. 3. Left plantar DTI 5.0 cm x 4.0 cm. 4. Left lateral heel DTI 6.5 x 7.0 5. Left lateral ankle DTI 2.0 cm x 2.5 cm 25% epthelialized, 75% dark non-blanchable intact skin. 6. Left upper shin unstageable 2.0 cm x 3.5 cm, 80% yellow - 10% eschar - 10% non-granulating pink tissue. 7. Left Lateral upper calf 2.0 cm x 3.5 cm 40% yellow slough - 10% eschar - 50% non-granulating. 8. Left posterior calf 1.0 cm x 12.5 cm 75% eschar - 25% non-granulating tissue 9. Coccyx unstageable 100% yellow, with 2 small islands of intact skin in the center. The wound assessment above in the nursing notes goes on to state "upon removal of Ted hose bilateral lower extremities noted with these wounds" listed above, as well as "dry flaky skin." Weekly Skin assessment sheets were reviewed and documented the following;	F 686		

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F 686	Continued From page 122 10-23-17 no wounds. 11-4-17 crease of buttocks not a pressure sore. 11-8-17 wound not a pressure sore no location 11-13-17 sacrum pressure sore. 11-20-17 no wounds ADL documents were reviewed and revealed that after a bath on the afternoon of 11-8-17, the Resident did not receive another bath until 11-16-17 (8 days later). The director of nursing (DON) was asked what standard practice was used for bathing Residents, she stated atleast twice weekly. She was made aware that this Resident only received one bath during the week immediately following 9 wounds being identified on 11-6-17. The care plan was reviewed and revealed no problem areas or interventions for behaviors or refusals of care. The physician's orders were reviewed and revealed no preventative care for skin breakdown ordered for this Resident prior to multiple wound identification. The facility administration was informed of the findings during an end of day briefing on 6-21-18 at approximately 4:00 p.m. The facility did not present any further information about the findings up to the time of exit on 6-27-18.	F 686		
	COMPLAINT DEFICIENCY			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		
	§483.25(d) Accidents. The facility must ensure that -			

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F 689	Continued From page 123 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, closed record review, and in the course of a complaint investigation, the facility staff failed to ensure 2 residents (Resident #477 and #14) of 61 residents in the survey sample was free from accidents. Resident #477 sustained harm after the application of a hot compress resulted in second degree burns and the facility staff failed to ensure the Resident #14's mobility wheel chair was in safe operating condition. 1. Resident #477 sustained second degree burns after a hot compress was applied to his left hand. (A second degree burn is described according to the University of Rochester Medical Center as: the epidermis or top layer of skin appears red, and blistered and my be painful and swollen). 2. For Resident #14, the wheel chair had torn arms, a torn seat, and a torn back rest. Findings included: Resident #477 was admitted to the facility on 6/7/17 with diagnoses that include and were not limited to: Osteomyelitis of the vertebra (infection in the bones of neck), bilateral upper extremities paralysis, Type 2 diabetes, drug abuse, respiratory failure, viral hepatitis C, cystitis (urinary tract infection), urinary retention, and encephalopathy (damage or malfunction of the	F 689	1. Resident #477 no longer resides at the facilty (discharged 11/15/17) Resident # 14 wheel chair was replaced. 2. Residents with orders for warm/hot compresses are at risk for harm for this deficient practice. Residents in wheelchairs are at risk for deficient practice 3. The Clinical Manager or designee will complete a skin assessment on each resident by 7/27/18. LTC Consultants, License Nurse, or designee will educate nursing staff on Scope of Practice of Certified Nursing Assistants and Licensed Nurses will receive training on Scope of Practice of CNA's and appropriate delegation of tasks. All microwaves have reminders to not warm up any medical devices and personal care items . Facility wheelchairs will be examined by maintenance for torn or broken parts by 7/27/18 and any areas of concern identified will be repaired or the wheelchair will be taken out of service. Director of Maintenance or designee will educate facility staff on completion of Maintenance repair request of wheelchair. 4. The administrator, DON or designee will audit rounding tools/observations to assure staff are performing within their scope of practice and resident's needs are being met, 10% of the weekly tallies x 4 weeks, 10% weekly x 2 months. The Director of Maintenance or designee will audit maintenance request for wheelchair repairs to assure the	

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F 689	Continued From page 124 brain). Resident #477 sustained second degree burns to his left hand after CNA #1, under the direction of LPN #2, applied a hot compress to his hand. A care plan for Resident #477 was revised on 11/18/17 which included: Problems: Transfers - Resident #477 is totally dependent on the staff. Goals: Resident #477 will be out-of-bed daily (as tolerated) transfers will be conducted by the staff (transfer boards/lifts) as required. Interventions - Resident #477 to be out of bed in chair PRN (as needed), transfer using the transfer board PRN. Problem: Personal Hygiene - Resident #477 requires assistance. Goal: Resident #477 will have oral hygiene, hair combed, and other personal hygiene needs met daily. Intervention: Complete personal hygiene and encourage patient to complete what he can. Problem: Bathing - Resident #477 is totally dependent on the staff. Goal: Resident #477 will be bathed/showered by the staff over the next 90 days. Interventions: Bathe/shower PRN. Problem: Listing burns to the fifth, fourth, and third fingers. Goals: No complications related to blisters within the next 30 days. Intervention: Apply appropriate treatments as per orders, Assess areas and report and s/s of infection to MD. An Admission MDS 3.0 (Minimum Data Set) assessment for Resident #477 was dated 6/20/2017 which included coded with a BIMS (Brief Interview for Mental Status) score of 15, indicating cognitively intact. Resident #477's ADL (Activities of Daily Living) status was coded as total dependence upon staff for Transfers, and needing extensive assistance for	F 689	the repairs or replacements were completed, 100% x 1 months, 25% x 1 months. Results of these audits will be reviewed for tracking and trending and reported to QAPI monthy x 3 months for input and recommendation 5. Date of compliance: 8/12/18	

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F 689	Continued From page 125 self-performance and assistance of 1 -2 staff for Bed mobility, Dressing, Eating, Toilet use, and Personal hygiene. Resident #477 was documented as being seen by Physical Therapy and Occupational Therapy. Functional Status is coded as limited range of motion, impaired on both sides to his upper and lower extremities. A Quarterly MDS 3.0 assessment was completed for Resident #477 on 9/8/17. ADL coding reflected Resident #477 required extensive assistance for self-performance and assistance from 1 staff member for bed mobility and transfers. Resident #477 was totally dependent for self-performance and assistance of 1 staff member for Dressing, Eating, Toilet use, and Personal Hygiene. Functional Status is coded as "limited range of motion, impaired on both sides to [his] upper extremities". A complaint investigation was conducted regarding the burn sustained by Resident #477. The complaint documented that "the resident complained of pain to his left hand. He requested a warm compress. The CNA [certified nursing assistant] heated a washcloth in the microwave and placed it in a plastic bag and applied it to the resident's [#477] hand. The resident sustained blisters to his left second, third and fifth digits [fingers]. He was sent to the hospital for evaluation and treatment". On 6/21/18 at 1:00 PM a review of the facility document titled Incident Abstract Report related to the burn injury was completed. The report was dated 10/31/17 and documented "Event Description Nursing issues: heating pad protocol, catheter care, personal care," The report asks the question did the deviation reach the patient to	F 689		

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F 689	Continued From page 126 which "Y Yes - Reached Patient" was documented. On 6/21/18 at 16:00 (4:00 PM) a documentation review for Resident #477's emergency room visit which took place on 10/30/17 at 9:25 PM was conducted. The chief complaint was listed as "thermal burn" and pain scale was reported as a "7" (0 = no pain and 10 = the worst pain) and his pain was described as "constant and sharp". The diagnosis listed was "superficial burn of multiple fingers of his left hand excluding thumb." The emergency room nurse documented "Pt [patient] came by rescue [ambulance] from [facility name], pt reports his hand was burnt by putting a towel in the microwave and then in a plastic bag, then it was placed on his hand". On 06/22/18 at 2:11 PM a closed record review for Resident #477 was conducted. A nurse's note written on 10/28/17 at 6:49 AM stated the "resident [#477] complained about pain in his left hand". On 6/22/18 at 2:30 PM a review of the physician's orders noted that there was no order obtained to apply a warm compress to resident #477's hand prior to application. On 6/22/18 at 3:00 PM a nurses note written on 10/30/17 at 4:50 PM documented "Measurements for blisters: Left index finger (second digit) 2.5 cm x 1.7 cm Left middle finger (third digit) 4.7 cm x 4.5 cm Left ring finger (fourth digit) 1.3 cm x 1 cm Left pinky finger (fifth digit) 2 cm x 1.9 cm All blisters are fluid filled and intact. Pain at site. Opsite [dressing/bandage] remains over the blisters".	F 689		

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F 689	Continued From page 127 On 06/25/18 at 09:58 AM a review of Resident #477's clinical record noted he had an office visit on 11/3/17 for a surgical procedure to debride [removal of dead tissue] the burn on his left hand. The physicians note stated Resident #477 has "scant movement of his bilateral hands and fingers. He does have a 1% total body surface area deep partial-thickness burn involving the dorsal aspect of his second, third, fourth and fifth fingers. There is a large bullae [blister] present over each one of these areas that was excised off [removed] with suture scissors, cleansed and Mepilex Ag [dressing] was applied." On 6/25/18 at 1:42 PM an attempt was made to call LPN #2 (licensed practical nurse) who was caring for Resident #477 on the date of the burn injury with a message left. On 6/25/18 at 4:50 PM a telephone interview was conducted with CNA #1 who was caring for Resident #477 on 10/28/17. He stated the LPN #2 "told him to apply heat to Resident #477's left hand". CNA #2 stated he "heated a wet washcloth in the microwave oven for 30 seconds and placed the cloth in a plastic bag", and he "placed a towel on Resident #477's hand". CNA #1 was asked if he had been trained in the use of heat for residents and he stated he had not. When asked what prompted him to apply the hot pack to Resident #477 he stated "the nurse told me to do it, I just do what she tells me to do. I had done it couple of times before." CNA #1 was asked if he was aware that Resident #477 had very limited movement in his upper extremities which made it more difficult for him to move away from the hot washcloth. CNA #1 stated he was aware that Resident #477 has limited movement	F 689		

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F 689	Continued From page 128 in his hands and arms. On 6/26/18 at approximately 1:00 PM a second attempt to call LPN #2 was made and a message was left for her to return the call. No return call were received prior to the end of the survey. On 6/26/18 at 1:51 PM an interview was conducted with RN #1 in regard to LPN #2. RN #1 confirmed that she authored disciplinary action and termination for LPN #2 related to her failure to follow facility policy. When asked specifically what LPN #2 had failed to do RN #1 responded that it "is against policy to put any wet item into the microwave and then apply it to a patient. Only food goes into the microwave". RN #1 further explained that there is a "sticker on the all the microwaves" about what can be put into the microwave. RN #1 confirmed that the warning sticker has been on the microwaves since she "started employment at the facility in August of 2017", 2 months prior to the burn injury to Resident #477. During the same interview RN #1 was asked what actions she would have expected to take place if a warm compress was indicated for a resident. RN #1 responded that the nurse should have notified the physician about what was going on with the resident. RN #1 stated that if an order had been obtained for a warm compress from the physician "we could have gone to the hospital to get a real heat pack instead of a washcloth." RN #1 added that LPN #2 should not have instructed CNA #1 to apply the heat, and that CNA #1 "needed to question anything he is asked to do if he has a concern about being correct or not company policy." RN #1 was asked if the application of heat was within the scope of	F 689		

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F 689	Continued From page 129 practice for a CNA she state no, it is not, the LPN should never have instructed him to do that. On 6/26/18 at 1:55 PM an observation of the microwave ovens behind the nurse's station on Units 1, 3, and 4 noted each had a red sticker prominently placed on the microwave door which measured approximately 4 inched square. The red sticker reads: "Microwave is for heating food and drinks only. Please DO NOT heat any medical supplies in this microwave. Those actions have the potential to burn our patients." On 6/26/18 at 4:02 PM an interview was conducted with PT (physical Therapist) (other staff) #4 about Resident #477's burn. PT #4 was asked if Resident #477 had been assessed for the use of heat as a therapeutic treatment and he stated he "had assessed him as safe for use of the hydroculator [warming machine] pads" used by therapy personnel. PT #4 stated "the temperature in the hydroculator is set to be between 130-140 degrees and the use of 4 layers of towels is standard to protect the resident's skin" from burns. He further stated that the skin under the towels "should be checked within 2 minutes to assess effectiveness" and the patient's skin should be "supervised." PT #4 was asked if nursing had been instructed on how to use the hydroculator warming machine and pads and he said "no." On 6/27/18 at 1:00 PM an interview with the administrator was conducted to review the complaint. She stated that she was unfamiliar with the incident because she was new at the facility.	F 689		

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F 689	Continued From page 130 On 6/27/18 at 4:10 PM an interview was conducted with the DON (Director of Nursing) RN #2. When asked what her expectation of the nursing staff if warm compress was indicated for a resident to which she replied "if someone needs heat we would call the doctor to clarify the order. Now we have disposable hot packs". When asked if staff had been trained on the application of warm compresses she stated the staff has now been in serviced. On 6/28/18 at 2:00 PM a review of Policy # 301a - Employee Conduct Procedure Policy noted: Examples of Critical Violations in part listed "violation of organizational or departmental policy, procedure and/or practice". The facility failed to ensure one resident (#477) of 58 residents in the survey sample was free from accidents which caused harm after the application of a hot compress resulted in second degree burns. COMPLAINT DEFICIENCY	F 689		

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F 689	Continued From page 131 2. Resident #14 was admitted to the facility on 11-27-09. Diagnoses for Resident #14 included but were not limited to; hypertension, hemiplegia, and chronic obstructive pulmonary disease. Resident #14's most recent Minimum Data Set (an assessment protocol) was an annual assessment, with an Assessment Reference Date of 6-8-18. The MDS coded Resident #14 as alert, oriented to person, place, time and situation, with no cognitive impairment, no memory impairment, and no behavior problems. The Minimum Data Set further coded Resident #14 as needing only supervision, or otherwise independent for Activities of Daily Living care. The Resident was coded as at risk for skin breakdown, and currently having no wounds. On initial tour of the facility on 6-19-18 at approximately 11:40 a.m. Resident #14 was interviewed and observed. The Resident was sitting on her bed wiping a small scrape on her arm with a paper napkin. The napkin had a small smear of blood on it. The Resident was asked what happened to her arm, and she complained that she had scratched her arm on the wheel chair because the arm rests were so torn. The surveyor observed the chair which had worn so thin on the seat, that the threads inside the leather covering were exposed and the seat was splitting in the center. The arms were torn as well as the back of the chair. Resident #14 was asked how long the chair had been that way, and she stated she didn't remember, however she stated she had been asking for a new one for about a year (since last summer), and no one would give her one. On 6-20-18 at approximately 4:00 p.m., the	F 689		

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F 689	Continued From page 132 Administrator and Director of Nursing (DON) were made aware of the condition of the wheel chair and asked why the Resident was using an unsafe mobility device. The Administrator stated that the Resident was "Private Pay" and would have to buy her own wheel chair. On 6-21-18 the Administrator stated they had given Resident #14 a wheel chair that was in good repair and safe, and that the Resident stated she liked the new wheel chair. On 6-22-18 the Resident was seen in the wheel chair which appeared to be in good repair and safe. No further information was requested or received.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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	F 690		

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F 690	Continued From page 133 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, facility document review, and closed record review the facility staff failed for one (Resident #477) of 61 residents in the survey sample, to assess, prevent, and treat a penile injury caused by an indwelling catheter which resulted in a 2 cm (centimeter) split to the meatus (opening) of Resident #477's penis resulting in harm. For Resident #477, the facility staff failed to prevent an indwelling Foley catheter related injury. Findings included: Resident #477 was admitted to the facility on 6/7/17 with diagnoses that include and were not limited to: urinary retention, cystitis, osteomyelitis of the vertebra (infection in the bones of neck), bilateral upper extremities paralysis, Type 2 diabetes, drug abuse, respiratory failure, viral hepatitis C, and encephalopathy (damage or	F 690	1. Resident #477 was discharged from the facility on 11/15/17 2. All residents with indwelling catheters are at risk for harm from this deficient practice. 3. Residents with catheters will be assessed for any skin issues or concerns related to indwelling catheter use by Clinical Manager, DON or designee, no other skin issues were identified. Residents with indwelling catheters will have the orders reviewed to ensure appropriate orders are present for the foley catheters, catheter care and anchoring of catheter for any variances identified will be corrected. LTC consultants, Registered Nurse or designee will educate nursing staff on catheter care, maintenance and anchoring of the catheter and prevention of catheter related injuries. 4. The Clinical manager or designee will visually observe, audit and document the indwelling catheter is appropriately ordered and anchored on residents with catheters; 10% weekly x 4 weeks, then 5% monthly x 4 weeks. Results of audits will be reviewed for patterns or trends and reported to QAPI monthly x 3 months for input and guidance. 5. Date of compliance: 8/12/18	

