STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/9/19 through 07/11/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced annual Medicare/Medicaid standard survey was conducted 07/09/2019 through 07/11/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 90 certified bed facility was 82 at the time of the survey. The survey sample was 36 which consisted of 33 current Resident reviews and 3 closed record reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583	RECEIVED AUG 0 2 2019 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: ADMINISTRATOR

(X6) DATE: 07/24/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583	Continued From page 1 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to protect resident from public view during wound care for 1 resident (Resident #21), of 36 residents in the survey sample. The facility staff failed to ensure privacy was maintained during a wound care dressing change for Resident #21. The findings included: Resident #21 was originally admitted to the facility on 03/29/19. Diagnosis for Resident #21 included but are not limited to Type II Diabetes Mellitus. Resident #21's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 05/04/19 coded the resident with a 15 out of a possible score of	F 583	F 583 1. Resident #21's window blinds have been closed during her care and treatment. 2. All resident's receiving care in the facility have the potential to be affected. 3. The Director of Nursing or designee and Department Managers will educate all staff on maintain patient's privacy, particularly during patient care. 4. The director of Nursing or designee will conduct random audits to ensure resident privacy during care is being honored. These audits will be conducted 3x a week for 3 months. The audit will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19//19	

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F 583	Continued From page 2 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #21 as requiring extensive assistance of two with personal hygiene, extensive assistance of one with bathing, toilet use, dressing and bed mobility for Activities of Daily Living care. Section M-skin condition was coded for pressure ulcer care. During a wound dressing observation on 07/10/19 at approximately 10:56 a.m., with Licensed Practical Nurse (LPN) #6 the following observations were made: Resident #21 resided in a private room. The resident's window blind remained open throughout the entire dressing change to Resident #21's left heel pressure ulcer. Anyone walking outside of Resident #21's window could view the wound care dressing change performed on Resident #21. On the same day at approximately 2:50 p.m., an interview was conducted with LPN #6 who stated, "I should have closed the window blinds to maintain privacy during the wound care dressing change to Resident #21's left heel pressure ulcer." An interview was conducted with the LPN #5 (Unit Manager on East) on 07/10/19 at approximately 2:55 p.m., who said the window blinds should have been closed. She stated, "If you can see out then they can see in; that is a violation of their privacy." On 07/11/19 at approximately 6:00 p.m., and interview was conducted with the Director of Nursing (DON) who stated, "The window blinds should have been closed to maintain dignity for Resident #21 during his wound care dressing change."	F 583		

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F 583	Continued From page 3 The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the findings. The facility's policy titled Resident Rights and Facility Responsibilities (Revision date 11/16). -Policy: It is the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they can understand. -Dignity, Respect & Quality of Life. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 583		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 604		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/26/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 604	Continued From page 4 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to ensure for 1 resident (Resident #44) out of 36 residents in the survey sample was free from physical restraint. The facility staff failed to ensure that Resident #44 was free of physical restraint. The findings included: Resident #44 was admitted to the facility on 05/15/2019. Diagnoses included but were not limited to, Alzheimer's Disease with Early Onset, Unspecified Dementia with Behavioral Disturbance and Osteoarthritis. Resident #44's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/24/2019 coded Resident #44 with short-term and	F 604	F 604 1. Resident #44 mechanical lift sling was unfastened immediately on 7/11/19. CNA #44 was counseled on the use of restraints on 7/15.19. 2. All residents in facility have the potential to be affected by this practice. A 100% audit of all residents was completed to identify any other residents at risk for physical restraints. 3. The Director of Nursing or designee will educate all staff on the use, definition and identification of physical restraints. 4. The Director of Nursing or designee will conduct random audits/rounds/observations to identify/ensure residents are free from physical restraints. These audits will be conducted 5x weekly for 3 months. The results of these audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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F 604	Continued From page 5 long-term memory problems, and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #44 as requiring total dependence of 2 for bed mobility and transfer, and total dependence of 1 for dressing, eating, toilet use, personal hygiene and bathing. On 07/09/2019 at 1:26 p.m., Resident #44 was observed sitting in his wheelchair in his room. A divided leg mechanical lift sling was observed behind the resident in his wheelchair and the sling leg straps were under each leg and criss-crossed between his legs. The left leg strap was extended across in front of the resident and a loop on the leg strap was wrapped around the right handle on the back of the wheelchair and the right leg strap extended across in front of the resident and a loop on the leg strap was wrapped around the left handle on the back of the wheelchair. On 07/10/2019 at 11:30 a.m., Resident #44 was observed sitting in his wheelchair in his room. A divided leg mechanical lift sling was observed behind the resident in his wheelchair and the sling leg straps were under each leg and criss-crossed between his legs. The left leg strap was extended across in front of the resident and a loop on the leg strap was wrapped around the right handle on the back of the wheelchair. On 07/11/2019 at 11:41 a.m., Certified Nursing Assistant (CNA) #4 was observed pushing Resident #44 down the hallway from his room. Resident #44 was sitting in his wheelchair with a divided leg mechanical lift sling behind him in the wheelchair, the leg straps were under his legs and criss-crossed between his legs. The left leg strap was extended across in front of the resident	F 604		

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F 604	Continued From page 6 and a loop was hooked onto the right wheelchair handle on the back of the wheelchair. The Surveyor asked CNA #4 and Registered Nurse (RN) #2 to step into a empty community area room and CNA #4 was asked, "What is the purpose of the criss-crossed leg strap being hooked onto the handle on the back of (Resident's name) wheelchair?" CNA #4 stated, "To prevent him from scooting, sliding down in his wheelchair. His wife know's and she's ok with it." CNA #4 was asked, "Have you told the nurse about Resident #44 sliding?" CNA #4 stated, "Yes, I told RN #2." RN #2 stated that she was not aware that the staff were looping the leg straps of the sling to the wheelchair to prevent the resident from sliding down in the wheelchair. RN #2 was asked, "What is this considered when the sling is hooked onto the handle of the wheelchair to keep (Resident's name) from sliding down in his wheelchair?" RN #2 stated, "It is considered a restraint." On 07/11/19 at 12:33 p.m., an interview was conducted with the Director of Nursing (DON) and the observations were discussed. The DON stated, "I will be doing some inservicing." The DON was asked, "What are your expectations of staff and restraining of residents?" The DON stated, "I expect my staff not to restrain residents. This facility is restraint free." The Administrator, Director of Nursing and the Regional Director of Clinical Services were informed of the finding on 07/11/2019 at approximately 8:10 p.m. at the pre-exit meeting. The facility did not present any further information about the findings.	F 604		
F 622	Transfer and Discharge Requirements	F 622		