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F 690	Continued From page 134 malfunction of the brain). An Admission MDS 3.0 (Minimum Data Set) assessment for Resident #477 was dated 6/20/2017. The MDS coded Resident #477 with a BIMS (Brief Interview for Mental Status) score of 15, indicating cognitively intact. Resident #477's ADL (Activities of Daily Living) status was coded as total dependence upon staff for Transfers, and needing extensive assistance for self-performance and assistance of 1 -2 staff for Bed mobility, Dressing, Eating, Toilet use, and Personal hygiene. The MDS coded Resident #477 as having an indwelling catheter in his bladder. Resident #477 was documented as being seen by Physical Therapy and Occupational Therapy. Functional Status is coded as limited range of motion, impaired on both sides to his upper and lower extremities. A Quarterly MDS 3.0 assessment was completed for Resident #477 on 9/8/17. ADL coding reflected Resident #477 required extensive assistance for self-performance and assistance from 1 staff member for bed mobility and transfers. Resident #477 was totally dependent for self-performance and assistance of 1 staff member for Dressing, Eating, Toilet use, and Personal Hygiene. Functional Status is coded as limited range of motion, impaired on both sides to his upper extremities. The use of an indwelling catheter was coded on the MDS. A care plan for Resident #477 was revised on 11/18/17 which included: Problems: Transfers - Resident #477 is totally dependent on the staff. Goals: Resident #477 will be out-of-bed daily (as tolerated) transfers will be conducted by the staff (transfer boards/lifts) as required. Interventions -	F 690		

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F 690	Continued From page 135 Resident #477 to be out of bed in chair PRN (as needed), transfer using the transfer board PRN. Problem: Personal Hygiene - Resident #477 requires assistance. Goal: Resident #477 will have oral hygiene, hair combed, and other personal hygiene needs met daily. Intervention: Complete personal hygiene and encourage patient to complete what he can. Problem: Bathing - Resident #477 is totally dependent on the staff. Goal: Resident #477 will be bathed/showered by the staff over the next 90 days. Interventions: Bathe/shower PRN. Problem: At risk for infection related to indwelling catheter. Goal: Resident #477 will remain free of urinary tract infection during period of catheterization. Intervention: Change drainage bag, Clean around catheter with soap and water, keep tubing below level of the bladder and free of kinks and twists, Record output per shift, Report any sign of infection. Problem: Skin opening of head/shaft of penis related to Foley catheter. Goals: Open area decreases in size within 30 days. Interventions: Assess area and report any s/s (signs and symptoms) of infection to MD. Keep skin clean and dry. The care plan prior to the wound included the above information except the penile skin opening. On 06/21/18 at 10:25 AM a review of the closed medical record was conducted. A nurse's note dated 10/23/17 at 12:03 AM documented Resident [#477] "stated he would like to see the nurse practitioner about having his Foley removed he is concerned about long term use complications of penile erosion". A nurse's note written on 10/25/17 at 2:15 PM noted "Resident [#477} is requesting to see his MD and message left at his office and in the MD	F 690		

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F 690	Continued From page 136 book at the station". A Nurse's note dated 10/26/17 at 12:36 PM documented "Dr. [redacted for privacy] saw resident [#477] at approx. 8 am this morning about concerns of penis "tear". MD examined resident and told him the penis was not a tear, there was no trauma. The area beneath the penis he was talking about is caused by prolonged Foley catheter use and since resident has his concerns MD asked for the resident to be seen by urologist. Appointment was made and resident made aware and asked [family member] to be notified and she will meet resident at his appointment". A noted a nurse's notes written on 10/27/17 at 4:31 PM which documented "tear on head of the penis underneath foley catheter. Skin opening r/t [related to] foley cath measuring 0.4cm x 2cm [centimeters]. The doctor was notified, steri strips were applied and the resident was sent to the urologist. On 6/21/18 at 1:00 PM a review of the resident medical record noted a skin sheet dated 10/31/17 documented the penile erosion (split/tear in the head of the penis) measured 2 cm x 2 cm. On 6/21/18 at 3:00 PM Administrative RN #3 was asked about the expectation for staff to use an anchor to secure the Foley catheter tubing to prevent injury she stated "it's already a part of our expected process. This was a performance issue by staff." A physician's order to anchor the Foley catheter was not written until 11/1/17, which was after the injury. On 6/25/18 at approximately 2:00 PM an Incident	F 690		

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F 690	Continued From page 137 Abstract Report was reviewed. The report was dated 10/27/17 and noted "Open area to head / shaft of penis r/t [related to] foley cath. Measuring 0.4cm x 2.8cm x 2cm. Serous sanguineous drainage. No odor. Urology f/u (follow up appointment) on Monday". The primary cause was listed as "Device Related" (Foley catheter). On 6/25/18 at 3:45 PM a phone call was placed to the LPN #3 who first documented the penile injury to Resident #477. LPN #3 is no longer employed by the facility. A message was left for her to return the call. On 06/26/18 at 10:15 AM a record review noted Resident #477 had a urology appointment on 10/30/17. The physicians noted in his progress note "discussion repair of erosion [split penis]". "Further erosion can be prevented by eliminating traction [pulling due to having the tubing not secured i.e. to the leg] on catheter. Catheter must be off traction and loose at all times". On 6/26/18 at 2:00 PM a second attempt to reach LPN #3 by phone regarding the documentation of Resident #477's penile injury. A second message was left with instructions to return the call. No return call was received prior to the end of the survey. On 6/26/18 at 4:10 PM an interview was conducted with the DON (Director of Nursing) Administrative RN #2 about the use of anchoring devices to secure Foley catheter tubing to prevent injury. The DON stated the Foley catheter kit "comes with the anchor in the package, there was no reason it was not applied. I set up a urology appointment the next day.	F 690		

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F 690	Continued From page 138 On 6/26/18 at 4:30 PM the facility procedure for Urinary Catheter, Indwelling (Foley): Inserting in the Adult Male Patient includes: "Secure the catheter and tubing to prevent movement and traction against the urethra [opening at the tip of the penis] that could damage urethral tissue. Typically the catheter is strapped to the patient's inner thigh using a commercial tube holder. Allow for enough slack in the drainage tubing so the patient can move his thighs without pulling the catheter".	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692	1. Resident # 95 care plan was revised to include feeding needs, diet and supplement order on date 7/25/18. Resident #95 received a comprehensive nutrition assessment by the Registered Dietitian on 7/19/18. Speech Therapy completed a ST screen on 7/19/18 to ensure appropriate texture modified diet is prescribed. Resident #95's physician orders were reviewed to ensure all nutrition orders were active. 2. All residents living in facility are at risk of not receiving their complete nutrition related orders and for inaccurate care planning for nutrition 3. Director of Regulatory or designee will educate the RD and Dining Director on diet order accuracy and provision of timely nutritional assessment. EMR Training facilitator or designee to educate facility staff on process of entering and activating physician orders. LTC consultant	

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F 692	Continued From page 139 Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to meet the nutritional needs of one resident (Resident #95) of the 61 residents in the survey sample. For Resident #95, the facility staff failed to provide the ordered diet on 6-19-18, failed to provide the Pro-stat supplement as ordered, provide ongoing nutritional assessments, and failed to revise the care plan with feeding needs, during a significant weight loss. Findings included: Resident #95 was admitted to the facility on 6-30-16. Current diagnoses included; Altered mental status, nutrition deficiency, vitamin D deficiency, and urinary tract infection. The current MDS (Minimum Data Set) was a significant change assessment with an ARD (assessment reference date) of 5-11-18. Staff assessment of mental status coded the Resident with severely impaired cognition. The Resident was coded as having no behaviors, and needing extensive to total assistance of 1-2 staff members for all activities of daily living. he Resident was also coded as needing to be fed. The MDS coded the Resident as having no swallowing disorder, no weight loss, and on a mechanically altered diet, and edentulous (no teeth). The quarterly assessment due for this assessment reference date was changed to a significant change assessment due to "Resident's weight and overall decline", as stated in nursing notes by MDS staff on 5-23-18. On 6-19-18 at approximately 12:00 p.m. during	F 692	or designee will educate the inter-disciplinary team on strategies for person-centered comprehensive care planning. MDS Coordinators will review the resident's care plans for appropriate, person centered and comprehensive interventions and approaches for diet provisions, supplements and feeding needs 4. Dining Director or designee will audit diet orders from Vision (facility EMR) against orders entered in Netimpac (diet office software) to ensure accuracy 25% weekly x 4 weeks, then 10% x 1 month. Clinical Managers, DON or designee will audit resident care plans, diets, supplements and/or feeding needs to ensure comprehensiveness and person centered approaches are included in the care plan, 10% x 1 month then 5% x 1 month. The Director of Regulatory or designee will audit the resident records to assure RD has completed the required assessments timely and accurately 25% x 4 weeks, 10% x 4 weeks. Results of the audits will be reviewed for patterns or trends and reported to QAPI x 3 months for input and guidance. 5. Date of compliance: 8/12/18	

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F 692	Continued From page 140 initial tour of the facility Resident #95 was sitting in a reclined chair, in the dining area of the south unit with a meal tray in front of her and she was staring at the food, which was an untouched pureed diet. A staff member was asked if the Resident would feed herself, and she replied, "I don't know, but I will help her", and she began to feed the Resident. On 2-9-18 the Resident went out to the hospital after a fall and laceration to the head which was repaired in the emergency room, and the Resident was readmitted to the facility the same day. The Resident had a wet cough and refused to eat throughout the next 24 hours and was again sent to the emergency room. The Resident returned on 2-15-18 (5 days later) and was given a pureed diet and was being fed. On 2-15-18 The Resident had a "Pre-Albumin" blood test, and the result was low at 13 (malnutrition). Normal range is 15-36, and the Resident was diagnosed with "under weight, inadequate caloric intake, at risk of further weight loss, weight loss 6.8% in less than 30 days. No further nutrition assessment occurred until 3 months later on 5-14-18 and the Resident had lost 9.8% of her weight by 3-13-18. On 2-18-18 a Speech therapy consult was ordered by the physician, and was begun on 2-20-18. The consult states "No recent weight loss." On 2-25-18 the Resident's weight had dropped 8 lbs (pounds) since the 2-1-18 weight, and on 2-26-18 the doctor ordered "Pro-stat AWC 17 grams- 100 kcal (calories) per 30 ml (milliliters) liquid for nutritional deficiency one time daily.	F 692		

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F 692	Continued From page 141 On 2-27-18 The physician changed the pro-stat order to increase it to three times per day, as documented in the physician progress notes, instead of once per day. That order was never instituted, and the Resident remained on Pro-stat once per day through the time of survey. The diet order was also changed this day and was "Mechanical soft ground with thin liquids." The Resident's weights were documented in the facility for 2018 as follows; 1-2-18 120 lbs 2-1-18 120.20 lbs 2-25-18 112 lbs 3-1-18 110 3-13-18 108.2 3-20-18 108 3-29-18 108.2 4-2-18 108.2 5-4-18 109.4 6-7-18 108.5 The Resident's current care plan was reviewed, and even though many areas in the clinical record including nursing notes, the MDS, and speech therapy notes indicated the Resident needed to be fed by staff, the care plan still documented an intervention that the resident would feed herself. The care plan also documented the intervention of supplements per doctor's orders would be administered, which also did not happen, as Pro-stat was only given once per day and not three times per day as had been ordered. The Resident was ordered to have a mechanical ground diet with honey thickened liquids, and was observed consuming a pureed diet at lunch on 6-19-18 during initial tour of the facility. No	F 692		

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F 692	Continued From page 142 nutrition evaluation was completed from 2-26-18, until 5-14-18 (approx 3 months later) and the Resident had already experienced a 9.8% weight loss between 2-1-18 and 3-13-18. (approx 6 weeks). On 6-21-18 at the end of day debrief at 4:00 p.m.The Director of Nursing, and Administrator were made aware of the issues, and asked to bring any information available to explain the lack of services provided for this Resident. No further information was supplied by the time of exit on 6-28-18.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interview the facility staff failed to provide one resident (Resident #103) with Respiratory care in accordance with professional standards of practice and the person centered care plan, in the survey sample of 61 residents. The findings included: Resident #103 was admitted to the facility on 10/31/14 with diagnoses which included	F 695	1. The Respiratory Therapist caring for Resident # 103 on 4/10/18 was educated on providing physician prescribed orders for oxygen for transport to off-site appointment on 7/20/18 by Respiratory Manager Respiratory Manager educated and communicated with transport company regarding the transport safety check list requirement on 7/20/18. 2. Residents receiving orders for oxygen that are transported out to appointments are at risk for harm by this deficient practice 3. A Medical Transport Checklist for transfer Care of Ventilated patients was developed. The Respiratory Manager or designee will educate Respiratory Therapist and facility staff on the appropriate use of Medical Transport CheckList for Transfer of Ventilated Patients form; communcate with transport company and educate the family and the RT on oxygen requirement for residents transporting to off-site appointment	

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F 695	Continued From page 143 hypertension, GERD, hemiplegia, Chronic Respiratory Failure, Tracheostomy, Gastrostomy Status, Pneumothorax, seizures, and CVA. The facility staff failed to provide Respiratory care and services in accordance with the residents care needs. A re-entry Minimum Data Set (MDS) dated 2/19/18 for Resident #103 indicated this resident is not able to communicate with speech. This resident is not able to make self understood or understand others. In the area of Cognitive Patterns for daily decision making this resident is assessed as being severely impaired. In the area of Activities of Daily Living (ADL) this resident is assessed as being totally dependent on staff. In the area of Special Treatments, Procedures, and Programs -Respiratory Treatment- this resident was assessed for receiving oxygen therapy, suctioning and tracheostomy care. A Care Plan dated 5/30/18 indicated: Problem- Resident is at risk for ineffective airway clearance due to tracheostomy as a result of acute respiratory failure. Intervention- Provide humidified oxygen to maintain O2 (oxygen) level as ordered. Assess for evidence of respiratory distress, trachypnea, nasal flaring and increased use of accessory muscles. Assess for changes in mental status; lethargy, confusion, restlessness and irritability. Provide humidified oxygen to maintain FiO2 at 28%. A Physician's order indicated: oxygen orders per protocol continuous. Tracheal Suctioning PRN and chronic trach collar with humidification to keep O2 saturations greater than 95%, Therapeutic Range: Pulse Oximetry Every shift due to demonstrated unstable oxygen saturation	F 695	4. Respiratory Manager or designee will audit resident records fo ventilated resident records for transport safety check list completion 2x weekly x 4 weeks then weekly x 4 weeks. Results will be analyzed for patterns and trends and reported to QAPI x 3 months for input and guidance. 5. Date of compliance: 8/12/18	

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F 695	Continued From page 144 levels. During a family interview on 6/19/18 at 4:30 P.M. Resident #103's sister indicated: "On April 10, 2018 her sister was sent out on a doctors appointment and didn't have an oxygen taken with her. The sister stated, upon arrival to the appointment she noticed her sister not breathing well and gasping for air. She stated, she asked the transportation driver where was her oxygen tank and why didn't they bring her oxygen? The family member stated, the driver informed her that the Respiratory Therapist (RT) stated, she did not need it because she was going around the corner for her doctors appointment." During an interview on 6/27/18 at 10:15 A.M. with the Respiratory Therapist he stated. Resident #103 was sent out to a doctors appointment on 4/10/18 without her oxygen. The Respiratory Therapist stated, transportation came and transported the resident out before he could put her on oxygen. When asked was it the facilities responsibility to ensure that Resident #103 was prepared to go on her doctors visit, he stated, "Yes". An appointment Scheduling form dated 4/10/18- Time: 3:15 P.M. Indicated: "Resident #103 Had an appointment a a local hospital for Podiatry care (swollen left big toe)." During an interview on 6/26/18 at 2:15 P.M. with the Respiratory Therapy Manager, she stated, Resident #103 was sent out to an appointment without her oxygen on 4/10/18. The Respiratory Therapy Manager stated as a result of the incident a Medical Transport Checklist for Transfer Care of Ventilated Patients was	F 695		

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F 695	Continued From page 145 developed. The check off list included the following guide lines: "1. Paramedic verifies o2 tank is greater than 1500 PSI is attached to ventilator on/before arrival to unit. 2200 psi if o2 if patient greater than 50% Fio2 (fraction of inspired oxygen). 2. Paramedic verifies that suction is set -up/functioning in ambulance. (Ask them) 3. Paramedic requests Respiratory Therapist (RT) to bedside upon transport's arrival unless RT already present, for verbal hand-off of ventilator settings and any other significant patient information. Trach size_____ Back ups given_____ . 5. Transport team places patient on Cardiac Monitor / Spo2 (saturated percentage of oxygen) monitor." The facility staff failed to provide Resident #103 with physician's ordered respiratory care (oxygen).	F 695		
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, and clinical record review the facility staff failed to provide pain management for 1 resident (Resident # 5) in the survey sample of 61 Residents.	F 697	1. Resident #5 was provided scheduled pain medication on 5/10/18 2. All residents receiving pain medication are identified as at risk for not receiving services that are consistent with professional standards of practice, comprehensive person-centered care and the resident's goals and preferences 3. Manager of Education or designee will educate licensed nurses on standards of practice governing pain management, to include hard scripts for narcotics, reordering medications timely, stat box utilization and administering other PRN	

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F 697	Continued From page 146 For Resident # 5 facility staff failed to provide pain management according to physician's orders. The finding included: Resident #5 a 66 yr. old female was admitted on 1/25/17 with diagnoses of but not limited to anemia, CAD (coronary artery disease), hypertension (high blood pressure), CVA (stroke), and depression and psychotic disorder. Resident # 5's most recent MDS (Minimum Data Set) was coded as an annual an ARD (assessment reference date) of 6/4/18. She was coded as having a BIMS (Basic Interview of Mental Status) score of 15, indicating no cognitive impairment. She was coded as needing physical assistance of 1 staff member for activities of daily living as well as being always incontinent of bowel and bladder as well as being totally dependent on staff for bathing. She was coded as being at risk for pressure ulcers however she was also coded as having no open areas or pressure ulcer On 6/22/18 at 1030 AM a review of Resident #5's clinical record was conducted it was found that Resident #5 had a physician's order for pain management. Resident #5 was to receive the scheduled pain medication, Oxycodone (narcotic pain medication) 5 mg (milligram) 1 tablet 3 times per day The MAR (Medication Administration Record) for May 2018 was reviewed and revealed the resident was not administered 12 consecutive doses of the scheduled narcotic pain medication. The notes on the MAR state the reason as "medication not available" as well as "awaiting hard script from MD".	F 697	pain medications for assistance with pain management. 4. Clinical Manager, DON or designee will complete a Pain Management Audit to assure schedule and/or PRN medication are administered as ordered and pain assessments are complete timely and accurately per physician order 25% x 4 weeks then 10% x 4 weeks. Results of these audits will be reviewed for patterns and/or trends and reported to QAPI monthly x 3 months for input and guidance. 5. Date of Compliance: 8/12/18	

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F 697	Continued From page 147 The MAR also showed that the Resident had PRN (as needed) orders for Tylenol as well as Ibuprofen that could have been utilized for pain however were not signed off as given or as offered and refused. Interview on 6/26/18 at 9:30 AM resident stated she receives pain medicine because her knees hurt every time she moves or is turned in the bed. " I have arthritis all over my other joints too, its painful business that arthritis". On 6/26/18 and interview with the DON (director of nursing) who stated " During the time the medication was not given the doctor had been contacted by the staff and had not yet sent over the hard script [paper prescription] which is why she missed the medication". She further stated it is the expectation of the nurses that they utilize the stat box to pull meds from if the patient does not have them in their drawer. She also stated the nurses should have continued to call the physician for the prescription. She went on to say if there is no more of a particular drug in the stat box they could use the stat box on another units and fax the pharmacy to refill the stat box. Administration notified on 6/26/18 at 2:45 p.m. and no further information was given.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		

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F 698	Continued From page 148 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 record review and staff interview the facility staff failed to provide on communication with the dialysis facility for one resident (Resident #110) in the survey sample of 61 residents. The findings included: Resident #110 was admitted to the facility on 3/13/18 with diagnosis of colon cancer, failure to thrive, type two diabetes, depression, end stage renal disease and anemia. The facility staff failed to have ongoing communication with the dialysis facility regarding dialysis care and services. A Quarterly Minimum Data Set (MDS) dated 3/13/18 assessed this resident in the area of Hearing, Speech and Vision as having highly impaired Vision. In the area of Cognitive Patterns this resident was assessed as having a Brief Interview for Mental Status (BIMS) score of 15. In the areas of Activities of Daily Living (ADL) this resident was assessed as requiring limited assist of one person for bed mobility, not able to walk in room, eats with supervision of set-up and one person assist, requires extensive assistance with one person for person hygiene. In the area of Special Treatments, Procedures and Programs this resident was assessed as receiving dialysis services. A Care Plan dated 6/12/18 indicated: Dialysis Monday, Wednesday, and Friday. Interventions- allow to verbalize feelings of disease process. provide for assist with adls and comfort measures	F 698	1. Resident # 110 dialysis notes from March 19, 2018 to July 20, 2018 were obtained from dialysis center. 2. All residents receiving dialysis living in facility have the potenital for harm of this deficient practice. 3. Registered Nurse or designee will educate facility nursing staff and dialysis center staff on continuity of care communication between dialysis center and facility to include pre and post dialysis form completion. The dialysis center entered orders in dialysis center in dialysis EMR to send dialysis flow sheets with resident post dialysis to assure communication of care between dialysis center and facility. 4. The clinical manager or designee will complete audit of all dialysis flow sheets to assure continuity and completeness of communication between facility and dialysis center 100% weekly x 4 weeks, weekly x 1 month. Results of audits will be reviewed for patterns and trending and reported to QAPI monthly x 3 months for input and guidance. 5. Date of Compliance: 8/12/18	

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F 698	Continued From page 149 as needed. Physician's orders dated June 2018 indicated: Dialysis Monday, Wednesday, and Friday. A review of the facility's leave of absence flow sheet indicated this resident went out to dialysis 30 times from 3/19/18 until 6/25/18. A review of the Hemodialysis Communication form for this resident documented on communication with the dialysis facility on 6/20/18, 5/14/18, 5/11/18, 5/9/18, 5/2/18, and 4/25/18. During an interview on 6/27/18 at 11:45 A.M. with the Director of Nursing (DON) she stated, the facility and dialysis center do not always communicate. A facility Dialysis Care policy indicated: Policy: The facility will provide patients and residents who require renal dialysis services that are consistent with professional standards of practice. Procedures: This agreement will address at least: Interchange of information necessary for the resident's care. Facility staff failed to provide on ongoing communication with the dialysis facility.	F 698		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first	F 712		

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F 712	Continued From page 150 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observations, clinical record review, staff and resident interview, the facility staff failed to ensure 1 of 61 residents (Resident #107) in the survey sample were seen by a physician, nurse practitioner or physician assistant every 60 days with 10 day grace period. Resident #107 was not seen every 60 days with 10 day grace period by the physician, nurse practitioner or physician assistant per mandate. Specifically, there was a 5 month gap between physician visits from 9/14/17 to 2/13/18. The findings include: Resident #107 was admitted to the nursing facility on 2/12/15 with diagnoses that included multiple sclerosis, contractures and neurogenic bladder.	F 712	1. Resident #107 changed physican providers on 2/1/18 and has received monthly visits (totalling 19 visits) from physician providers as of 7/20/18. 2. All residents are at risk for this deficient practice under the care of this provider 3. Communication to physician providers regarding timeliness of visits was communicated by the facility medical director. Medical records staff completed an audit on timeliness of physican visits 7/16/18 and any variances identified will be corrected and physicians re-education. Senior Medical Director and Director of Operations met with resident # 107 physician regarding regulation and standards of practice governing visit frequency. Medical Records Clerk audits timeliness of physician visits and validates if resident has a certification or recertification assessements prior to submission of MDS 4. Resident medical records clerk will audit 2 per x 1 month, then 1x per month. Results of these audits will be reviewed for patterns and/or trends and reported to QAPI x 3 monthsfor input or guidance 5. Date of compliance: 8/12/18	

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F 712	Continued From page 151 The most recent Minimum Data Set (MDS) assessment was a quarterly dated 5/25/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was cognitively intact for the skills in daily decision making. An interview was conducted with Resident #107 on 6/25/18 at 10:30 a.m. She stated she was not being seen by the pervious attending physician on a routine basis at least every 60 days. She stated she changed physicians in February 2018. Upon review of the clinical record from to change of physician on 2/13/18, it was validated that Resident #107 was not seen by a physician or designee every 60 days: -1/19/17 -4/27/17 -6/29/17 -9/14/17 -2/13/18 (new physician) On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). They stated the delay in conducting all visits by the previous attending physician caused the facility to change to another physician group, but the attending physician that failed to conduct Resident #107's visits still sees other Residents in the facility. They stated there were no audits conducted to evaluate all residents in the facility for delay in visits with possible unmet care and services issues. No further information was provided prior to exit. COMPLAINT DEFICIENCY	F 712		

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interview, and facility documentation review, the facility failed to ensure sufficient staff was in place to provide nursing and related services to maintain the highest practicable physical, mental and psychosocial well-being for 4 of 61 residents (Resident #124, #23, #118 and #5) in the survey sample.	F 725	1. Resident # 124 and #23 have received incontinent care. Staff identified in the survey report have been counseled re-educated on the importance of providing timely care. Staff have been meeting frequently with Resident # 118 regarding her physical therapy appointments outside of the facility and she has been offered to have staff accompany her to those appointments. Bathing schedule for Resident # 5 has been discussed with the resident and a bathing schedule has been established that meets the resident's preferences. 2. All residents may have potentially been at risk. 3. The corporate leadership team and the facility leadership team are examining staffing models and are monitoring to ensure sufficient are scheduled and assigned to care for all of the residents. Shift assignments are being monitored by the administrator and/or DON to ensure there are sufficient staffing to care for all residents and care is being taken to ensure that staff are deployed according to resident needs. The facility made changes within "Staffing Coordinator" position effective	

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F 725	Continued From page 153 1. Resident #124 was not provided timely incontinence care due to insufficient staffing on the 3 pm-11 p.m. shift on 6/25/18. She was left soiled and cold for 2.5 hours before she was able to receive incontinence care. 2. Resident #23 was not provided timely incontinence care due to insufficient staff on the 3 p.m.-11p.m. shift on 6/25/18. She was left up in her wheel chair soiled for 5.5 hours. The next shift (11 p.m.-7 a.m.) placed her in bed and provided incontinence care at 12:20 p.m. 3. The facility staff failed to assure there was sufficient staff to accompany Resident #118 to pre-planned Physical Therapy (PT) appointments on 6/7/18, 6/14/18, 6/19/18 and 6/22/18. 4. For resident # 5 facility failed to provide sufficient staff to provide care. The findings include: 1. Resident #124 was admitted to the nursing facility on 10/20/14 with diagnoses that included high blood pressure, diabetes mellitus, paralytic syndrome and history of falling. Resident #124's most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/1/18 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the skills need for daily decision making. The resident was not assessed to have any mood or behavioral problems. Resident #124 was coded totally dependent on two staff for	F 725	7/18/18 for greater accountability to ensure that staff are being utilized and deployed appropriately. Additional tools are being implemented to assist with monitoring "call-offs" effective 7/27/18 and the adminstrative team held staff meetings on 7/18/18 to instill a sense of renewed responsibility, expectation, and accountability for work habits including the attendance policy. The corporate leadership team has interfaced with Human Resources and several key areas have been accomplished including: waiver to remove the BSN requirement was obtained 7/9/18 and will be in effect unitl the end of the year; financial incentives for recruitment and relocation were implemented 7/20/18; plans for increased and targeted digital advertising including social media are being re-designed to increase awareness of new opportunities and benefits; direct mailing to RNs within local zip codes and increased awareness through event advertising in local newpaper is being designed for approval by the leadership team. In addition, community events with participation of key leadership representatives including corporate representatives, adminstrators, physicians, etc., are being planned to promote a sense of culture change within the organization and a renewed focus on quality of care	

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F 725	Continued From page 154 transfers, bed mobility and personal hygiene. She was assessed totally dependent on one staff for toilet use and bathing. The resident was impaired on both sides of lower extremities and one side upper extremity. She required stabilization from staff for all surface to surface transfers. The resident was coded as non-ambulatory and used a wheelchair as her primary mobility device. She was able to fully understand staff and was fully understood. The resident was assessed as frequently incontinent of bladder and had a colostomy. The resident was not coded to resist care to include ADL assistance. The care plan dated 6/12/18 indicated Resident #124 was identified with ADL care needs to be provided by staff and some ADLs with supervision, was at risk for falls and would receive the necessary assistance for bladder incontinence. The goals set for the resident by the staff was that the resident would maintain the highest level of psychosocial well-being, transfer with assist without falls and was dependent on staff with assistance for in and out of bed transfers via mechanical lift. Some of the interventions to implement these goals included anticipate her needs, always use mechanical lift with two staff for all transfers and monitor for incontinence, provide hygiene after voiding with mild soap and water, change pads and briefs as needed, as well as check for areas of redness related to urinary incontinence. On 6/26/18 at 10:10 a.m., Resident #124 stated she sat in urine over 5.5 hours waiting to be cleaned up and put to bed on the evening shift (3-11) 6/25/18. She stated she told the Certified Nursing Assistant (CNA) staff around 7:00 p.m.,	F 725	and life for residents and staff. Enhanced training is being provided to ensure that not only does the facility have sufficient staff, but that they sufficient staff who are qualified and competent to provide the care needed. In addition, the organization has engaged outside consultants to work collaboratively with the team at Sentara Norfolk. A seasoned, well respected licensed interim administrator was engaged with start date of 7/23/18. A long-term care consulting company composed of experienced RNs and a licensed nursing home administrators were engaged effective 6/26/18 to offer additional support, resources and guidance to the facility and corporate team. 4. The administrator and DON will monitor the established staffing schedule to ensure that sufficient staff are assigned and deployed to meet the needs of the facility. The facility leadership team will review open positions, recruitment / retention efforts, and trends in "call-offs" weekly and report to the corporate leadership team. A report on staffing will be provided to the QAPI Committee for additional oversight and monitoring 5. Date of Compliance: 8/12/18	

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F 725	Continued From page 155 and was told there was not enough staff to put her to bed and clean her up. She said she was not placed back to bed and provided incontinence care until 12:20 a.m. of the next shift (6/26/18). The resident added, " I was so hurt because I wearing a designer dress my son gave me and it was ruined sitting in urine. I took it to the activities department to use their washer because I was afraid of the the industrial machines for general wash. I told them to throw away the Hoyer (brand name for mechanical lift pad) pad in the incinerator because it was saturated with urine." On 6/26/18 at 12:30 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #8 who was the staffing scheduler. She stated the CNA that was scheduled for the 3-11 shift on Unit 1 was supposed to work a double which would have been 7-3 and 3-11, but did not show up for the 7-3 shift and thus she did not show up for the 3-11 shift. The LPN stated that left 2 CNAs instead of the required 3 CNAs to provide care and assistance to bed for 45 patients. The LPN was not able to explain why an earlier initiative was not taken to find coverage when the CNA did not show up for the first scheduled 7-3 shift. She stated the licensed nurses can help, but usually are busy passing medications or performing treatments. On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit. The facility's policy titled Staffing-Nursing dated 6/29/17 indicated sufficient nursing staff will be	F 725		

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F 725	Continued From page 156 employed on a twenty-four hour basis to ensure that nursing and related services are provided to enable each resident to attain or maintain his/her highest practicable physical, mental and psychosocial well-being, as determined by assessments and individual plans of care. Sufficient staff will be employed to ensure direct care needs are met. 2. Resident #23 was admitted to the nursing facility on 8/21/13 with diagnoses that included diabetes mellitus, high blood pressure and major depressive disorder. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/15/18 and coded the resident with a score of 15 out of a possible score of 15 which indicated Resident #23 had intact cognitive skills for daily decision making. The resident was not assessed to refuse care to include ADL assistance. The resident was assessed to require extensive assistance from one staff for dressing and was totally dependent on one staff for toilet use and bathing. The care plan dated 6/20/18 indicated Resident #23 had a left ankle fracture with boot in place, was at risk for falls, and that she required assistance from staff for activities of daily living (ADL) needs to include dressing, personal hygiene, bathing and toileting. The goal set for the resident by the staff was that she would be free from further injuries, she would receive assistance from staff to meet all ADL needs. Some of the interventions the staff would use to accomplish these goals included assist as needed for transfers, monitor for incontinence and change briefs and pads as needed, as well as provide hygiene after voiding and bowel	F 725		