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F 622 SS=D	Continued From page 7 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 622	F 622 1. Residents #45 and #78 have returned to the facility and have comprehensive care plans in place. 2. All residents that are transferred to another facility have the potential to be affected. 3. The Director of Nursing, or designee will educate the Licensed Nursing staff on the regulations regarding discharge/transfer notice requirements, including care plans. 4. The Director of Nursing, or designee will audit all transfers and discharges to the hospital or other facilities for 3 months. These audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be completed on 8/19/19	

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F 622	Continued From page 8 discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F 622		

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F 622	Continued From page 9 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record reviews the facility staff failed to send comprehensive care plan goals for 2 residents (Resident #45, Resident #78) out of 36 residents in the survey sample when discharged to the hospital. 1. The facility staff failed to send comprehensive care plan goals for Resident #45 when discharged to the hospital on 05/17/19. 2. For Resident #78, facility staff failed to evidence that the comprehensive care plan goals were sent with the resident upon transfer to the hospital on 9/1/18. The findings included: 1. Resident #45 was discharged to the hospital on 05/17/2019 and readmitted to the facility on 05/21/2019. Diagnoses included but were not limited to, Non Traumatic Intracranial Hemorrhage, unspecified and Hypertension. Resident #45's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/28/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident	F 622		

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F 622	Continued From page 10 #45 as requiring extensive assistance of 2 with bed mobility and transfer, extensive assistance of 1 with dressing, toilet use and personal hygiene and physical help in part of bathing with assistance of 1. On 07/10/2019 documentation was requested evidencing Resident #45's comprehensive care plan goals were sent when the resident was discharged to the hospital. On 07/10/2019 at 4:00 p.m., an interview was conducted with the Director of Nursing. The Director of Nursing was unable to provide evidence that the comprehensive care plan goals were sent to the hospital when Resident #45 was discharged. The Director of Nursing stated, "The Nurses usually send the Bed Hold Notice and care plan goals with the residents when they are discharged to the hospital but since the resident had went out for an appointment and then ended up going directly to the hospital I guess we weren't thinking. We know now and will send the written Bed Hold Notice and the care plan goals to the hospital going forward." On 07/11/2019 at approximately 8:10 p.m., at the pre-exit meeting the Administrator, Director of Nursing and the Regional Director of Clinical Services were informed of the findings. The facility did not present any further information about the findings. 2. For Resident #78, facility staff failed to evidence that the comprehensive care plan goals were sent with the resident upon transfer to the hospital on 9/1/18. Resident #78 was admitted to the facility on 6/2/17 and readmitted on 6/20/19 with diagnoses	F 622		

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F 622	Continued From page 11 that included but were not limited to muscle weakness, anemia, high blood pressure, and heart failure. Resident #78's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 6/28/19. Resident #78 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #78's clinical record revealed that she had been transferred to the hospital for a fractured leg on 9/1/18. The following nursing note was written: "Resident had x-ray done and results back shows acute tibial fracture and cannot exclude a fibula fracture (sic). waiting on call to see if we can send out to ER (emergency room) for brace and stronger pain medication. Both on call and DON (Director of Nursing) made aware of x-ray results." The next note dated 9/1/18 documented the following: "Resident son called and updated that X-ray came back and showed FX (fractured) tibia and will send out to ER Hospital (sic) also called report. Will let on coming shift know sent out." There was no evidence that all the required documentation to include the comprehensive care plan goals were sent with the resident upon transfer to the hospital. On 7/11/19 at 3:16 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #78's nurse. When asked what documents were sent with Residents upon transfer to the hospital, LPN #2 stated that she will send the SBAR (situation, background, assessment, and recommendation) form,	F 622		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495232	A. BUILDING ______ B. WING ______	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

(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 622	Continued From page 12 Transfer Interact Form, all current physician orders, bed hold policy, and the care plan. When asked if she documents what items were sent with the resident upon transfer to the hospital in the clinical record, LPN #2 stated that she will document. LPN #2 stated that she has a check off list that alerts the nurse what documents to send. When asked when the staff starting using this list, LPN #2 stated, "It's been awhile." LPN #2 could not recall if she had sent Resident #78's care plan goals to the hospital. LPN #2 could not recall that far back. On 7/11/19 at approximately 3:30 p.m., an interview was conducted with LPN #5, the unit manager. When asked what documents were sent with Residents upon transfer to the hospital, LPN #5 stated that care plan goals were now being sent after the facility changed their policy. When asked if she could find evidence that care plan goals were sent with Resident #78 for her 9/1/18 transfer to the hospital, LPN #5 stated that back then nursing was not sending the care plan goals. On 7/11/19 at 5:05 p.m., administrative staff member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing) were made aware of the above concerns.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		

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F 623	Continued From page 13	F 623	F 623	

language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;

Provider's Plan of Correction — F 623

1. The State Ombudsman was notified of resident #83's discharge on 7/10/19. The State Ombudsman was notified of resident #45's discharge on 7/10/19.
2. All residents that are discharged from the facility have the potential to be affected.
3. The Administrator will educate the Director of Social Services and the Social Worker on the regulations regarding discharge and transfer requirements, including the State Ombudsman notification.
4. The Director of Social Services will audit all discharges for 3 months to ensure discharges are being reported to the State ombudsman's office. The audit will be reported to the facility's QAPI meeting for discussion and necessary revision.
5. Corrective action will be completed on 8/19/19

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F 623	Continued From page 14 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623		

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F 623	Continued From page 15 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 2 of 36 residents (Resident #83 and #45) in the survey sample. 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #83 discharge to the hospital on 05/06/19. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #45's discharge to the hospital on 05/17/2019. The findings included: 1. Resident #83 was admitted to the facility on 05/03/19. Diagnosis for Resident #83 included but not limited to Cerebral Infarction. On 05/06/19, according to the facility's documentation, Resident #83 complained of chest pain. Resident #83 was transported to the local ER via Emergency Medical Services (EMS). Review of the May's 2019, faxed list to the ombudsman of all the resident's emergency	F 623		

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F 623	Continued From page 16	F 623		

transfers to the hospital was reviewed on 07/10/19 at approximately 10:25 a.m. The transfer list did not include Resident #83 who was discharged to the hospital on 05/06/19. On the same day at approximately 1:53 p.m., the Director of Social Services presented another sheet that was faxed to the Ombudsman on 07/10/19 at approximately 1:36 p.m., which included Resident #83's discharge to the hospital on 05/06/19 but only after requested from the surveyor.