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F 725	Continued From page 157 movements to prevent skin breakdown and clean and dry skin if wet or soiled. On 6/26/18 at 10:40 a.m., Resident #23 stated on the 3/11 shift at 9:00 p.m. she was set up to have the routine personal care and the Certified Nursing Assistant (CNA) and told by the CNA that she would return at 9:30 p.m. The resident stated she was in bed and had completed some of her peri-care and as per her routine the CNA would return 30 minutes later to wash her buttocks and apply a new brief and bed pad. She stated she called around 9:30 p.m. when the CNA did not return and again at 10:30 p.m. She said she was re-soiled herself, was cold and had stuffed the clean towel between her legs to absorb the urine. The Call Bell Response log verified the call times as stated by the resident. According to the resident, the CNA returned around 11:15 p.m. and finished the ADL care. The resident stated this was not an isolated event and it happens frequently. She said she reports these occurrences to the Director of Nursing (DON), Unit Manager and or the Administrator. On 6/26/18 at 12:30 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #8 who was the staffing scheduler. She stated the CNA that was scheduled for the 3-11 shift on Unit 1 was supposed to work a double which would have been 7-3 and 3-11, but did not show up for the 7-3 shift and thus she did not show up for the 3-11 shift. The LPN stated that left 2 CNAs instead of the required 3 CNAs to provide care and assistance to bed for 45 patients. The LPN was not able to explain why an earlier initiative was not taken to find coverage when the CNA did not show up for the first scheduled 7-3 shift. She stated the licensed nurses can help,	F 725		

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F 725	Continued From page 158 but usually are busy passing medications or performing treatments. On 6/28/18 at 3:35 p.m., the aforementioned issues were shared with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit. 3. Resident #118 was originally admitted to the facility 8/10/16. The admission diagnoses included Parkinson's disease, Major Depressive disorder, Unspecified Psychosis, an anxiety disorder, and an Adjustment disorder with mixed Disturbance of emotions and conduct. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #118's cognitive abilities for daily decision making were intact. In section "D" (Mood), the resident was coded for feeling downed, depressed and hopeless and in section "E" (Behaviors), the resident was coded for exhibiting physical and verbal behaviors directed towards others 1-3 days each week. The resident was also coded indicating the behaviors didn't put the resident at risk for illness/injury, not significantly interfering with resident care, activities or social interactions, and the resident was coded to indicate the behaviors didn't put others at significant risk for physical injury or as causing disruption to the living environment. The resident was also coded for	F 725		

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F 725	Continued From page 159 rejection of care 1-3 days each week. In section "G" (Physical functioning), the resident was coded as requiring supervision of 1 person with wheelchair locomotion, limited assistance with transfers, extensive assistance of 1 person with bed mobility, personal hygiene, dressing and toileting and total care with bathing. The clinical record revealed Resident #118 had a physician's order dated 4/3/18, for physical therapy (PT) services; heat therapy to the left posterior shoulder, for muscle pain; limiting range of motion. Resident #118 stated during an interview on 6/20/18, at approximately 10:30 a.m., that she was told by the facility physical therapist they saw no improvement in her and they couldn't help her therefore; the Neurologist recommended she see a community based physical therapist. The resident further stated, during the initial visit approximately 4/26/18, her needs were assessed and the therapist developed a treatment plan and a schedule of future appointments. The appointments were later changed to Tuesdays and Thursdays at 10:00 a.m. A copy of the scheduled appointments were sent to the nursing facility and the Unit Secretary arranged transportation for travel to and from the community based PT office. Resident #118 stated facility staff accompanied her to the initial appointment and no one informed her that was not the plan for future PT appointments. The resident also stated she frequently reminded staff she preferred and required 2 staff during care and 1-2 staff for non activities of daily living. Resident #118 stated the facility staff was aware	F 725		

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F 725	Continued From page 160	F 725		

she has only 3 relatives locally and they are unable to accompany her to appointments because her daughter is visually impaired and requires assistance and her 2 granddaughters have commitments to their jobs and families. She stated on one occasion her sister traveled from South Carolina to accompany her on an appointment. The resident further stated because of her family's obligations and inability to aide her with needed services she elected to remain in the nursing facility.

During the 6/20/18 interview at approximately 10:30 a.m., Resident #118 stated, the first official day of therapy was 6/5/18. The resident stated she got ready for the appointment, went to the nurse's station and was told by the Unit secretary and the information was confirmed by the Unit Manager that the Administrator and Director of Nursing stated said she was to go alone to the appointment because she had no cognitive deficits or other limitations preventing her from going unaccompanied. The resident then, stated the Assistant Administrator told her "go ahead and try going by yourself".

The resident stated, she was reluctant but left the facility without facility staff accompanying her, she arrived to the PT office, the driver assisted her inside, she had therapy, the office staff called the transport company to pick her up and she asked the office staff to sit her outside the office so the transport driver could see her upon arrival. Resident #118 stated she waited approximately 20-30 minutes outside the PT office but; the transport company didn't arrive therefore; she used her cell phone to call the nursing facility and alerted them that the transport company hadn't returned to transport her back to the nursing

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F 725	Continued From page 161 facility. Resident #118 stated the nursing facility staff told her to calm down because she couldn't understand what she was saying, then the nurse stated (name of resident), the transport company says you have already been picked up". Resident #118 stated she asked the Unit Secretary each Monday and Wednesday after the 6/5/18 event, "who would be accompanying me" to the community PT office on Tuesday and Thursday; if the Unit Secretary stated no one, she stated she told her to cancel the appointment because she felt unsafe going unaccompanied. An interview was conducted with the Unit Secretary 6/20/18 at approximately 11:15 a.m. The Unit Secretary stated prior to 6/5/18 she accompanied Resident #118 to appointments in the community if family was unable to attend. The Unit Secretary stated she didn't work 6/5/18 and there was no one to accompany the resident to the appointment therefore she was sent alone. The Unit Secretary stated she was told the resident returned to the facility 6/5/18 crying and upset. A nurses's note dated 6/14/18 read; Resident scheduled to go out for therapy today. She refused to go because a staff member is unable to accompany her. She is alert and oriented with a BIMS score of 15. This resident makes all her needs known. She is her own responsible party. (name of resident) is able to self maneuver herself in her wheelchair. Staff offered to get her ready for this appointment but she still refused to go". An interview was conducted with Licensed Practical Nurse (LPN) #5 on 6/22/18 at	F 725		

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F 725	Continued From page 162 approximately 1:10 p.m. LPN #5 stated she was aware it was Resident #118's preference for a staff member to accompany her on appointments in the community and she was aware on 6/5/18, Resident #118 returned to the facility upset because the transportation driver didn't pick the resident up until approximately 2 hours after transport was called to return the resident back to the facility. LPN #5 stated she informed the resident that hand to hand transport; (transportation driver takes the resident inside the office and picks the resident up inside the office) was requested on her behalf therefore what occurred on 6/5/18, should not happen again, but the resident stated she would not go again unless she was accompanied because she didn't feel safe. LPN #5 stated she kept the Administrator and Director of Nursing informed of the resident's preference to be accompanied by a staff member and of each episode of refusal to attend appointments when there wasn't a staff member to accompany her. LPN #5 stated the Administrator and Director of Nursing stated each time Resident #118 was alert, oriented, had a BIMS score of 15 and a cell phone therefore; capable of going unaccompanied. On 6/25/18 at approximately 11:30 a.m., the Unit secretary provided the surveyor with the appointment scheduling forms for Resident #118's past community PT appointment; some of the forms had a note written across the top that stated, "canceled appointment due to resident's request". The Unit Secretary stated the resident canceled the appointments because staff was not available to accompany her and it was the resident's preference to have an escort. The facility didn't have a policy for determining a	F 725		

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F 725	Continued From page 163 resident's needs for community appointments but a document was drafted 6/25/18 explaining their process. The document was titled (Name of Facility) Social worker's Outlined Process for Appointments. It read; at Bullet #3, The Unit securities also discuss the coordination with families and resident's to ensure communication and coordination is agreed upon by both family designee and or resident. Bullet #4 read; If the resident is a Long Term Care resident the Unit Securities will schedule appointments with specialized providers and will set transportation based on transportation needs. Bullet #5 read; as a courtesy, resident is reviewed by nursing for mobility and BIMS to see if a need for additional assistance at appointments. Bullet #6 read; If assistance at appointments is needed, family or caregivers are contacted first and then if needed, staff may attend the appointment with the resident which usually is the unit security or designee. Bullet #7 Social Worker staff also support staff with reaching out to family designee and or resident to discuss barriers with transportation. On 6/28/18 at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing, Director of Operations, 2 visiting Administrators and the Dietitian. An opportunity was given to the facility staff to provide additional information but; none was presented. 4. Resident #5 a 66 yr. old female was admitted on 1/25/17 with diagnoses of but not limited to anemia, CAD (coronary artery disease), hypertension (high blood pressure), CVA (stroke),	F 725		

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F 725	Continued From page 164 and depression and psychotic disorder. Resident # 5's most recent MDS (Minimum Data Set) was coded as an annual an ARD (assessment reference date) of 6/4/18. She was coded as having a BIMS (Basic Interview of Mental Status) score of 15, indicating no cognitive impairment. She was coded as needing physical assistance of 1 staff member for activities of daily living as well as being always incontinent of bowel and bladder as well as being totally dependent on staff for bathing. She was coded as being at risk for pressure ulcers however she was also coded as having no open areas or pressure ulcers. . On 6/20/18 a review of resident clinical record was conducted and it was noted that Resident #5 did not get bathed on 6/15/18 it was noted on the TAR (treatment administration record) that Resident did not get bathed due to "Insufficient Staffing". On 6/22/18 at 9:45 AM (licensed practical nurse) LPN #4 was contacted via telephone and an interview was conducted with LPN #4 about her documentation of "Insufficient Staffing" for reason Resident #5 did not get bathed. LPN #4 stated that she correctly documented the events and the resident had not been bathed because the 3-11 staff was short that day and so when she arrived at work at 11:00 PM Residents still were not touched that is they had not been changed or put to bed yet. LPN #4 stated the 11-7 shift was short by 2 (certified nursing assistants) CNA's and that they all had to immediately start changing Residents and putting them to bed. She further elaborated	F 725		

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F 725	Continued From page 165 saying "We had only 2 CNA's and an orientee however the orientee cannot take her own assignment because she is just learning so the nurses had to help Even with all of us helping everyone was not in bed until around 2:00AM or 3:00 AM." LPN #4 stated "We are supposed to have 4 CNA's we are happy if we have 3 but we should have 4. When there is only 2 it is just too much for anyone to do 20 + residents each. It started getting bad in March around the 17th and its steadily getting worse. People are leaving or being let go" Review of staffing sheet and staff punch reports reveal the LPN's statement was accurate they should have had 4 CNA's and only had 2 CNA's working on the 15th of June. On 6/26/18 at 10:30 AM DON (director of nursing) was interviewed about staffing and she presented the punch reports and the staffing schedule and stated that they did have call outs on the evening and night shifts on that date. Administration was made aware and no further information was provided. COMPLIANT DEFICIENCY	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726		

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F 726	Continued From page 166 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and facility documentation review the facility staff failed to ensure license nurses received the necessary training to be competent in the assessment of a hemodialysis resident and to access skin integrity problems and the facility's Skin Dyad Program's appropriate pressure ulcer protocols. 1. The facility staff failed to communicate an ongoing assessment with the dialysis center who	F 726	1. Licensed Nurse caring for resident # 110 on 6/25/18 was educated on bruit and thrill and was able to return competency to Team Coordinator of Resource Pool. Physician orders were entered into the medical record for the assessment of bruit and thrill for resident #110 on 3/14/18. Resident #18 had a skin assessment completed and is being followed by facility wound physician for impaired skin integrity. Care Plans for Resident #110 and #18 have been revised to reflect current care. 2. Although no residents experienced actual harm, residents who received dialysis are at risk from this deficient practice. Resident are at risk impaired skin integrity. 100% audits of current residents on dialysis has been completed to ensure that orders are present to monitor Bruit and Thrill as appropriate. Skin Assessments have been conducted on current residents for impaired skin integrity, orders will be reviewed for appropriateness of treatment 3. Registered Nurse or designee will validate licensed nurse competency of dialysis assessment to include bruit and thrill. Nursing Staff will be educated on facility process for communicating with dialysis center. LTC consultants, WOCN, Wound Treatment Associates and/or designees will educate and validate competency of licensed staff on identification, assessement, treatment	

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F 726	Continued From page 167 attended an outpatient dialysis three days per week every Monday, Wednesday and Friday. 2. The facility staff failed to ensure licensed nurses were competent to assess skin integrity problems and implement the facility's Skin Dyad Program's appropriate pressure ulcer protocols. The findings included: 1. Resident #110 was admitted to the facility on 3/13/18. Diagnosis included but not limited to End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week every Monday, Wednesday and Friday. *Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week. The current Minimum Data Set (MDS) an Admission Assessment with an Assessment Reference Date (ARD) of 03/20/18 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The MDS coded Resident #110 requiring extensive assistance of two with bed mobility, extensive assistance of one with toilet use, personal hygiene and bathing. In addition, under section (O) for Special Treatments, Procedures and Programs was coded for dialysis. Resident #110's comprehensive care plan indicated resident requires dialysis. The goals	F 726	documentation, and monitoring of skin conditions. Nursing Staff will be educated on prevention of impaired skin integrity. STARs (Sentara Tracking and Reporting System - online reporting) reports will be reviewed in morning meeting to identify new areas of impaired skin integrity and new wounds will be reviewed by the interdisciplinary team during the weekly Standards of Care meeting. 4. Manager of Education or designee will audit retention of bruit and thrill competency on 3 Licensed Nurses weekly x 4 weeks and 1 Licensed Nurse monthly x 1 month. WOCN or designee will complete 2 wound treatment observations weekly x 4 weeks to ensure treatments are carried out in a manner consistent with the order and to promote wound healing and that the assessment of the wound is accurately documented. Variances observed during treatment observation will be investigated and feedback provided to the responsible staff member; corrections will be made as needed. Findings from these audits will be presented to QAPI for review and recommendation. 5. Date of Compliance: 8/12/18	

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F 726	Continued From page 168	F 726		

the facility staff set for the resident is to have no complications or infected access site of the next 90 days. Some of the interventions included but not limited to resident right AVF monitor for *Bruit and *Thrill every shift to left upper extremity, monitor resident for increased complications from dialysis - report abnormal finding to MD.

*Bruit is listening for adequate bruit with a stethoscope. A continuous low pitched bruit should be present (www.laminatemedical.com/assessment-and-monitoring-of-av-fistulas-for-new-dialysis).

*Thrill - Check the pulse in your access arm. You should feel blood rushing through that feels like a vibration. This vibration is called a "thrill."(Source: https://medlineplus.gov/ency/patientinstructions/000705.htm)

Resident #110's physician orders contained the following order: May attend outside dialysis on Monday, Wednesday and Saturday.

An interview was conducted with License Practical Nurse (LPN) #6 on 6/25/18 at approximately 10:10 a.m. The surveyor asked, "How do you check for Bruit and Thrill on a dialysis patient." The LPN stated, "You touch for bruit and should hear a flush sound and for thrill - I have to and read up on that one again, I usually have to Google to make sure I'm doing the right thing. On the same day at approximately 6/25/18 at 2:10 p.m., the LPN stated, "After I came to my senses; you feel for the trill and listen with the stethoscope for the bruit."

An interview was conducted with the Cooperate Staffing Development Coordinator on 06/25/18 at

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F 726	Continued From page 169 approximately 11:40 a.m., who stated, "I recognized from the other building there was a problem with the assessment of dialysis residents- we incorporated interventions in the other building but have not in this building. We will be bringing the same training to this building. On 06/25/18, the surveyor was given a Staff Development Attendance Record for Dialysis dated 04/26/18. The facilities objective of session read in part: All staff will be familiar with care management of a resident on dialysis. The review of the attendance record revealed that LPN #6 attended the meeting. On 06/25/18 at approximately 3:00 p.m., the Cooperate Staffing Development Coordinator stated, "If I had taught the dialysis in-service they would have done a return demonstration to make sure they know how to properly access a dialysis patient shunt site. An interview was conducted with Director of Nursing (DON) on 6/27/18 at 9:30 a.m., who stated, "If you have to Google it, then you don't know it and that worries me." The facility's policy titled Life Care - Dialysis - Guidelines of Care (Revision 1/22/18). -Policy statement: The facility will provide patients and residents who require renal dialysis services that are consistent with professional standards of practice. 2. On 6/25/18 at 11:30 a.m., the Corporate Staff	F 726		

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F 726	Continued From page 170 Development Coordinator (CSDC) presented the facility's Skin Dyad Program which indicated all licensed nurses received the training 11/21/2016, 11/7/2017 and as recently as 6/8/18. During new hire orientation, licensed nurses received training on the Skin Dyad Program during the day 3 review. She stated The skin Dyad Program included the following: -Pressure injury prevention -Guidelines for skin integrity (discipline specific) -Pressure injury (PI) Stage 1-4 -Unstageable PI and Deep Tissue Injury (DTI) -MASD (Moisture Associated Skin Damage) and skin tears -Venous, arterial, and neuropathic ulcers -Unavoidable pressure injuries -Process improvement The facility's Skin Dyad Protocol training objectives included the following: -Recall pressure injury characteristics and staging based on such characteristics -Recall types and characteristics on non-pressure injury wounds -Verbalize how to assess, measure, and document a wound assessment -Understand the facility's Skin Protocols and which to implement based on wound assessment -Differentiate between intended use of wound care products -Recall appropriate dressing change technique -Verbalize interventions for pressure injury prevention On 12/5/17, Resident #18 was re-admitted to the nursing facility Resident #18 was readmitted to the nursing facility on 12/5/17 with an *unstageable sacral pressure ulcer. The facility staff failed to accurately assess and initiate an effective pressure ulcer treatment protocol,	F 726		

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F 726	Continued From page 171 instead the ulcer was assessed as a *Stage I. In addition the facility staff failed to assess the wound every 7 days per facility protocol until 13 days later at which time the wound had progressively worsened and ultimately led to wound management by a specialized wound care physician. *Category/ Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). *Category/ Stage I is Pressure Injury: Non-blanchable erythema of intact skin (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org). On 6/28/18 at 12:10 p.m., an interview was conducted with the licensed nurse (LPN #6) that completed the re-admission nursing assessment for Resident #18 on 12/5/17. She stated she had received training on the Skin Dyad Program and knew the difference between a Stage I and unstageable, but stated it was late when the resident was admitted and she may not have performed her best assessment, and implemented Stage I pressure ulcer protocol.	F 726		

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F 726	Continued From page 172 She also stated, "You know sometimes training is only as good as the trainer around here." On 6/28/18 at 3:35 p.m., the aforementioned issues were re-shared during a debriefing with the Administrator, Director of Operations and Director of Nursing (DON). No further information was provided prior to exit.	F 726		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on a information obtained during a complaint investigation, resident, staff and family interviews, and review of the clinical record, the facility staff failed to ensure residents who displays or has a history of a mental disorder and trauma receives the care and services necessary to reach and maintain the highest level of mental and psychosocial functioning for 1 of 61 residents (Resident #118), in the survey sample. The facility staff failed to acknowledge, assess, develop and implement a person centered plan for the underlying cause of displayed expressions of distress exhibited by Resident	F 742	1. Facility notified Resident #118 phyician of resident refusing therapy on 6/28/18 as indicated in clinical record. Resident #118 care plan was revised to include need for behavioral/companion support to and from off site appointments. The resident was seen by a LCSW until May 2018 when resident declined to schedule additional or follow-up appointments. Since that time and before the resident was visited for emotional support and to discuss customer service on multiple occasions by the LNHA, the assistant administrator, social workers and the chaplain. Resident #118 also requested a physician provider change in June 2018. Since that time the resident has been seen by the new provider 2-3 x per month. 2. All residents who need companion and support for transfer to offsite appointments are identified at risk by this deficient practice. 3. The Director of Patient Care Services the Chaplain, the Administrator, the Assistant Administrator, Social Workers and the	

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F 742	Continued From page 173 #118 on 6/5/18 and 6/12/18, and to ensure Resident #118 received appropriate, individualized treatment, services and assistance to meet her needs during community physical therapy appointments; which resulted in a decline in her psychosocial well-being. The findings included; Resident #118 was originally admitted to the facility 8/10/16. The admission diagnoses included Parkinson's disease, Major Depressive disorder, Unspecified Psychosis, an anxiety disorder, and an Adjustment disorder with mixed Disturbance of emotions and conduct. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #118's cognitive abilities for daily decision making were intact. In section "D" (Mood), the resident was coded for feeling downed, depressed and hopeless and in section "E" (Behaviors), the resident was coded for exhibiting physical and verbal behaviors directed towards others 1-3 days each week. The resident was also coded indicating the behaviors didn't put the resident at risk for illness/injury, not significantly interfering with resident care, activities or social interactions, and the resident was coded to indicate the behaviors didn't put others at significant risk for physical injury or as causing disruption to the living environment. The resident was also coded for rejection of care 1-3 days each week.	F 742	Clinical Manager visit/round with the resident minimally weekly to discuss customer service and provide emotional support. The IDT will meet to discuss a plan of care on 7/31/18. The facility staff have been accompanying the resident on offsite appointments. A STARs report will be completed on any reported issues and addressed as appropriate until resolution. 4. The Administrator / DON or designee will review the STARs report weekly x 1 month for psychosocial concerns. Concerns will be tracked and trended for commonalities and reported to QAPI for additional recommendations and/or guidance. 5. Date of Compliance: 8/12/18	

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F 742	Continued From page 174 In section "G" (Physical functioning), the resident was coded as requiring supervision of 1 person with wheelchair locomotion, limited assistance with transfers, extensive assistance of 1 person with bed mobility, personal hygiene, dressing and toileting and total care with bathing. A facility reported incident which occurred 2/3/17, revealed Resident #118 had a history which included an allegation of sexually assault by a certified nursing assistant during peril-care therefore; a plan of care was developed to have a second staff member accompany the assigned caregiver during provision of care and the resident agreed to counseling services. The clinical record contained progress notes revealing Resident #118, was receiving psychological services for 1 hour each week from 1/2/18 through 3/5/18. The 3/5/18 progress note stated the resident would be seen next week but no further visits were made with the resident. An interview was conducted with the Administrator 6/19/18, at approximately 1:30 p.m. The Administrator disclosed the Licensed Clinical Social Worker (LCSW), providing the therapy no longer practiced in the nursing facility and the Resident #118's services had not been assigned to another practitioner. The LCSW progress notes stated the therapist was working with Resident #118 on the following targeted symptoms; helplessness, interpersonal problems, marital/family problems, nervousness, worry, stress, anxiety, grief, loss issues, hopelessness, irritability, pain, paranoia, suspiciousness and negative thinking. The Resident's top targeted symptoms were; anxiety, suspiciousness and unusual thought content. Her	F 742		

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F 742	Continued From page 175 mood was described as worried, helpless, anxious, worthless and irritable and her insight was described as limited. The clinical record revealed Resident #118 had a physician's order dated 4/3/18, for physical therapy (PT) services; heat therapy to the left posterior shoulder, for muscle pain, limiting range of motion. The clinical record also revealed Resident #118 missed community PT appointments; 6/7/18, 6/14/18, 6/19/18 and 6/22/18, because facility staff was not available to accompany her. The resident's person centered care plan dated 6/5/18; had a problem titled locomotion on/off the unit (name of resident) requires assistance. The goal read; (name of resident) will participate in unit activities/social interactions 3-5 times per week over the next 90 days, 9/1/18. The interventions read; Assist (name of resident) to desired location. (name of resident) requires wheel chair and staff assistance. Another person centered care plan problem read; (name of resident) has a diagnosis of an anxiety disorder. The goal read; Periods of distress/anxiety will be reduced over the next 90 days, 9/1/18. The interventions included; Assess and record behaviors. Assess need for "as needed" antianxiety medication if interventions do not relieve anxiety. Conduct 1:1 visits with (name of resident). Help (name of resident) identify specific thoughts/ideas that cause anxiety. Reassure (name of resident) during distress/anxiousness. Speak in a calm voice. Validate feelings.	F 742		

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F 742	Continued From page 176 The resident also had a person centered care plan problem which read; Behavioral symptoms; (name of resident) has verbal and physical behavioral symptoms directed at others. The goal read the number of verbal incidents will be decreased over the next 90 days, 9/1/18. The interventions included; Encourage caregivers to participate in activities with (name of resident) to promote positive interactions. Gently remind (name of resident) screaming/cursing is not appropriate. Record behaviors on the Behavior Tracking form. Monitor pattern or behavior (time of day, precipitating factors, specific staff or situations). Respond in a calm voice, maintain eye contact, Remove from area if (name of resident) is verbally and physically abusive to others. Talk with family and friends to identify potential sources/reasons. Conduct 1:1 sessions with (name of resident), encourage resident to verbalize feelings in an appropriate manner and provide realistic feedback. Review of the Care Plan confirmed that the facility staff had not developed an individualized care plan that addressed Resident 118's anxieties surrounding attending community appointments unaccompanied. Resident #118 stated during an interview on 6/20/18, at approximately 10:30 a.m., that she was told by the facility physical therapist they saw no improvement in her and they couldn't help her therefore; the Neurologist recommended she see a community based physical therapist. The resident further stated, during the initial visit approximately 4/26/18, her needs were assessed and the therapist developed a treatment plan and a schedule of future appointments. The appointments were later changed to Tuesdays	F 742		

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F 742	Continued From page 177 and Thursdays at 10:00 a.m. A copy of the scheduled appointments were sent to the nursing facility and the Unit Secretary arranged transportation for travel to and from the community based PT office. Resident #118 stated facility staff accompanied her to the initial appointment and no one informed her that was not the plan for future PT appointments. The resident also stated she frequently reminded staff she preferred and required 2 staff during care and 1-2 staff for non activities of daily living. Resident #118 stated the facility staff was aware she has only 3 relatives locally and they are unable to accompany her to appointments because her daughter is visually impaired and requires assistance and her 2 granddaughters have commitments to their jobs and families. She stated on one occasion her sister traveled from South Carolina to accompany her on an appointment. The resident further stated because of her family's obligations and inability to aide her with needed services she elected to remain in the nursing facility. During the 6/20/18 interview at approximately 10:30 a.m., Resident #118 stated, the first official day of therapy was 6/5/18. The resident stated she got ready for the appointment, went to the nurse's station and was told by the Unit secretary and the information was confirmed by the Unit Manager that the Administrator and Director of Nursing stated said she was to go alone to the appointment because she had no cognitive deficits or other limitations preventing her from going unaccompanied. The resident then, stated the Assistant Administrator told her "go ahead and try going by yourself".	F 742		

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	495173	A. BUILDING _____ B. WING _____	C 06/28/2018

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F 742	Continued From page 178 The resident stated, she was reluctant but left the facility without facility staff accompanying her, she arrived to the PT office, the driver assisted her inside, she had therapy, the office staff called the transport company to pick her up and she asked the office staff to sit her outside the office so the transport driver could see her upon arrival. Resident #118 stated she waited approximately 20-30 minutes outside the PT office but; the transport company didn't arrive therefore; she used her cell phone to call the nursing facility and alerted them that the transport company hadn't returned to transport her back to the nursing facility. Resident #118 stated the nursing facility staff told her to calm down because she couldn't understand what she was saying, then the nurse stated (name of resident), the transport company says you have already been picked up". Resident #118 stated, she became very upset, began crying and thought she needed to go back inside the office but; she was unable to self propel herself back inside the PT office therefore; she asked a male stranger, passing by to assist her back into the office. The resident explained if there are no rails she is unable to pull the wheelchair along and the wheelchair just goes around in circles. The resident also stated, upon returning inside the office, she informed the office staff she had been outside waiting but the transport company had not come. The resident stated the office staff said, "The van didn't pick you up!" and proceeded to telephone the transport company again, after approximately 25 more minutes the transport van still had not arrived therefore; the PT office staff telephoned the nursing facility and inform them the resident was still at the PT office because the transport company hadn't returned to transport her back to	F 742		

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F 742	Continued From page 179 the facility. Resident #118 stated, approximately 2 1/2 hours after her therapy session ended the transport company arrived to transport her back to the nursing facility. The resident stated she was still very upset and continued to cry on the van and an individual told her to stop crying for she was now safe and on her way home. Resident #118 also stated during the 6/20/18, interview that on 6/12/18, she got ready to go to the PT office for therapy, the Unit secretary accompanied her to the transport van, watched her get belted in but didn't enter the van so she asked the transport driver what time will you return to pick me up. The resident stated, the transport driver answered "I can't give you a time", and she began crying, swinging her arms and yelling, I'm not going, get me out of here, I'm not going by myself to be left and told I've been picked up. I'm afraid to go alone, not knowing when I will picked up, disabled and confined to this wheelchair, that not safe". Resident #118 stated the transport driver unbelted her and she was assisted back into the nursing facility. Resident #118 stated she asked the Unit Secretary each Monday and Wednesday after the 6/5/18 event, who would be accompanying her to the community PT office on Tuesday and Thursday; if the Unit Secretary stated no one, she stated she told her to cancel the appointment because she felt unsafe going unaccompanied. An interview was conducted with the Unit Secretary 6/20/18 at approximately 11:15 a.m. The Unit Secretary stated prior to 6/5/18 she accompanied Resident #118 to appointments in	F 742		

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F 742	Continued From page 180 the community if family was unable to attend. The Unit Secretary stated she didn't work 6/5/18 and there was no one to accompany the resident to the appointment therefore she was sent alone. The Unit Secretary stated she was told the resident returned to the facility 6/5/18 crying and upset. A nurses's note dated 6/14/18 read; Resident scheduled to go out for therapy today. She refused to go because a staff member is unable to accompany her. She is alert and oriented with a BIMS score of 15. This resident makes all her needs known. She is her own responsible party. (name of resident) is able to self maneuver herself in her wheelchair. Staff offered to get her ready for this appointment but she still refused to go". An interview was conducted with Licensed Practical Nurse (LPN) #5 on 6/22/18 at approximately 1:10 p.m. LPN #5 stated she was aware it was Resident #118's preference for a staff member to accompany her on appointments in the community and she was aware on 6/5/18, Resident #118 returned to the facility upset because the transportation driver didn't pick the resident up until approximately 2 hours after transport was called to return the resident back to the facility. LPN #5 stated she informed the resident that hand to hand transport; (transportation driver takes the resident inside the office and picks the resident up inside the office) was requested on her behalf therefore what occurred on 6/5/18, should not happen again, but the resident stated she would not go again unless she was accompanied because she didn't feel safe. LPN #5 stated she kept the Administrator and Director of Nursing informed of the resident's	F 742		

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F 742	Continued From page 181 preference to be accompanied by a staff member and of each episode of refusal to attend appointments when there wasn't a staff member to accompany her. LPN #5 stated the Administrator and Director of Nursing stated each time Resident #118 was alert, oriented, had a BIMS score of 15 and a cellphone therefore; capable of going unaccompanied. LPN #5 was asked during the 6/22/18 interview at approximately 1:10 p.m., if she or the Interdisciplinary Team (IDT) had addressed Resident #118 displayed behaviors (crying, swinging her arms, yelling and demanding to get off the transport van) regarding attending community appointments unaccompanied, after the 6/5/18 and 6/12/18 events. The response was "no". LPN #5 was also asked if the resident's Social Worker, Mental Health Counselor or physician had been notified about the resident's voiced fears, exhibited behaviors and frequent refusal to keep appointments if not accompanied by staff member. The response was "no". LPN #5 was asked if a care plan had been developed to address Resident #118's new problem of fear to leave the facility unaccompanied had been documented so the staff could consistently implement the interventions and the IDT could evaluate the interventions to ensure the resident's needs are met. The response was "I'm not sure". During an interview with the social workers on 6/24/18 at approximately 3:20 p.m. The social workers stated they hadn't been notified Resident #118 had voiced fears and displayed behaviors	F 742		

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F 742	Continued From page 182 regarding attending community appointments unaccompanied by staff. The social workers stated they would immediately follow-up with the resident and get back with the surveyor. The following day 6/25/18 at approximately 12:30 p.m., the social worker presented a progress note documenting her conversation with Resident #118. The document stated the resident explained what occurred 6/5/18 and how the social worker would attempt to obtain volunteers to accompany the resident to future appointments. The progress note stated the resident didn't express fear during the ordeal and the it didn't state the social addressed the behaviors displayed by the resident 6/5/18, 6/12/18 and thereafter by refusing to attend appointments unaccompanied. An interview was conducted with the PT office Operations Coordinator on 6/25/18 at approximately 10:25 a.m. The Operations Coordinator stated, Resident #118 arrived to the office at approximately 9:30 a.m. accompanied by the transportation drive only, on 6/5/18, the therapy session concluded at approximately 10:45 a.m., the resident was assisted to the lobby and the transport company was telephoned by the PT office staff. The Operations Coordinator further stated, the resident asked to be assisted outside the office to wait for the transport van and the staff did, after approximately 20 minutes the resident returned inside the PT office stating the transportation van had not come therefore; the PT staff again called the transport company and the resident continued to wait in the lobby. The Operations Coordinator stated after another 20 minutes the nursing facility was telephone and the Operations Coordinator spoke with an individual who identified themselves as a supervisor but,	F 742		

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F 742	Continued From page 183	F 742		

the Operations Coordinator couldn't recall the supervisor's name. The Operations Coordinator stated the nursing facility supervisor stated the resident had been picked up and the PT staff informed the nursing facility supervisor the resident was still at the PT office, crying and upset. The Office Coordinator stated the PT office has limited staff and they are not equipped to provide care for the client after the therapy session ends.