An interview was conducted with the Director of Social Services on 07/11/19 at approximately 12:30 p.m. She said Resident #83 was missed when I notified the ombudsman via fax on 06/03/19 with all of the discharges to the hospital for May 2019.

The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the findings.

The facility's policy titled (Discharge/Transfer Letter Policy).
Procedure included but not limited to:
-Social Services or designee will assure the original discharge/transfer letter is given to the resident or guardian/sponsor, if applicable

-Copies will be sent to Department of Health, Ombudsman Office and filed in the business file and/or scanned into Point Click Care documents tab with administrator/designee, with the certified receipt if applicable.

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F 623	Continued From page 17 -For emergency transfers, one list can be sent to the Ombudsman at the end of the month. 2. Resident #45 was discharged to the hospital on 05/17/2019 and readmitted to the facility on 05/21/2019. Diagnoses included but were not limited to, Non Traumatic Intracranial Hemorrhage, unspecified and Hypertension. On 07/10/2019 documentation was requested to evidence that the Ombudsman was notified when the resident was discharged to the hospital. On 07/10/2019 at 4:00 p.m., an interview was conducted with the Director of Nursing and she stated, "The Social Worker usually notifies the Ombudsman of resident discharges at the first of each month, however she did not think to notify the Ombudsman of Resident #45's discharge. The Ombudsman was notified today." On 07/11/2019 at approximately 8:10 p.m., at the pre-exit meeting the Administrator, Director of Nursing and the Regional Director of Clinical Services were informed of the findings. The facility did not present any further information about the findings.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		

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F 625	Continued From page 18 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written bed hold notification for 2 of 36 residents in the survey sample, Residents #78 and #45. 1. For Resident #78, facility staff failed to provide the Resident and/or Resident Representative a written bed hold notification upon transfer to the hospital on 9/1/18. 2. For Resident #45 the facility staff failed to provide the Resident and/or Resident Representative a written bed hold notice when discharged to the hospital on 05/17/19. The findings include:	F 625	F 625 1. Residents #78 and #45 have returned to the facility. 2. All residents that are transferred or discharged from the facility have the potential to be affected. 3. The Director of Nursing or designee will educate the Licensed Nursing staff on the regulations regarding discharge and transfer notice requirements, including the facility bed hold policy. 4. The Director of Nursing or designee will audit all transfers and discharges to the hospital or other facilities for 3 months to ensure compliance with the regulation. These audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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F 625	Continued From page 19	F 625		

1. Resident #78 was admitted to the facility on 6/2/17 and readmitted on 6/20/19 with diagnoses that included but were not limited to muscle weakness, anemia, high blood pressure, and heart failure. Resident #78's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 6/28/19. Resident #78 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #78's clinical record revealed that she had been transferred to the hospital for a fractured leg on 9/1/18. The following nursing note was written: "Resident had x-ray done and results back shows acute tibial fracture and cannot exclude a fibula fracture (sic). waiting on call to see if we can send out to ER (emergency room) for brace and stronger pain medication. Both on call and DON (Director of Nursing) made aware of x-ray results."

The next note dated 9/1/18 documented the following: "Resident son called and updated that X-ray came back and showed FX (fractured) tibia and will send out to ER Hospital (sic) also called report. Will let on coming shift know sent out."

There was no evidence that written bed hold notification was sent with the resident upon transfer to the hospital.

On 7/11/19 at 3:16 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #78's nurse. When asked what documents were sent with Residents upon transfer to the hospital, LPN #2 stated that she

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will send the SBAR (situation, background, assessment, and recommendation) form, Transfer Interact Form, all current physician orders, bed hold policy, and the care plan. When asked if she documents what items were sent with the resident upon transfer to the hospital in the clinical record, LPN #2 stated that she will document. LPN #2 stated that she has a check off list that alerts the nurse what documents to send. When asked when the staff starting using this list, LPN #2 stated, "It's been awhile." LPN #2 could not recall if she had sent Resident #78's out to the hospital on 9/1/18.

On 7/11/19 at approximately 3:30 p.m., an interview was conducted with LPN #5, the unit manager. When asked what documents were sent with Residents upon transfer to the hospital, LPN #5 stated that the bed hold policy was now being sent after the facility changed their policy. When asked if she could find evidence that bed hold policy was sent with Resident #78 for her 9/1/18 transfer to the hospital, LPN #5 stated that back then nursing was not sending the bed hold policy that far back.

On 7/11/19 at 5:05 p.m., administrative staff member (ASM) #1, the administrator, ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

2. Resident #45 was discharged to the hospital on 05/17/2019 and readmitted to the facility on 05/21/2019. Diagnoses included but were not limited to, Non Traumatic Intracranial Hemorrhage, unspecified and Hypertension. Resident #45's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/28/2019 was coded with a

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F 625	Continued From page 21 BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #45 as requiring extensive assistance of 2 with bed mobility and transfer, extensive assistance of 1 with dressing, toilet use and personal hygiene and physical help in part of bathing with assistance of 1. On 07/10/2019 documentation was requested to evidence that the written Bed Hold Notice was sent when the resident was discharged to the hospital. On 07/10/2019 at 4:00 p.m., an interview was conducted with the Director of Nursing. The Director of Nursing was unable to provide evidence that the written Bed Hold Notice was sent to the hospital when Resident #45 was discharged. The Director of Nursing stated, "The Nurses usually send the Bed Hold Notice and Care Plan goals with the residents when they are discharged to the hospital but since the resident had went out for an appointment and ended up going directly to the hospital I guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital going forward." On 07/11/2019 at approximately 8:10 p.m., at the pre-exit meeting the Administrator, Director of Nursing and the Regional Director of Clinical Services were informed of the findings. The facility did not present any further information about the findings.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 22 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656	F 656 1. Resident #6 has been discharged from the facility 2. All residents using fall mats in the facility have the potential to be affected 3. The Director of Nursing or designee will educate the nursing staff on the implementation of care plan interventions, specifically related to the use of fall mats with residents and there placement. 4. The Director of Nursing or designee will conduct random audits/observations of resident with fall mats and the placement of fall mats in resident rooms. These audits will be conducted 5x a week for 3 months. The results of these audits will be reported the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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F 656	Continued From page 23 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement the comprehensive care plan for one of 36 residents in the survey sample, Resident #6. For Resident #6, facility staff failed to implement her plan of care and ensure a fall mat was in place to prevent injury from falls. The findings include: Resident #6 was admitted to the facility on 6/1/2015 with diagnoses that included but were not limited to Chronic Kidney Disease Stage 3, high blood pressure, type two diabetes, hypothyroidism and Bipolar disorder. Resident #6's most recent MDS (Minimum Data Set) assessment was a significant change assessment with an ARD (assessment reference date) of 4/22/19. Resident #6 was coded with no cognitive impairment; requiring extensive assistance from one staff member with toileting, personal hygiene and dressing; and extensive assist with two plus staff members with bed mobility and transfers. Review of Resident #6's current July 2019 POS (Physician Order Summary), revealed the following orders: "Fall mat at bedside, in place when resident is in bed..." This order was initiated on 5/30/18. Review of Resident #6's comprehensive care	F 656		