An interview was conducted with the Administrator 6/27/18 at approximately 1:55 p.m. The Administrator stated the facility had no formal assessment to determine who can go to a community appointment unaccompanied but she felt a resident with a BIMS of 15, capable of making sound decisions, can do a lot for herself as well as maneuver the wheelchair, and has a cell phone, can travel into the community unaccompanied. The Administrator further stated the appointments they did send staff with the resident was solely "common courtesy" and not based upon resident needs. The Administrator also stated she never understood what the resident meant when she frequently stated she was to have at least 2 persons with her.

The Administrator didn't consider the resident's mental disorders or previous traumatic event the resident considered sexual assault or the intervention instituted after the alleged sexual assault event. Neither did the Administration consider that the psychological counseling was discontinued abruptly and the indicators of increased anxiety, fear and more trauma was not acknowledged, assessed, and care planned.

The facility didn't have a policy for determining a

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F 742	Continued From page 184 resident's needs for community appointments but a document was drafted 6/25/18 explaining their process. The document was titled (Name of Facility) Social worker's Outlined Process for Appointments. It read; at Bullet #3, The Unit securities also discuss the coordination with families and resident's to ensure communication and coordination is agreed upon by both family designee and or resident. Bullet #4 read; If the resident is a Long Term Care resident the Unit Securities will schedule appointments with specialized providers and will set transportation based on transportation needs. Bullet #5 read; as a courtesy, resident is reviewed by nursing for mobility and BIMS to see if a need for additional assistance at appointments. Bullet #6 read; If assistance at appointments is needed, family or caregivers are contacted first and then if needed, staff may attend the appointment with the resident which usually is the unit security or designee. Bullet #7 Social Worker staff also support staff with reaching out to family designee and or resident to discuss barriers with transportation. On 6/28/18 at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing, Director of Operations, 2 visiting Administrators and the Dietitian. The Administrator stated she didn't feel the facility was responsible for a resident because transportation didn't pick her up when she thought they should have. The facility staff provided a staff member to accompany Resident #118 to community PT appointments during the last week of this survey, after it had been brought to their attention by the surveyor that the resident was refusing	F 742		

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F 742	Continued From page 185 appointments because the facility felt she should go unaccompanied. The Administrator stated again the resident was accompanied because of "common courtesy".	F 742		
F 755 SS=E	Complaint deficiency 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	F 755	1. Resident # 72 laxative medication for constipation was ordered and received on 6/15/18 and the care plan was updated to include constipation. Resident # 5 narcotics were ordered and received on 5/10/18. 2. Residents with potential for pain requiring narcotics for pain relief are at risk for this deficient practice. Residents with the potential for constipation are at risk. 3. House Audit of residents with constipation receiving laxative and residents receiving narcotics for pain to ensure medication is currently at facility and is available for residents will be completed by August 3, 2018. License Nurses will be educated on by pharmacy or designee regarding procedure / process for re-ordering medication not available and initiating contact with medical provider 3 days prior to last available dose and escalating to nursing leadership and/or medical director when physician fails to fax a hard-script as prescribed within 24 hours of request.	

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F 755	Continued From page 186 §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 Resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure medications were available for administration for two Residents (Resident #72, & #5) of the 61 residents in the survey sample. 1. For Resident #72 the facility staff failed to administer Magnesium Citrate as requested and ordered on 6-14-18. 2. The facility failed to provide Resident #5, with twelve consecutive doses of a scheduled narcotic pain medication. The findings included; 1. Resident #72 was admitted to the facility on 7-17-15. Diagnoses for Resident #72 included but were not limited to; Traumatic Brain Injury, constipation, and quadriplegia. Resident #72's most recent Minimum Data Set (an assessment protocol) was a quarterly assessment, with an Assessment Reference Date of 5-3-18. The MDS coded Resident #72 as alert, oriented to person, place, time and situation, with no cognitive impairment. The Minimum Data Set further coded Resident #72 as being totally dependent, on 1-2 staff members for all Activities of Daily Living care. On initial tour of the facility on 6-19-18 at	F 755	4. DON or designee will monitor residents with narcotic pain medication and/or laxative orders to assure of medication availability 25% x 1 months, 1and 5% x 1 month. Results of audits will be analyzed for patterns and trends and reported to QAPI x 3 months for input and guidance. 5. Date of Compliance: 8/12/18	

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F 755	Continued From page 187	F 755		

approximately 11:30 a.m. Resident #72 was interviewed and observed. The Resident was laying on a "Clinitron Bed" which is a specialty skin pressure removal bed used for individuals with skin breakdown from pressure. The Resident was asked if he had eaten his lunch, and he stated he had an upset stomach, and had no appetite. He was asked if this happened often, and he stated no, but for the last week he had not felt well because of constipation. He was asked if he was given medication for that problem, and he stated that staff had a hard time getting it for him, and he had to suffer and wait days sometimes to get the medicine.

A review of Resident #72's clinical record was conducted during the survey. The review revealed current physician orders for "Magnesium Citrate oral solution one bottle one time daily starting 6-14-18." The Medication Administration Record (MAR) was reviewed and revealed a medication note documented by a nurse stating "medication is unavailable, not administered, will be delivered 6-15-18."

Nursing progress notes were reviewed and revealed the medication was given 6-15-18.

The current care plan "starting 5-8-18" was reviewed and revealed no care plan for constipation.

The facility administration was informed of the findings during an end of day briefing on 6-21-18 at approximately 4:00 p.m. The facility did not present any further information about the findings up to the time of exit on 6-28-18.

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F 755	Continued From page 188 2. Resident #5 was admitted on 1/25/17 with diagnoses of but not limited to anemia, CAD (coronary artery disease), hypertension (high blood pressure, CVA (stroke), depression and psychotic disorder. Resident # 5's most recent MDS (Minimum Data Set) was coded as an annual an ARD (assessment reference date) of 6/4/18. She was coded as having a BIMS (Basic Interview of Mental Status) score of 15, indicating no cognitive impairment. She was coded as needing physical assistance of 1 staff member for activities of daily living as well as being always incontinent of bowel and bladder as well as being totally dependent on staff for bathing. On 6/21/18 a clinical record review was conducted and it was found that for the month of May 2018 the (Medication Administration Record) MAR was missing documentation of administration for 12 doses of routinely scheduled narcotic pain medication. The order read Oxycodone (a narcotic pain medication) 5 (mg) Milligram tablets - Give 1 tablet 3 times per day. The following dates and times the medication was not administered according to the MAR. 5/6/18 at 6:00 AM 5/6/18 at 2:00 PM 5/6/20 at 9:00 PM 5/7/18 at 6:00 AM 5/7/18 at 2:00 PM 5/7/18 at 9:00 PM 5/8/18 at 6:00 AM 5/8/18 at 2:00 PM	F 755		

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F 755	Continued From page 189 5/8/18 at 9:00 PM 5/9/18 at 6:00 AM 5/9/18 at 2:00 PM 5/9/18 at 9:00 PM The following notes were added the the last page of the MAR each time a dose was missed. Note to MAR 5/6/18 at 6:00 AM- Not administered-NIS [not in stock] Note to MAR 5/6/18/at 2:00 PM - Not Administered not available needs new script Note to MAR 5/6/18 at 9:00 PM - Not administered not available MD made aware Note to MAR 5/7/18 at 6:00 AM - Not available MD made aware Note to MAR 5/7/18 at 2:00 PM - Not administered awaiting hard script Note to MAR 5/7/18 at 9:00 PM - Not administered Note to MAR 5/8/18 at 6:00 AM - L/M [left message] with MD that resident needs hard script -not administered Note to MAR 5/8/18 at 2:00 PM - Not administered awaiting pharmacy delivery. Note to MAR 5/8/18 at 9:00 PM - NIS [not in stock] - awaiting hard script from MD Note to MAR 5/9/18 at 6:00 AM - Not available awaiting hard script from MD Note to MAR 5/9/18 at 2:00 PM - Not administered awaiting pharmacy delivery Note to MAR 5/9/18 at 9:00 PM - Medication not avail not administered. On 6/26/18 and interview with the DON (director of nursing) who stated " During the time the medication was not given the doctor had been contacted by the staff and had not yet sent over the hard script [paper prescription] which is why	F 755		

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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 755	Continued From page 190 she missed the medication". She further stated it is the expectation of the nurses that they utilize the stat box to pull meds from if the patient does not have them in their drawer. She also stated the nurses should have continued to call the physician for the prescription. She went on to say if there is no more of a particular drug in the stat box they could use the stat box on another units and fax the pharmacy to refill the stat box. Administration was notified on 6/26/18 at 2:45 PM and no further information was provided.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		

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	495173	A. BUILDING _____ B. WING _____	C 06/28/2018

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F 758	Continued From page 191 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to attempt gradual dose reductions of psychoactive medications for two residents (Resident #63 and 118) in the survey sample of 61 resident. 1. For Resident #63, the facility staff failed to attempt gradual dose reductions or document why gradual dose reductions are not indicated for ordered doses of Seroquel. 2. For Resident #118, the facility staff failed to	F 758	1. Resident #63 and #118 received gradual dose reduction (GDR) by pharmacy recommendation on 2/7/18 for resident # 118 and 5/31/18 for resident # 63. 2. Any resident receiving PRN psychotropic medication has the potential to be affected by this deficient practice 3. Pharmacy representative or designee will provide education to license nursing staff, and providers regarding the regulations, and standards of practice around use of PRN psychotropic medication and GDR. The pharmacy representative will continue review resident's receiving PRN psychotropics monthly and PRN and offering recommendations to Physician for consideration. 4. DON or designee will review 5% x 4 weeks of all resident medical records receiving PRN psychotropics to ensure that providers are following guidelines for renewing psychotropic medications within the 14 day time frame and GDRs. Results wil be reviewed for trends and patterns and reported to QAPI for 3 months for review and recommendation 5. Date of compliance: 8/12/18	

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F 758	Continued From page 192 attempt gradual dose reductions or document why gradual dose reductions were not indicated for ordered doses of Seroquel and Duloxetine; and to not prescribe "as needed" Xanax for greater than 14 days without documenting the rationale and duration of use in the medical record. The findings included: 1. Resident #63 was admitted to the facility on 1/15/18 with diagnoses of dementia without behavioral disturbance, epilepsy disorienting, anxiety and anemia. The facility staff failed to provide a Gradual Dose Reduction (GDR) for psychotropic medications for Resident #63. Resident #63 had Quarterly Minimum Data Set (MDS) May 15, 2018 which assessed this resident as not able to make self understood and does note understand others. In the area of vision this resident was assessed as being highly impaired. In the area of Cognitive Skills for daily Decision Making this resident was assessed as being severely impaired. In the area of Activities of Daily Living (ADL) this resident was assessed as being totally dependent of staff in areas of daily living. This resident was not assessed in the area of medications for documented GDR. A Care Plan dated 5/8/18 indicated: Antipsychotic medication- Interventions- Monitor for side effects (insomnia, agitation, nervousness, dizziness, rash, Tardive dyskinesia, hypertension, drowsiness, anxiety, tachycardia, leg pain, upper respiratory infection, metabolic syndrome, weight gain, increased blood sugar. Monthly review by Registered Pharmacist.	F 758		

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F 758	Continued From page 193 A facility Monthly Antipsychotic Report dated May 2018 indicated: Name-Resident #63 - Drug - Seroquel - Diagnosis-Anxiety disorder- Start Date- 1/15/18 - Last GDR Request- 5/31/18. A physician's order dated June 2018 indicated: " Quetiapine 25 mg tablet (2 tablets) . Frequency- two times daily starting 1/15/18." A Consultant Pharmacist Communication to Physician dated 5/31/18 indicated: Antipsychotic Gradual Dose Reduction. Drug Seroquel (Quetiapine) 50 mg BID - Last GDR -None (Seroquel was started on 1/15/18. last GDR request: None. Diagnosis: Anxiety. A facility policy for Psychotropic Medications indicated: "Gradual Dose Reduction-must be attempted in tow separate quarters within the first year of initiation of an agent. with at least a month in between attempts. unless clinically contraindicated." During an interview on 6/27/18 at 11:00 A.M. with the Director of Nursing (DON) she stated, " Gradual Dose Reductions had been performed for Resident #63. The facility staff failed to attempt a GDR for the psychoactive medication. 2. Resident #118 was originally admitted to the facility 8/10/16. The admission diagnoses included Parkinson's disease, Major Depressive disorder, Unspecified Psychosis, an anxiety	F 758		

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F 758	Continued From page 194 disorder, and an Adjustment disorder with mixed Disturbance of emotions and conduct. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #118's cognitive abilities for daily decision making were intact. In section "D" (Mood), the resident was coded for feeling downed, depressed and hopeless and in section "E" (Behaviors), the resident was coded for exhibiting physical and verbal behaviors directed towards others 1-3 days each week. The resident was also coded indicating the behaviors didn't put the resident at risk for illness/injury, not significantly interfering with resident care, activities or social interactions, and the resident was coded to indicate the behaviors didn't put others at significant risk for physical injury or as causing disruption to the living environment. The resident was also coded for rejection of care 1-3 days each week. In section N0410 A. antipsychotic medication was coded as "0", antianxiety was codes as "1", and antidepressant was coded as "7". In section N0450 A. Antipsychotic was coded as 'No", B. GDRs was not coded, C. Date of last GDR was not coded. D. physician documentation of GDR clinically indicated, not coded, E. date physician documented GDR as clinically was not answered. The clinical record revealed Resident #118 had a physician's order dated 2/9/17, for Seroquel 100 milligram (mg) tablet; 1 tablet orally at the hour of sleep for a diagnosis of unspecified psychosis, a physician's order dated 8/4/17, for Duloxetine 30	F 758		

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F 758	Continued From page 195 mg delayed released capsule; 1 capsule orally two times daily for an anxiety disorder and a physician's order dated 2/27/18, for Alprazolam 0.25 mg tablet; 1 tablet orally as needed every day for an anxiety disorder. Seroquel is an antipsychotic medicine that works in the brain. (https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/?report=details) Duloxetine is a drug used to treat depression and urinary urge incontinence (leakage of urine) and it can be also be useful for certain types of pain ... (https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010059/?report=details) Alprazolam (Xanax) is used to relieve symptoms of anxiety, including anxiety caused by depression. It is also used to treat panic disorder in some patients. (https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details) The resident had person centered care plan problems which included; (name of resident) has a diagnosis of an anxiety disorder. The goal read; Periods of distress/anxiety will be reduced over the next 90 days, 9/1/18. The interventions included; Assess and record behaviors. Assess need for "as needed" antianxiety medication if interventions do not relieve anxiety. Conduct 1:1 visits with (name of resident). Help (name of resident) identify specific thoughts/ideas that cause anxiety. Reassure (name of resident) during distress/anxiousness. Speak in a calm voice. Validate feelings;	F 758		

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F 758	Continued From page 196 Behavioral symptoms; (name of resident) has verbal and physical behavioral symptoms directed at others. The goal read the number of verbal incidents will be decreased over the next 90 days, 9/1/18. The interventions included; Encourage caregivers to participate in activities with (name of resident) to promote positive interactions. Gently remind (name of resident) screaming/cursing is not appropriate. Record behaviors on the Behavior Tracking form. Monitor pattern or behavior (time of day, precipitating factors, specific staff or situations). Respond in a calm voice, maintain eye contact, Remove from area if (name of resident) is verbally and physically abusive to others. Talk with family and friends to identify potential sources/reasons. Conduct 1:1 sessions with (name of resident), encourage resident to verbalize feelings in an appropriate manner and provide realistic feedback; Resident receives an antipsychotic medication. The goal read; Minimize/avoid harmful side effects during the next 90 days, 9/1/18. The interventions included; Complete AIMS assessment. Notify physician if resident appears to be drowsy or shows decrease in usual functioning. Monitor for side effects and adverse reactions. Monthly review by registered pharmacist. Labs per physician's order; (name of resident) is receiving an antidepressant drug on a regular basis. The goal read; Symptoms of depression will be controlled/managed with minimal side effects over the next 90 days, 9/1/18. The interventions included; Conduct 1:1 visit with (name of resident) to discuss current status and adjustment to lifestyle changes. Monitor for side	F 758		