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KEMPSVILLE HEALTH & REHAB CENTER	5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464

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F 656	Continued From page 24	F 656		

plan dated 6/4/15 and revised 5/3/19 documented the following for her falls: "(Name of Resident #6) is at risk for injury, multiple risk factors related to deconditioning, psychoactive drug use, bladder incontinence, bowel incontinence, functional problem related r/t (related to) hx (history) R (right) ankle fracture. Goal: (Name of Resident #6) will have no fall related injuries through next review. Interventions: "Fall matt (sic) to bedside. (Date Initiated: 5/31/2019)"

On 7/9/19 at 12:44 p.m., an observation was made of Resident #6. She was lying in bed on her back. A fall mat was not observed down on the side of her bed. At this time Resident #6 had asked this writer to get the nurse so she could be readjusted in bed.

On 7/9/19 at 1:49 p.m., an observation was made of Resident #6. She was lying in bed on her right side. A fall mat was not observed to be down on the side of the bed.

On 7/10/19 at 8:15 a.m., a blue fall mat was observed to be on the right side of her bed while the resident was in bed.

On 7/10/19 at 8:57 a.m., Resident #6 was observed up in bed eating breakfast with her over bed table in front of her. The base of the over bed table was to the right of Resident #6. The fall mat was folded up at the foot of her bed.

On 7/10/19 at 9:57 a.m., CNA (Certified Nursing Assistant) #1, (Resident #6's aide), removed her breakfast tray and walked out of Resident #6's room. Resident #6's over bed table was pushed off to the right of Resident #6's bed. CNA #1 did not come back to put the fall mat back down.

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On 7/10/19 at 10:10 a.m. and 10:25 a.m., Resident #6 was observed lying in bed without her fall mat in place.

On 7/10/19 at 10:40 a.m., LPN (Licensed Practical Nurse) #2, Resident #6's nurse, was observed entering Resident #6's room with her medication. LPN #2 exited her room shortly after. This surveyor made an observation at 10:45 a.m., that Resident #6's blue fall mat was now on the floor to her right side.

On 7/10/19 at 10:47 a.m., an interview was conducted with LPN #2. When asked if she had just put Resident #6's fall mat back down on the floor, LPN #2 confirmed that she did. When asked if it had been on the floor earlier that morning, LPN #2 stated that it was originally on the floor and that the staff usually pick it up when they deliver Resident #6's meal trays. LPN #2 stated that the over bed table cannot move on top of the fall mat and they have to remove the mat. When asked if staff should be placing the fall mat back down once Resident #6 has finished her meals, LPN #2 stated that it should be. When asked if Resident #6 was a fall risk, LPN #2 stated that Resident #6 used to be a high fall risk but that she had not had any falls in some time. LPN #2 stated the mat was a preventive measure to prevent injury from falls especially while the resident received a blood thinner.

On 7/11/19 at 10:27 a.m., an interview was conducted with CNA #1, Resident #6's aide. CNA #1 confirmed that she was assigned to Resident #6 on 7/10/19 and that she had probably had been the aide that removed her breakfast tray. When asked the process (what staff should do), if

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F 656	Continued From page 26 they see a fall mat that is folded up in a resident's room and the resident is in bed, CNA #1 stated that she would put the fall mat back on the ground. CNA #1 was told about the observations made on 7/10/19. CNA #1 confirmed that she should have put the fall mat back down once Resident #6 had completed her meal. When asked how CNAs know what things each resident needs in place such as fall mats, devices etc. CNA #1 stated that she will get report from the nurse or she can look at a nursing Kardex for each resident. Review of Resident #6's current nursing Kardex revealed that it did not address fall mats. On 7/11/19 at 3:20 p.m., further interview was conducted with LPN #2. When asked the purpose of the care plan, LPN #2 stated that the care plan was used to guide nurses on how to properly care for a patient. When asked if it was important for the care plan to be accurate, LPN #2 stated that it was. When asked if it was important for the care plan to be followed, LPN #2 stated that it was. When asked if the care plan was being followed for Resident #6 when her fall mat was folded up while she was in bed, LPN #2 stated that it was not being followed. On 7/11/19 at 5:05 p.m., administrative staff member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Care Plan," documented in part, the following: "All direct care staff must always know, understand and follow their Resident's Care Plan. If unable to implement any part of the plan, notify your Charge Nurse or MDS	F 656		

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F 656	Continued From page 27 Coordinator, so that this can be documented or the Care Plan changed if necessary."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to invite 1 of 36 residents in the survey sample to attend his	F 657	F 657 1. Resident #54 will be invited to his next scheduled care plan meeting. 2. All residents that have care plan scheduled in the facility have the potential to be affected by this practice. 3. The Administrator or designee will educate the Director of Social Services and the Social Worker on presenting and documenting resident's invitation to care plan meetings. A copy of all resident invitations to care plan meetings will be kept in the Social Services department. 4. The Director of Social Services or designee will perform an audit of all care plan invitations to ensure the resident have received the proper notification of their care plan meeting. These audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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F 657	Continued From page 28	F 657		

person centered care plan meeting (Resident #54) in the survey sample.

The findings included:

Resident #54 was admitted to the facility on 11/11/16. Diagnoses for Resident #54 included but not limited to, Diabetes Mellitus and Chronic Obstructive Pulmonary Disease (COPD).

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 06/14/19, coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

During the initial tour on 07/09/19 at approximately 1:09 p.m., an interview was conducted with Resident #54 who stated, "I am not being invited to attend my care plan meetings nor did I receive a letter to attend a care plan meeting."