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F 758	Continued From page 197 effects of medication; constipation, dry mouth, anxiety, agitation, headaches, falls. Report promptly to the physician. Plan (name of resident) and the physician for a trial period of dose reduction. Record behaviors on the Behavior Tracking Record. Observe (name of resident) for changes in mood/behavior, sleep patterns, fatigue, appetite, ability to concentrate, participation in activities, crying. An Interview was conducted with the Director of Nursing on 6/25/18 at approximately 2:25 p.m. The Director of Nursing stated the facility staff was unable to provide documentation the physician had attempted gradual dose reduction (GDR)/rationale for not attempting GDRs, or justification of continuous use and duration of "as needed" Xanax. On 6/28/18 at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing, Director of Operations, 2 visiting Administrators and the Dietitian. An opportunity was given to the facility staff to provide additional information but; none was presented. The facility's Pharmacy service policy with a revision dated of 10/26/17 read at bullet #5; Provide GDR and other recommendations surrounding psychotropic and antipsychotic medications. Bullet #7 read; If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically	F 758		

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F 758	Continued From page 198 contraindicated. The facility's Psychoactive Medications policy with a revision date of 1/17/17 read; The facility will develop and maintain a system for assuring the proper use and monitoring of psychoactive agents. Psychoactive agents can only be used on receipt of a physician's order to eliminate or reduce identified behavioral symptoms or to treat a specific diagnosis. Page 2 of the facility's policy included the following; Residents who receive an antipsychotic medication to treat a psychiatric condition will be monitored. Define and document specific behavioral problems within the nursing notes using the terminology in chart. Set reasonable and measurable objectives and reflect these in the resident's care plan. Occurrences of specific behaviors and incidences of adverse effects will be monitored daily and totaled monthly on the Psychoactive Drug Monitoring Form. Each occurrence or lack of occurrence will be noted for each day and shift. Physicians will routinely comment on progress of resident in medical progress notes.	F 758		
F 760 SS=E	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 medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, and clinical record review the facility staff failed to ensure 1 Resident (Resident #5) in a survey sample of 61 to be free of significant med error.	F 760		

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F 760	Continued From page 199 For Resident # 5 facility staff failed to follow physicians order to administer Oxycodone 5 mg. (narcotic pain medication) as scheduled. The finding included: Resident #5 a 66 yr. old female was admitted on 1/25/17 with diagnoses of but not limited to anemia, CAD (coronary artery disease), hypertension (high blood pressure, CVA (stroke), depression and psychotic disorder. Resident # 5's most recent MDS (Minimum Data Set) dated 6/4/18 was coded as quarterly. She was coded as having a BIMS (Basic Interview of Mental Status) score of 15, indicating no cognitive impairment. She was coded as needing physical assistance of 1 staff member for activities of daily living. She was coded as being at risk for pressure ulcers however she was also coded as having no open areas or pressure ulcers. She is also coded as being incontinent of bowel and bladder On 6/21/18 a clinical record review was conducted and it was found that for the month of May 2018 the Medication Administration Record (MAR) was missing documentation of administration for 12 doses of routinely scheduled narcotic pain medication. The order read Oxycodone (a narcotic pain medication) 5 (mg) Milligram tablets - Give 1 tablet 3 times per day. The following dates and times the medication was not administered according to the (medication administration record) MAR. 5/6/18 at 6:00 AM	F 760	1. Resident # 5 was provided scheduled pain medication on 5/10/18 2. All residents receiving pain medication are identified as at risk for not receiving services that are not consistent with professional standards of practice, comprehensive person-centered care and the resident's goals and preferences 3. Manager of Education or designee will educate licensed nurses on standards of practice governing pain management to include accurate and timely completion of pain assessments, obtaining hard scripts for narcotics, re-ordering medications timely, stat box utilization and administering other PRN pain medications for assistance with pain management per the physician orders 4. Clinical Manager, DON or designee will complete a pain management audit to assure scheduled and / or PRN medications are adminstered as ordered and pain assessments are completed timely and accurately per MD order 25% x 1 month, then 10% x 1 month. Audit results will be reviewed for trends and/or patterns and reported to QAPI x 3 months for input and guidance 5. Date of Compliance: 8/12/18	

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F 760	Continued From page 200 5/6/18 at 2:00 PM 5/6/20 at 9:00 PM 5/7/18 at 6:00 AM 5/7/18 at 2:00 PM 5/7/18 at 9:00 PM 5/8/18 at 6:00 AM 5/8/18 at 2:00 PM 5/8/18 at 9:00 PM 5/9/18 at 6:00 AM 5/9/18 at 2:00 PM 5/9/18 at 9:00 PM The following notes were added the the last page of the MAR each time a dose was missed. Note to MAR 5/6/18 at 6:00 AM- Not administered-NIS [not in stock] Note to MAR 5/6/18/at 2:00 PM - Not Administered not available needs new script Note to MAR 5/6/18 at 9:00 PM - Not administered not available MD made aware Note to MAR 5/7/18 at 6:00 AM - Not available MD made aware Note to MAR 5/7/18 at 2:00 PM - Not administered awaiting hard script Note to MAR 5/7/18 at 9:00 PM - Not administered Note to MAR 5/8/18 at 6:00 AM - L/M [left message] with MD that resident needs hard script -not administered Note to MAR 5/8/18 at 2:00 PM - Not administered awaiting pharmacy delivery. Note to MAR 5/8/18 at 9:00 PM - NIS [not in stock] - awaiting hard script from MD Note to MAR 5/9/18 at 6:00 AM - Not available awaiting hard script from MD Note to MAR 5/9/18 at 2:00 PM - Not administered awaiting pharmacy delivery Note to MAR 5/9/18 at 9:00 PM - Medication not	F 760		

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F 760	Continued From page 201 avail not administered. On 6/26/18 and interview with the DON (director of nursing) who stated " During the time the medication was not given the doctor had been contacted by the staff and had not yet sent over the hard script [paper prescription] which is why she missed the medication". She further stated it is the expectation of the nurses that they utilize the stat box to pull meds from if the patient does not have them in their drawer. She also stated the nurses should have continued to call the physician for the prescription. She went on to say if there is no more of a particular drug in the stat box they could use the stat box on another units and fax the pharmacy to refill the stat box. Administration notified on 6/26/18 at 2:45 p.m. and no further information was provided.	F 760		
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 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	F 761		

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F 761	Continued From page 202 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, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to ensure Insulin was stored correctly with both an open and a correct expiration date on 1 of 10 medication carts (Unit 4 Cart 2, and failed to ensure one PPD (purified protein derivative-tuberculosis skin test) vial was stored correctly with both an open and expiration date on 1 of 3 medication storage rooms (South 1 Medication Storage Room) and failed to ensure one treatment cart was secure by LPN #7 after leaving her keys in the treatment cart lock when not in direct supervision of the nurse. The findings included: 1. On 6/20/18 at approximately 12.08 PM an observation was made of the Facility's Unit 4 Cart 2. A Humalog 100 ml (milliliter) opened vial was observed with an open date of 6/13/18 with an expiration date marked 7/13/18. When RN #1 was asked what she thought was wrong with the labeling she stated, "They marked	F 761	1. The incorrect labeling of insulin vial and PPD vial were identified on 6/20/18 were both disposed of after being identified. LPN # 7 was educated on not leaving keys in treatment cart when cart is not in direct observation. 2. Any resident receiving medication has the potential to be affected by the deficient practice. 3. Staff Development Nurse or designee will provide education to licensed nurses regarding policy and procedure related to drug labeling, storage and disposal. Nursing staff will be educated on their responsibilities for dating medications, checking the medication carts for undated and expired medications and locking and securing medication and treatment carts. 4. Clinical Manager or designee will audit 100% of medication carts to ensure that all opened medication are dated, expired medication are discarded and unattended med carts are secured. Audits will be 2 per week x 4 weeks, then 2 per month x 1 month to validate adherence to the established standards governing labeling, storage, and disposal. Results will be presented to QAPI x 3 months for review and recommendations 5. Date of compliance: 8/12/18	

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F 761	Continued From page 203 it for 30 days instead of 28." The Clinical Manager stated that it was tabled incorrectly as insulin is to be expired 28 days after opening."Correct" An observation on the South 1 Medication Storage room was made on 6/20/18 at approximately 3:30 PM. An opened PPD vial was observed in the Medication storage room refrigerator. The PPD vial had an open date; however had no marked expiration date. LPN #1 stated that it would expire as the Manufacturer's Expiration date stated in the year 2019. The Facility Policy titled, "Storage of Medications" with a revision date of 2/15/18, documented the following: Policy Statement: Medications, treatments, and biologicals are stored safely, securely, and properly following manufacturer's recommendations or facility policy. The Facility Policy titled, "Medication: Expiration Dates" with a revision date of 1/17/17, documented the following: PPD-30 days from opening Insulin Once opened, ALL insulin kept in the refrigerator or in the medication cart expires 28 days after opening. The Administrator was notified of the findings during a meeting on 6/20/18 at approximately 5:45 PM. No further information was provided.	F 761		

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F 761	Continued From page 204 2. On 6/24/18 at approximately 1:05 a.m., this surveyor observed the treatment cart lock on Unit North 3 with a set of nursing keys left unsupervised. After 3 minutes, License Practical Nurse (LPN) #7 came to the treatment cart and stated, "I left me keys in my treatment cart, I went to assist a resident and just forgot to take them out." An interview was conducted with Director of Nursing (DON) who stated, "I expect for all nurses to make sure they remove their keys from the lock of the treatment or medication cart, push the button and make sure the cart is to locked then put their keys in their pocket before leaving the treatment or medication cart. The treatment or medication cart should never be left with the keys still in the lock unsupervised." The facility's policy titled Life care - Storage of Medications (Revision: 2/15/18). -Policy statement: Medications, treatments, and biologicals are stored safety, securely, and properly following manufacture's recommendations or facility policy. The medication supply is accessible only to licenses nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medications supplied are locked or attended by persons with authorized access.	F 761		

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F 761	Continued From page 205 Policy Life Care - Medication Administration (Revision 2/21/17). Policy statement: Medications will be administered in accordance with prescribed orders, manufactures specifications regarding the preparation and administration of the drug or biological and accepted professional standards and principles. -General Guidelines to include but not limited to: The key must be in the possession of the medication nurse, med tech, or charge nurse at all times.	F 761		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility staff failed to be administered in a manner that enables it to use it resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident for 4 (Resident #18, #28, #72, and #576) of 61 residents in the survey sample. 1. Resident #18 was readmitted to the nursing facility on 12/5/17 with an *unstageable sacral pressure ulcer. The facility staff failed to accurately assess and initiate an effective pressure ulcer treatment protocol, instead the	F 835	1. A. Resident # 18 MDS was revised and received a comprehensive nutrition assessment on 7/20/18. Resident #18 had a skin assessment completed on 7/18/18, 7/21/18, 7/23/18, 7/25/18 and skin dyad protocol orders were reviewed to ensure accurate treatments were ordered. Care plans for resident # 18 have revised to reflect current care on 6/26/18. B. Resident # 28 care plan was revised on 6/28/18 and resident received a skin assessment completed on 7/25/18. The resident is receiving appropriate treatments to promote skin integrity. C. Resident #72 care plan was revised on 6/21/18 and received a skin assessment on 7/23/18 and is receiving appropriate treatments to promote skin integrity. D. Resident #576 was discharged from the facility on 11/23/18 2. All residents are at risk for potential skin integrity issues are risk for this	

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F 835	Continued From page 206 ulcer was assessed as a *Stage I. In addition the facility staff failed to assess the wound every 7 days per facility protocol until 13 days later at which time the unstageable wound had progressively worsened and ultimately led to wound management by a specialized physician. All of the aforementioned issues constituted harm for Resident #18. 2. For Resident #28, the facility staff failed to complete weekly skin assessments, and failed to complete physician ordered treatments resulting in harm as evidenced by development of an un-stageable pressure ulcer on 5-31-18, and 2 Stage II pressure ulcers identified at the time of survey. 3. For Resident #72, the staff failed to identify a wound on the plantar surface of the left foot until it was 45% eschar (hard black dead tissue) and found by surveyors during wound care observations, due to observed exudate on the foot of the bed. The wound doctor was present, and unable to stage the wound. 4. For Resident #576, the facility staff failed to identify 9 unstageable wounds (4 of the 9 had slough and eschar present) until they were all found at one time on 11-6-17 during wound rounds with the wound nurse. The findings include: 1. Resident #18 was readmitted to the nursing facility on 12/5/17 with an *unstageable sacral pressure ulcer. The facility staff failed to accurately assess and initiate an effective pressure ulcer treatment protocol, instead the ulcer was assessed as a *Stage I. In addition the	F 835	deficient practice. Skin assessments will be completed on residents; physician are notified of any changes and appropriate treatment orders are in place to treat and promote skin integrity. 3. Administrator at the time of survey is no longer with Sentara. Interim Administrator started on 7/23/18. Administrator job expectations/responsibilities will be completed on 8/2/18. Interim Administrator Licenses validation completed on 7/20/18 in facility orientation. The interim DON at the time of survey was out on medical leave. DON job expectations / responsibilities completed and DON license was validated on 7/20/18 and job profile reviewed. LTC Consultant, WOCN, Wound Treatment Associate, and/or designee will educate and validate competency of licensed staff on identification, assessment, treatment, documentation and monitoring of skin conditions. Nursing staff will be educated on prevention of impaired skin integrity and the importance completing skin observations and reporting changes to a licensed nurse. The attendance policy reviewed with the facility staff in multiple staff meeting 7/19/18 New Staffing Coordinator to start on 7/18/18 Education of the Life Care Staffing Policy Statement give to Administrative Leadership on 8/2/18 to be used with facility staff for trending of staffing issues. 4. New wounds will be reported in the morning meeting and pressure injuries of non-healing wounds will be reviewed weekly during Standards of Care meetings	

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F 835	Continued From page 207 facility staff failed to assess the wound every 7 days per facility protocol until 13 days later at which time the unstageable wound had progressively worsened and ultimately led to wound management by a specialized physician. The next weekly assessment to be completed by the licensed nurse for would have been 12/12/17, which was not completed for Resident #18. On 6/20/18 at 12:15 p.m., the sacral wound care observation was made conducted by the wound specialist physician, assisted by the North 4 Unit Manager RN#1. The wound care specialist stated that she was not going to let the wound go until it was healed. She stated the wound was not accurately assessed from the beginning, wound assessments were not being performed by the nursing staff as they should have been which was one of the reasons she stated she stopped treating residents in the facility. On the same day, the UM RN #1 stated the resident was readmitted to the nursing facility on 12/5/17 with an unstageable wound and the wound was never a Stage I at that admission. She stated wound care assessments had been a problem, but they were working on consistency for all licensed nurse in the performance of wound assessments. 2. For Resident #28, the facility staff failed to complete weekly skin assessments, and failed to complete physician ordered treatments resulting in harm as evidenced by development of an un-stageable pressure ulcer on 5-31-18, and 2 pressure ulcers at the time of survey. On 06/21/18 at 2:20 PM during wound observation with the Unit manager (RN 2) and	F 835	The Clinical Managers of each unit will monitor that baths and weekly skin observations / assessments are completed and will investigate all variances. The WOCN nurse and/or designee will complete 2 visual wound treatment observation weekly x 4 weeks to ensure that treatments are carried out in a manner consistent with the order and to promote wound healing and that assessment of the wound is accurately documented. Variances observed during treatment observations will be investigated and feedback provided to the responsibile staff member; corrections / clarification will be made as needed. These audits will be given to the DON or designee for tracking and trending and further action as needed and a summary of the above audits will be provided to the QAPI committee for additional oversight and recommendation x 3 months. 5. Date of Compliance: 8/12/18	

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F 835	Continued From page 208 LPN 1 Unit Manager revealed that a "New Wound" was found 6/21/18 in same area under colostomy wafer. The new wound measures 0.3 x 1.0 x 0 .3 and is to the left of the existing wound. Existing wound measured 0.9 cm x 2.0 cm x 0.3 cm Unit manager explained she had new orders for the wound discovered on 6/21/18. On 6/21/18 at 4:00 PM the DON (Director of Nursing) was interviewed about the inconsistency in documentation of the skin assessments and the nursing notes and observations of the Residents pressure areas. The DON stated we realized the skin assessments and treatments weren't being done. The DON also stated she recognized the care plan had not been updated and no interventions were added for Pain and the pressure areas that were identified. On 6/25/18 at 10:30 a.m., the Corporate Staff Development Coordinator and DON were interviewed about the training for colostomy care. Corporate Staff Development stated "We recognized colostomy care was an issue in another building and so we will be bringing that training over here as it seems to be an issue here as well." 3. On 6-21-18 at 9:45 a.m., a wound care observation was conducted with the South unit nursing manager and the wound doctor (other #5). Resident #72 was laying in bed and the doctor and wound nurse were asked why the Resident had drainage on the air wall of the bed. They lifted the Resident's foot and revealed a new wound measuring 1.5 centimeters x 1.8 centimeters circular wound which was 45% necrotic according to the wound doctor. An interview was conducted at that time, and the	F 835		

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F 835	Continued From page 209 wound doctor and the wound nurse both stated that pressure ulcers should not be found at necrotic eschar. The wound was not identified nor prevented prior to eschar formation and thus found at "unstageable". The wound was further encouraged to form by pressure on the plantar surface of the foot caused by the inappropriate placing of pillows in the bed under both feet for "floating" purposes which pushed the feet on top of the bumper/air wall surrounding the mattress, and pressing them onto the foot board of the bed causing pressure. 4. Nursing notes were reviewed and revealed that 9 wounds were all first identified and found at the same time on 11-6-17 on Resident #by the wound nurse when the Resident's TED hose (compression stockings were removed. The progress notes document the wound measurements, stages, treatments ordered, and results of one Albumin blood test which was 3.5. The nursing notes documented no refusals of care. The short descriptions of those 9 wounds are as follows; 1. Right lateral heel DTI (deep tissue injury) 6.5 cm (centimeters) x 7.0 cm. 2. Right plantar DTI 4.5 cm x 4.5 cm. 3. Left plantar DTI 5.0 cm x 4.0 cm. 4. Left lateral heel DTI 6.5 x 7.0 5. Left lateral ankle DTI 2.0 cm x 2.5 cm 25% epithelialized, 75% dark non-blanchable intact skin. 6. Left upper shin unstageable 2.0 cm x 3.5 cm, 80% yellow - 10% eschar - 10% non-granulating pink tissue. 7. Left Lateral upper calf 2.0 cm x 3.5 cm 40%	F 835		

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F 835	Continued From page 210 yellow slough - 10% eschar - 50% non-granulating. 8. Left posterior calf 1.0 cm x 12.5 cm 75% eschar - 25% non-granulating tissue 9. Coccyx unstageable 100% yellow, with 2 small islands of intact skin in the center. The wound assessment above in the nursing notes goes on to state "upon removal of Ted hose bilateral lower extremities noted with these wounds" listed above, as well as "dry flaky skin." Weekly Skin assessment sheets were reviewed and documented the following; 10-23-17 no wounds. 11-4-17 crease of buttocks not a pressure sore. 11-8-17 wound not a pressure sore no location 11-13-17 sacrum pressure sore. 11-20-17 no wounds An interview was conducted with the Administrator on 6/28/18 at approximately 10:35 a.m., who stated, "We knew we had a problem identifying wounds but we put an Action Plan in place" the surveyor asked, "Is your Action Plan working since wounds were identified at an advance stage while surveyors were on site" she replied, "No, our plan is not working." A review of the facility's Job Description for the LTC Administrator indicated the following job summary: Provides leadership and management direction for LTC facility. Supervises staff; development and manages operating and capital budgets, develops, communicates implements, and monitors goals, objective, and strategic planning for the facility, establishes and monitors a system for tracking all customers service activities.	F 835		

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F 835	Continued From page 211 The LTC Administrator competencies include but not limited to able to understand and discuss (team/department/division/organization) performance relative to goals and able to take appropriate action to ensure results are achieve and are able to break down complex problems into manageable tasks for action plan implementation. A review of the facility's Job Description for the Director of Nursing indicated the following job summary: Provides Nursing leadership and staff supervision and it is responsible for the clinical and administrative operations of the nursing department to include regulatory compliance, resident care, patient safety, customer service and employee retention. The Director of Nursing competencies include but not limited to able to understand and discuss (team/department/division/organization) performance relative to goals and able to take appropriate action to ensure results are achieve and are able to break down complex problems into manageable tasks for action plan implementation. A review of the facility's Job Description for the CNA Guidelines for Skin Integrity include but not limited to: The CNA inspects the skin daily during provisions of care, specifically bony prominences daily for any signs of pressure ulcer/injury or any alteration in skin, especially non-blanchable erythema and reports to the Nurse any skin impairments or concerns using the Stop and Watch Form. The CNA's are to use to Stop and Watch Form to include but not limited to: Skin impairments or concerns. Bony prominences	F 835		

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F 835	Continued From page 212 include but not limited to: elbows, hips/trochanters, heels, sacrum buttocks, ankles, shoulders, knees etc. The facility's policy titled Life care - Staffing - Nursing (Revision date: 6/29/17). -Policy statement: Sufficient staff will be employed on a twenty-four basis to ensure that nursing and related services are provided to enable each resident to attain or maintain his/her highest practical physical, mental and psychosocial wellbeing, as determined by assessments and individual plans of care. -Sufficient nursing staff will be employed to ensure that: A). Direct care needs are met and assessments, planning, evaluations and supervision will be provided. B). Care will be carried out according to professional practice standards on each shift. C). Sudden changes in resident health status and emergencies will be properly identified and managed in a timely manner. The facility's policy title Life Care - Standards and Requirement Characteristics - Skin Condition (Revision date: 09/28/7). -Purpose: Residents are provided with care to prevent and treat skin breakdown. -Required Characteristics: a). Contributing factors are identified and addressed in the Plan of Care b). Proper treatment is provided c). Residents do not develop skin breakdown unless their medical condition makes breakdown	F 835		

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F 835	Continued From page 213 unavoidable. d). Residents with skin breakdown show improvement and healing unless their medical condition makes healing unattainable. The facility's policy titled Life Care - Skin care and wound Product Guide (Pressure Ulcer/Injury - Original date: 03/06/17). Definitions: Avoidable Pressure Ulcers: Avoidable means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs; resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. The facility's policy and procedures titled Guidelines for Skin Integrity dated 3/6/17 indicated the following: -Licensed nurse would measure, stage using the National Pressure Ulcer Advisory Panel (NPUAP) guidelines, describe and document all identified impaired skin integrity and surrounding skin areas. -Initiate the Wound Care Protocol for all identified skin impairments. -Complete the Unavoidable Pressure ulcer documentation assessment in Vision on all high-risk residents at time of identification (Clinical Manager and/or DON). -Initiate the Weekly Skin Condition Progress Report (embedded in the initial nursing assessment) for residents with identified skin impairments and will be continued weekly.	F 835		

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F 835	Continued From page 214 -Weekly skin assessments to be completed on "ALL" residents through the assessment widget. Residents with skin impairment will have "BOTH" Weekly Skin Inspection Assessment and Weekly Skin Condition Progress reports completed. -All alterations of skin are re-evaluated for healing progress. If not progressing, notify Clinical Manager/DON and physician for review and recommendations for skin care orders and/or additional treatments. If wound is progressing re-new existing order every 14 days. If wound is not progressing and current treatment continues, discuss with physician and provide documentation to support rational. -Care plans must identify separately existing skin integrity areas and must include their own goals and interventions. -The wound care specialist team will make recommendations regarding wound care, however, the facility is responsible for ongoing care, follow-up, care, notification to the physician, all documentation and referrals as needed.	F 835		
F 880 SS=F	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 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:	F 880		

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F 880	Continued From page 215 §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 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.	F 880	1. RN #1 providing care for Resident # 23 was educated on proper infection control procedures and use of glucometer by the clinical manager. The facility's interim Infection Control Coordinator resigned. The Infection Control Program was expanded to include Antibiotic Stewardship tracking to the Infection Surveillance worksheet 7/1/18. 2. All residents are at risk for the deficient practice of not having an effective infection control program. Residents who receive blood glucose monitoring are at risk. 3. DON/Registered Nurse or designee will educate licensed nurses on appropriate infection control practices for glucose testing and appropriate use of disinfectant wipes and guidance on where to place supplies during glucose testing. The Infection Control Preventionist or designee will implement and educate the staff on the facility's infection control program. 4. Clinical Managers or designee will complete 2 observations of glucose monitoring 2 per week x 4 weeks. Results of the audits will be reviewed for patterns and trends and reported to QAPI x 3 months for input and guidance. The Infection Preventionist or Infection Control Coordinator will present the Infection Control Program to the QAPI team members for additional recommendation and/or guidance. 5. Date of compliance: 8/12/18	

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F 880	Continued From page 216 §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 staff interview, and facility document review, the facility staff failed to maintain an active facility wide Infection Prevention and Control Program (IPCP) and failed to ensure infection control measures to prevent the potential transmission of infection while performing a blood glucose test on 1 resident of 61 residents in the survey sample (Resident #26) The finding's included; 1. On 6-25-18 at approximately 5:00 p.m., During the end of day debriefing, the Administrator was asked who surveyors should speak with, the next morning in regard to the facility infection control program. The Administrator stated the Director of Nursing (DON) who was no longer employed at the facility had previously been in charge of it, however, since she was no longer there, the new interim DON would be responsible. On 6-26-18 at 10:00 a.m., the Registered Nurse (RN-2) south unit manager and the Corporate Infection Preventionist (Other 3) RN came into the conference room and stated they would be in	F 880		

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F 880	Continued From page 217 charge of infection control, not the DON. RN-2 and Other 3 were interviewed in the conference room by surveyors. RN-2 stated she was working in the new roles of "south unit nursing manager, facility wound nurse, med and treatment nurse, and now infection control nurse coordinator". The Corporate Infection Preventionist RN was asked for the RN-2's infection control education record, and she stated it had not been completed at this time. RN-2 stated she was hired at the facility in January 2018 (6 months prior to survey) and had never been responsible for an infection control program and she was in training now for it, but had not completed the online training as yet. RN-2 stated the previous Director of Nursing left in May 2016. RN-2 stated she assumed the role. RN-2 was asked what the objectives of the facility infection control program were, and how records were maintained for incidents of infection and what analysis occurs as a result. She was also asked to provide the following items; 1. Corrective actions related to infections, tracking information about their antibiotic stewardship program. 2. The facility process for communicating with acute care institutions when transfers (to and from) occurred, involving, multi-drug resistant organisms (MDRO's), Labs, diagnoses, discharge summaries, organism colonization, and health care associated infections (HAI's). 3. Protocols for making adjustments to antibiotic therapy. 4. Identify and produce infection assessment tools or management algorithms used for infections.	F 880		

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F 880	Continued From page 218 5. Notes from the QAPI committee on data review, and follow up planning. On 6-26-18 during the interview, the Corporate Infection Control Preventionist and RN-2 stated they did not have those documents, RN A was unable to explain the processes verbally as her training was not yet completed, and they stated they would be unable to produce the documents requested. The Administrator was made aware of the findings. During the end of day debriefing on 6-28-18 at approximately 4:00 PM, the Administrator and Director of Nursing were again informed of the findings. No further information was provided. 2. Resident #26 was admitted to the Facility on 3/16/18. Diagnoses for Resident #26 included, but not limited to: Diabetes. Resident #26's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 6418, coded Resident #26 with a score of 7 out of a possible 15 BIMS (Brief Interview for Mental Status) indicating severe cognitive impairment. Resident #26's 6/14/18 Comprehensive Person Centered Care Plan documented: Focus Area: Potential for hypo/hyperglycemia related to Diabetes Goal: Resident will be without negative outcomes related to hypo/hyperglycemia with goal date of 9/14/18 Interventions: Monitor accuchecks per Medical Doctor order	F 880		

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F 880	Continued From page 219 On 6/20/18 at approximately 11:41 AM, an observation was made of RN #1 performing a blood glucose check on Resident #26. RN #1 sanitized the glucometer prior to going into Resident #26's room. RN #1 placed the sanitized glucometer on Resident #26's bed along with the opened bottle of glucometer strips. RN #1 continued to perform Resident's #26's blood glucose test. Upon completion of the test, RN #1 obtained the bottle of glucose strips from the Resident's bed and returned them to the medication cart. RN #1 sanitized the glucometer and left in on top of the medication cart. RN #1 was asked what she thought may be an issue with having the glucometer and glucose testing strips on the Resident's bed. RN #1 stated that it could be an infection control concern and that she should have placed the testing supplies on the Resident's bed side table. The Facility Policy titled, "Glucose Monitoring" with a revision date of 9/28/17, documented the following: Purpose: Blood for serum glucose levels will be obtained in aseptic manner Cleaning: Clean outside of meter using a disposable bleach wipe or a germicidal disposable wipe (Sani-wipes or (Sani Wipe-Clorox for C-Diff patients). Allow to air dry. Note: Clean and disinfect blood glucose meter after every use with Sani Wipe or (Sani Wipes with Clorox for C-Diff patients.) The Policy titled, "Glucose Monitoring" did not document any guide for where to place supplies at the bedside	F 880		

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F 880	Continued From page 220 Fundamentals of Nursing; Eighth Edition, Page 410, documented the following: "Medical Asepsis, or clean technique, includes procedures reducing the number or organisms present and preventing the transfer of organisms. Hand hygiene, barrier techniques, and routine environmental cleaning are examples of medical asepsis. The Administrator was notified of the findings during a meeting on 6/20/18 at approximately 5:45 PM. No further information was provided.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility document review, the facility staff failed to maintain an active antibiotic stewardship program. The finding's include; On 6-25-18 at approximately 5:00 p.m., During the end of day debriefing, the Administrator was asked who surveyors should speak with, the next morning in regard to the facility infection control program. The Administrator stated the Director of Nursing (DON) who was no longer employed at	F 881	1. Facility physicians were re-educated on the facility's Antibiotic Stewardship program at the Medical Executive Meeting on 6/7/18. The Infection Control Program has been expanded to include antibiotic stewardship tracking which was added to the Infection Surveillance worksheets on 7/1/18. 2. Residents who are at risk for infection are at risk for this deficient practice fight infections are at risk. 3. Antibiotic Stewardship education was provided by Pharmacy to the Medical Staff 6/7/18 meeting. The Infection Preventionist or designee will provide antibiotic stewardship program education to licensed nurses. The program will be designed to targeted areas with a focus on different types of infection in each area. The initial roll-out will focus on UTI.	

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F 881	Continued From page 221 the facility had previously been in charge of it, however, since she was no longer there, the new interim DON would be responsible. On 6-26-18 at 10:00 a.m., the Registered Nurse (RN-2) south unit manager and the Corporate Infection Preventionist (Other 3) RN came into the conference room and stated they would be in charge of infection control, not the DON. RN-2 and Other 3 were interviewed in the conference room by surveyors. RN-2 stated she was working in the new roles of "south unit nursing manager, facility wound nurse, med and treatment nurse, and now infection control nurse coordinator". The Corporate Infection Preventionist RN was asked for the RN-2's infection control education record, and she stated it had not been completed at this time. RN-2 stated she was hired at the facility in January 2018 (6 months prior to survey) and had never been responsible for an infection control program and she was in training now for it, but had not completed the online training as yet. RN-2 stated the previous Director of Nursing left in May 2016. RN-2 stated she assumed the role. RN-2 was asked what the objectives of the facility infection control program were, and how records were maintained for incidents of infection and what analysis occurs as a result. She was also asked to provide the following items; 1. Corrective actions related to infections, tracking information about their antibiotic stewardship program. 2. The facility process for communicating with acute care institutions when transfers (to and from) occurred, involving, multi-drug resistant	F 881	4. Pharmacy or designee to audit antibiotic use monthly x 3 months and report findings to the facility's Medical Directors, VPMA and to QAPI for review and recommendations. 5. Date of Compliance: 8/12/18	

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F 881	Continued From page 222 organisms (MDRO's), Labs, diagnoses, discharge summaries, organism colonization, and health care associated infections (HAI's). 3. Protocols for making adjustments to antibiotic therapy. 4. Identify and produce infection assessment tools or management algorithms used for infections. 5. Notes from the QAPI committee on data review, and follow up planning. On 6-26-18 during the interview, the Corporate Infection Control Preventionist and RN-2 stated they did not have those documents, RN A was unable to explain the processes verbally as her training was not yet completed, and they stated they would be unable to produce the documents requested. The Administrator was made aware of the findings. During the end of day debriefing on 6-28-18 at approximately 4:00 PM, the Administrator and Director of Nursing were again informed of the findings. No further information was provided.	F 881		