An interview was conducted with the Social Worker (SW) on 07/10/19 at approximately 11:40 a.m. The SW reviewed the residents Care Plan invitation book. After he reviewed the Care Plan invitation book the SW stated, "I am unable to locate the original invitation form in the MDS Coordinator book or in the resident's medical record." He stated "I am puzzled because I usually get the residents to sign the invitation form, down load it in the computer then give the original to the MDS Coordinator." The surveyor asked, "When was the last time Resident #54 attended his care plan meeting?" The SW stated, "I am only able to locate care plan invitations for 2018; nothing for 2019." The SW presented a

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F 657	Continued From page 29 form dated 05/16/19, which included that Resident #54's was scheduled to have a care plan meeting on 05/16/19 at 11:15 a.m. The SW stated, "I am unable to provide evidence that the resident was invited or that he attended the care plan meeting on 05/16/19 or any care plan meeting for 2019. The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the findings. The facility's policy titled Care Plan (Revision: April 6, 2017). Policy: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective. Procedure include but not limited to: -The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation (original) is presented to the resident at least five (5) days prior to the date of conference. A designated time of meeting is given to each resident. A copy of the letter is maintained for reference.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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F 658	Continued From page 30	F 658		

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to maintain professional standards for 1 resident (Resident #1) in the survey sample of 36 residents.

The facility staff failed to communicate an ongoing assessment with the dialysis center for Resident #1 who attended outpatient dialysis three days per week on Monday, Wednesday and Friday; And, the facility staff failed to obtain weights on Resident #1 per the comprehensive care plan and physician's order.

The findings included:

Resident #1 was originally admitted to the facility on 04/19/17. Diagnoses 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 at an outpatient dialysis center.

The current Minimum Data Set (MDS) a Quarterly assessment with an Assessment Reference Date (ARD) of 01/24/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, under section (O) for Special Treatments, Procedures and

Provider's Plan of Correction:

F 658

1. Resident #1 has a Dialysis Communication book and a physician's order to be weighed when returning from dialysis.
2. All Dialysis patients in the facility have the potential to be affected by this practice.
3. The Director of Nursing or designee will educate the Licensed Nursing staff on following physician's orders and appropriate communication with the dialysis center regarding the facility's patients. A communication note book will be provided to each dialysis resident to take to dialysis. This will be used as a communication tool between the dialysis center and the facility. In the event that the note book is not complete upon return from the dialysis center, the Licensed Nurse will contact the dialysis center to receive any necessary information and document that information in the resident's medical record.

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F 658	Continued From page 31 Programs, the resident was coded for dialysis. Resident #1's Care Plan included: weigh per protocol and as needed. Use aseptic technique and universal precautions. Resident #1's physician orders contained the following orders: (1) Dialysis on Monday, Wednesday and Friday. (2) If bleeding occurs from the dialysis site apply pressure and call 911 as needed. (3) Monitor Dialysis port for signs and symptoms of infection for every shift. (4) Obtain weights upon return from dialysis. Notify MD if 3+ lbs is noted one time a day every Monday, Wednesday and Friday. (5) Dialysis return assessment in the evening every Monday, Wednesday and Friday. A review of Resident #1's weights for the Month of May showed the following: 05/01/19 resident weighed 106 lbs. 05/14/19 resident weighed 103.4 lbs. 05/16/19 resident weighed 105.5. 05/20/19 resident weighed 108.2 lbs. A review of Resident #1's weight for the Month of June showed the following: 06/19/19 resident weighed 106.4 lbs. No other weighs were recorded for the month of June. A review of Resident #1's weight for the Month of July showed the following: 07/05/19 resident weighed 105 lbs. 07/10/19 resident weighed 105.5 lbs. No other weights were obtained. An interview was conducted with Licensed Practical Nurse (LPN) #5 on 07/11/2019 at	F 658	4. The Director of Nursing or designee will audit the dialysis communication book for each resident for appropriate content and correspondence 3x a week for 3 months. Additionally, the Director of Nursing or designee will audit each dialysis patient's weight upon return from dialysis 3x a week for 3 months. The results of these audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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F 658	Continued From page 32	F 658		

approximately 9:45 am. She was asked if she could view Resident #1's Dialysis Communication Book. LPN #1 stated that she would have to get permission from the resident because she has her communication book with her at all times. The communication sheet listed that resident was receiving dialysis at (Name) Dialysis Center on Monday, Wednesday and Fridays at 11:00 AM. There were no communication notes from 7/10/19. The last communication notes in the book were dated 06/07/19-06/10/19. LPN #5 stated that resident is attending a new facility as of Monday because she was disruptive to other residents. She had to change dialysis centers. Resident told nurse she left the communication sheet in the transportation van. LPN #5 was asked what should have been done. She said "They should have called the dialysis place and received the notes."

An interview was conducted with LPN #5 (Licensed Practical Nurse) Unit Manager (East Wing) on 07/11/19 at approximately 5:20 PM. She stated that the resident will refuse to be weighed sometimes. LPN #5 was asked what should have been done. She said that when the resident returns after dialysis the 3-11 (PM) shift should document resident's weight because she usually returns to the facility between 4:30 PM and 5:00 PM. and if she refuses to be weighed her POA (Power of Attorney/responsible party) should be called.

On 07/11/19 at approximately, 3:14 PM a briefing was held with the Administrator, Director of Nursing, the Regional Director of Clinical Services. The administrator stated "We should have communicated with the dialysis center by telephone or fax."

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F 658	Continued From page 33	F 658		

On 07/11/19 at approximately 7:30 PM an interview was conducted with Resident #1 concerning staff obtaining her weights when she returns from dialysis. Resident was asked if she was refusing being weighed when she comes back from dialysis. She stated "No," "That's a lie." She was also asked if she gives staff her communication book to keep for her when she returns from dialysis. She stated "No." "because they lost it one time." "I keep it myself."

On 07/11/19 at approximately 7:35 PM the following Certified Nursing Assistants (CNAs) were interviewed concerning weighing resident when she returns from dialysis.
CNA #2 was asked if resident #1 is assigned to her when resident returns from dialysis and does she obtain resident weights. She stated "No."
CNA #5 stated "I normally work the 11 (PM)-7 (AM) shift; If I come in early, no one tells me to weigh her."
CNA #6 stated "When (Resident #1) come in from dialysis I get her vital signs and weigh her. I record the vital signs and her weight on a piece of paper with the date, time and give the information to the nurse to record in the system."

The facility's policy titled Hemodialysis Care Policy-Effective date-June 16, 2017.

-Policy statement: The licensed nursing staff will use the following criteria as part of the patient/resident's comprehensive assessment to determine whether or not to proceed with care planning. Risks and complications unique to each patient/ resident will be documented on the individualized plan of care. The general guidelines and emergency guidelines The goal

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F 658	Continued From page 34 should provide: 1. The specialized care needed. 2. Maintain patency of the shunt/central line. 3. Prevent infection or medical complications. Plan of Care Protocol: Pre and post dialysis weight for every visit provided by dialysis center. The above issues were addressed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/11/19 at approximately 3:14 PM. No additional information was presented.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to conduct a thorough skin assessment of a pressure ulcer prior to it advancing to an unstageable pressure ulcer, and failed to evidence that a barrier cream was implemented per the plan of care, for one of 36 residents in the survey sample, Resident #6; and the facility staff	F 686	F 686 1. Resident #6 has been discharge from the facility. The Director of Nursing reviewed the physician's order for wound treatment for resident #21 with the LPN on 7/10/19. 2. The facility completed a 100% review of current resident's skin assessments to identify residents at high risk for skin break down to insure that interventions are in place. Additionally, all residents that are receiving wound treatments are at risk to be affected. 3. The Director of Nursing or designee will educate the Licensed Nurses on following physician's orders for wound treatments, as well as, prevention of skin break down, including assessment, intervention and documentation.	

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F 686	Continued From page 35 failed to follow physician's orders for a wound care dressing for one of 36 residents, Resident #21. The findings include: 1. For Resident #6, the facility staff failed to conduct a thorough skin assessment and failed to provide evidence that an intervention was implemented once redness was documented as being observed on 4/10/19 to Resident #6's sacrum. Resident #6 was admitted to the facility on 6/1/2015 with diagnoses that included but were not limited to Chronic Kidney Disease Stage 3, high blood pressure, type two diabetes, hypothyroidism and Bipolar disorder. Resident #6's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 4/22/19. Resident #6 was coded with no cognitive impairment; requiring extensive assistance from one staff member with toileting, personal hygiene and dressing; and extensive assist with two plus staff member with bed mobility and transfers. Resident 6 was coded in Section M (Skin Conditions), as having an acquired unstageable (1) pressure ulcer.* Review of Resident #6's bi-weekly skin assessments revealed no skin issues to her sacral area until 4/10/19, when redness was identified. The following skin assessment was documented on 11-7 shift (11:45 p.m.): "Does the resident have current skin issues: Yes. Site 53) Sacrum, Description: redness." Further review of Resident #6's clinical record failed to evidence a thorough assessment to determine a possible	F 686	4. The Director of Nursing or designee will audit physician's order and TARs to ensure treatments are being done as ordered. This audit will be conducted 3x w week for 3 months. The Director of Nursing or designee will audit/observe wound care treatments to ensure proper technique and that physician's orders are being followed. This audit will be conducted 3x a week for 3 months. The Director of Nursing or designee will audit the bi-weekly skin checks to ensure they are completed and accurate. This audit will randomly review 10 residents, 3x per week for 3 months. The results of these audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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cause of the sacral redness.

Review of Resident #6's most recent Braden Score for Pressure Ulcer Risk (2) prior to 4/10/19 was on 3/12/19. Resident #6 was documented as being a low risk for obtaining pressures sores with a Braden score of 14.

Review of Resident #6's April 2019 POS (physician order summary) failed to evidence an order for barrier cream (skin protective cream) prior to 4/10/19. Review of Resident #6's skin integrity care plan dated 1/11/19 and revised 7/3/19, documented the following intervention dated 1/11/19: "Preventative barrier cream/ointment after incontinence care as needed." There was no evidence in Resident #6's clinical record that she was receiving barrier cream.

Further review of Resident #6's April 2019 POS revealed that Resident #6 was taking the following supplements prior to the sacral redness found on 4/10/19:

"1) ProStat (3)- two times a day for wound care, Make sure Prostat is sugar free by mouth 30 cc BID (two times a day)." This order was initiated on 12/14/18. (This order was put into place for a left heel unstageable ulcer that was identified on 11/28/18 and resolved (healed) on 3/4/19).

2) "MV-One (Multi-Vitamin) Give 1 capsule by mouth one time a day for wound care." This order was initiated on 12/15/18." (This order was put into place for a left heel unstageable ulcer that was identified on 11/28/18 and resolved (healed) on 3/4/19).

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F 686	Continued From page 37 Further review of Resident #6's April 2019 POS revealed that Resident #6 was on a pressure reduction mattress and had an order to turn and reposition the resident every two hours prior to the 4/10/19 sacral redness. There was no evidence that an intervention was put into place to prevent further skin breakdown after Resident #6's sacral redness was identified on 4/10/19. Review of Resident #6's skin integrity care plan dated 1/11/19 and revised 7/3/19, failed to evidence that a new intervention was put into place or that her care plan was reviewed after redness was found on 4/10/19. The next skin assessment documented in the clinical record was conducted during the overnight shift 4/13/19-4/14/19 (11 PM-7 AM shift). The following was documented: "Does the resident have current skin issues: Yes. Site 53) Sacrum, Description: redness." Further review of the the nursing notes failed to evidence a thorough assessment to determine a possible cause of the sacral redness. There was no evidence that an intervention was put into place for Resident #6's sacral redness identified again on 4/14/19. The next skin assessment dated 4/14/19 at 10:03 a.m., revealed that an unstageable pressure ulcer was found to Resident #6's sacral area. The following was documented by the DON (Director of Nursing): UTD (unable to determine) Wound Location: Sacrum Length (cm (centimeters))2 Width (cm) 0.8	F 686		

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Depth (cm)0
Area is in house acquired.
Skin impairment was not present on admission.
04/14/2019 Drainage type: Sanguineous
Drainage (4) Scant (small amount) Drainage
Wound bed appearance is Pink No odor
Periwound (around wound) appearance is Pink."

A skin assessment conducted by the LPN (Licensed Practical Nurse #2) assigned to Resident #6, documented the following on a Change of Condition Interact form on 4/14/19: "Skin evaluation: Pressure Sore: Sacrum
Describe the pressure sore: New onset Grade 2 or higher pressure ulcer, OR progression of pressure ulcer despite interventions.
Document location and details: 2.0 x 0.8 x 0.0 100% slough (dead tissue), surrounding tissue, pink and intact."

A nursing note dated 4/14/19 documented the following: "Open area noted to sacral region during ADL (activities of daily living) care, measurement 2.0 x 0.8 x 0.0, MD (medical doctor) and RP (responsible party) notified, treatment initiated, TAPS (turning and positioning) compliance, resident educated on importance of TAPS, stated understanding, will cont. to monitor and note changes."

Review of Resident #6's April 2019 physician orders, revealed the following treatment orders for her unstageable wound: "Santyl (5) Ointment 250 UNIT/GM (Collagenase). Apply to sacrum topically every day shift for wound care cleanse wound to sacrum with normal saline, pat dry, apply santyl to wound bed, followed by moistened saline gauze, cover with dry drsg (dressing), change QD (every day) and prn (as needed) until

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F 686	Continued From page 39 resolved." The next wound assessment conducted on 4/21/19 continued to identify Resident #6's sacral pressure ulcer as an unstageable. The following measurements were documented: "2.5 x 1.0 x 0 cm." Review of Resident #6's clinical record revealed that the wound care physician assessed Resident #6 on 4/24/19. The following was documented: "Patient presents with a wound on her sacrum. She has an unstageable (due to necrosis) sacrum for at least 1 days in duration. There is moderate serous exudates (6). The patient verbalizes pain with score of 5 out of 10. Medication affecting wound healing: No medication found to be affecting wound healing in clinical context. Unstageable due to necrosis (dead tissue) (Sacrum): etiology: Pressure, Wound Size: 3.0 x 1.0 x not measurable. Thick adherent devitalized necrotic tissue: 90 % (percent). Granulation tissue: 10 %. Primary dressings: santyl apply once daily for thirty days; Dakins (7) solution apply once daily for 30 days. 1/4 strength dakins moistened gauze. Secondary Dressing: Foam silicone border apply once daily for 30 days. Plan of Care Reviewed and Addressed: Off-load wound, Reposition per facility protocol, Gel cushion to wheelchair, low air low mattress (LAL), Vitamin C 500 mg (supplement) twice daily PO (by mouth); Zinc sulphate (supplement) 220 mg once daily PO for 14 days." Review of Resident #6's clinical record revealed that the above recommendations made by the wound care physician were put into place and wound treatments were completed. The following	F 686		

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F 686	Continued From page 40 interventions were added to her skin integrity care plan dated 1/11/19: "LAL (low air loss) mattress (4/23/19), Supplement as ordered (4/26/19)." On 5/17/19 per wound care assessment by the wound care physician, her sacral wound remained an unstageable. The following recommendation was made: "Would recommend foley catheter placement for healing." Review of Resident #6's clinical record revealed a Foley catheter was placed on 5/9/19. The following order was documented: "FOLEY... WOUND HEALING: Foley Cath Size (16)Fr (french) with a (30) ml (milliliter) Balloon." Further review of Resident #6's wound care physician notes revealed that her sacral wound improved to a stage 3 on 5/14/19 and then deteriorated (worsened) to a stage 4 on 6/25/19. The following was documented: "Stage 4 pressure wound sacrum- deteriorated due to generalized decline of patient, nutritional compromise. Add Negative Pressure (wound vac) (8) twice a week." On 7/11/19 at 10:00 a.m., an observation of Resident #6's wound was attempted. The resident was in too much pain despite given medication prior and the resident did not want to continue the dressing. On 7/11/19 at 9:47 a.m., an interview was conducted with ASM (administrative staff member) #2. It was explained to ASM #2 that this writer could not find evidence that anything was put into place after sacral redness was found on 4/10/19. Additional evidence was requested. ASM #2 stated that anytime the staff see redness they	F 686		

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F 686	Continued From page 41 will implement a barrier cream. When asked if there was evidence that this barrier cream was being used, ASM #2 stated that they didn't normally write orders for it. ASM #2 stated that she could not provide evidence that staff were implementing the barrier cream once the redness was found. ASM #2 stated that every resident usually has a barrier cream and that the staff will use if needed. ASM #2 stated that Resident #6 had been using barrier cream. When asked if the barrier cream was in place prior to the sacral redness, if she would consider changing treatment if it was not effective, ASM #2 stated, "I think it was working." ASM #2 stated that the resident would also sit up in her chair all day long that could also contribute to her pressure sore. When asked if she would expect to see a more thorough skin assessment of the sacral redness documented on 4/10/19; ASM #2 stated that she would have expected to see if the skin was blanchable or non-blanchable. When asked if she could describe the difference between blanchable and non-blanchable skin, ASM #2 stated that blanchable skin will return to normal color after pressed which means the redness was caused by lying on the area for certain amount of time or just irritation to the skin. LPN #2 stated that non-blanchable skin could indicate a stage one pressure ulcer. On 7/11/19 at 1:40 p.m., ASM #1, the administrator and ASM #2, the DON were made aware of a concern for harm. On 7/11/19 at 3:20 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, the nurse who discovered the unstageable on 4/14/19. When asked the process if she were to see redness to a resident's sacral area during a	F 686		

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F 686	Continued From page 42 skin assessment, LPN #2 stated that if there was redness she would implement a barrier cream and try to turn and reposition the resident every 2 hours and offload the resident off the area. LPN #2 stated that as long as the skin was not open, she would implement barrier cream. When asked if a physician's order was required to use barrier cream, LPN #2 that there needed to be an order so that staff know to put it on. When asked if she would assess the redness further, LPN #2 stated that she would assess and document if the redness was blanchable or non-blanchable etc. LPN #2 stated that non-blanchable skin could indicate a pressure ulcer. LPN #2 stated that whether the skin was blanchable or non-blanchable should be included in the skin assessment. LPN #2 stated that she would document what treatment or interventions should put into place. When asked how often skin assessments were completed, LPN #2 stated that skin assessments were completed bi-weekly on 11-7 shift and if there is a new skin condition. When asked what she could remember about Resident #6's sacral wound, LPN #2 stated that it was reported to her by the aide on 4/14/19, that Resident #6 had a new skin area. LPN #2 could not remember what the wound had looked like when she did her initial assessment. LPN #2 looked at Resident #6's physician orders and stated that if she had obtained an order for Santyl, than the wound must of had slough. LPN #2 then stated that the wound must have been an unstageable. LPN #2 stated that the DON usually comes behind her to stage and measures wounds. LPN #2 stated that Resident #6 had an air mattress prior to the wound but that they had switched her mattress to a LAL (low air loss) mattress after the wound was found. When asked if it was common or possible for a wound to	F 686		

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F 686	Continued From page 43 deteriorate from nothing to an unstageable, LPN #2 stated that it may have been common for Resident #6 because she liked to stay up in her chair for a very long time and that Resident #6 was also diabetic which affected wound healing. LPN #2 stated that 4/14/19 was the only day the aide had reported a skin area. LPN #2 stated that she was not aware of any sacral redness on 4/10/19. On 7/11/19 at 3:48 p.m., an interview was conducted with ASM (administrative staff member) #4, the physician. When asked if it was possible for a resident to have no skin impairments and then a wound be found at an unstageable, ASM #4 stated, "It does happen, but it's going to be rare." ASM #4 stated that there was a gap of time before she was able to see Resident #6 for the first time so she could not say how Resident #6's wound first presented. ASM #4 stated that if the nurse had documented sacral redness on 4/10/19, then that sacral redness should have been assessed further and documented. ASM #4 could not say for certain if her sacral wound was avoidable or unavoidable but that Resident #6 was non-compliant and wanted to sit in her chair all day. ASM #4 stated that the staff also had to combat moisture due to incontinence and that a Foley catheter was eventually placed for healing. Further review of Resident #6's comprehensive care plan dated 1/11/19, failed to evidence Resident #6's noncompliance with getting out of her wheelchair to offload pressure. The 11-7 nurse who had originally documented the sacral redness on 4/10/19 was attempted for an interview and could not be reached on 7/11/19	F 686		

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at 4:23 p.m.

On 7/11/19 at 4:33 p.m., an interview was conducted with LPN #1, the nurse who identified sacral redness for the second time on 4/14/19, 11-7 shift. When asked the process if she were to identify sacral redness that was not previously present, LPN #1 stated that if the resident had a treatment in place, she would continue the treatment or put a treatment in place such as turning the resident side to side, offloading the wound, an order for Calmoseptine (barrier cream etc). LPN #1 stated that she would check to see if the skin was blanchable or non-blanchable. LPN #1 stated that if it was non-blanchable, the redness would be a stage one pressure. When asked if she could recall Resident #6, LPN#1 stated that she worked with Resident #6 every other weekend. LPN #1 was shown her skin assessment conducted 4/14/19 on 11-7 shift. When asked what "redness" meant to Resident #6's sacral area, LPN #1 stated that when she had completed that assessment she looked at Resident#6's bottom, saw that barrier cream was applied, saw redness around the wound and just documented sacral redness. LPN #1 confirmed that she did not fully assess the wound because barrier cream was in place and she did not want to disrupt the barrier cream.

On 7/11/19 at 5:05 p.m., ASM #1, the administrator, ASM #2, the DON, and Corporate #1, the Regional Director of Clinical Services were made aware of the above concerns.

Facility policy titled, "What is a Pressure Ulcer," documents in part the following: "Pressure Ulcers can appear differently depending on the severity of the injury. They can appear simply as a

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discoloration (or redness) of the skin or as complex as dead, black tissue (called necrosis) with exposure of underlying structures like muscle and bone...If you notice any suspicious discoloration or skin breakdown over a bony prominence, you should notify your doctor immediately."

Facility policy titled, "Skin and Wound Care Guideline," did not address the above concerns.

(1) Unstageable pressure ulcer*- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. 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 website at http://www.npuap.org/pr2.htm.

*A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

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(2) The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. <http://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN/>

(3) Prostat is a supplement high amino acids that are a critical factor in replenishing depleted protein stores and accelerating tissue healing in patients with pressure ulcers. This information was obtained from https://www.cwimedical.com/liquid-supplement/pro-stat-awc-sugar-free-advanced-wound-care-liquid-protein-ps-awc-sf.

(4) Sanguinous Drainage is the blood and the liquid part of blood (serum). This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4717498/.

(5) *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

(6) Serous exudate is thin, clear, watery drainage. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4717498/.

(7) Dakins 1/4 strength solution is an

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F 686	Continued From page 47 antimicrobial used to prevent and treat infections of the skin and tissue. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9906e5fe-7bf5-4d99-8107-c048bb5e42d5. (8) A wound vacuum (Wound Vacuum Assisted Closure) is a device that assists in wound closure by applying localized negative pressure to draw the edges of the wound together....accelerates wound healing...." This information was obtained from Fundamentals of Nursing 6th Edition, Potter & Perry, 2005. Page 1536. 2. The facility staff failed to follow physician orders for a wound care dressing change to Resident #21's left heel *pressure ulcer on 7/10/19. Resident #21 was originally admitted to the facility on 03/29/19. Diagnoses for Resident #21 included but are not limited to Type II Diabetes Mellitus. Resident #21's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 05/04/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #21 extensive assistance of two with personal hygiene, extensive assistance of one with bathing, toilet use, dressing and bed mobility for Activities of Daily Living care. Under section M-skin condition was coded for pressure ulcer care. Resident #21's comprehensive care plan revised on 04/15/19, documented Resident #21 with area	F 686		

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to left heel. The goal: resident will have intact skin, free from redness, blisters or discoloration by/through next review. Some of the intervention/approaches to manage goal included: administer treatments as ordered and monitor for effectiveness of treatment and update physician as needed and assess/document/report to physician as needed with changes in skin status.

Review of Resident #21's July 2019 Treatment Administration Record (TAR) consisted of the following order: starting on 06/28/19-cleanse left heel with normal saline, pat dry, apply *calcium alginate and dry dressing every day shift for wound care; *skin prep around peri-wound (skin surround the wound.)

On 07/10/19 at approximately 10:56 a.m., Resident #21 was observed lying in bed in supine position. The treatment supplies consisted of 4 x 4 gauzes, normal saline, dry adhesive dressing, Calcium Alginate and hand sanitizer. The LPN washed her hands for 18 seconds then donned a set of gloves. The wound was cleaned twice with a saline soaked gauze, pat dry, the LPN cut a piece of Calcium Alginate to fit the left heel wound, placed the cut Calcium Alginate to the wound bed then secured the Calcium Alginate in place with the dry adhesive dressing, removed her gloves then washed her hands for 19 seconds.

On 07/11/19 at approximately 2:58 p.m., an interview was conducted with LPN #5. The LPN read Resident #21's treatment order for the pressure ulcer to the left heel. The surveyor asked, "Should you have used skin prep to the peri-wound of the left heel ulcer." The LPN

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F 686	Continued From page 49	F 686		

stated, "I though peri-wound meant the sacrum then stated, "Yes, I should have used skin prep around the left heel wound."

An interview was conducted with the Director of Nursing (DON) on 07/11/19 at approximately 6:00 p.m. The DON read Resident #21's treatment order for the pressure ulcer to the left heel. The surveyor asked, "Should the nurse have applied skin prep around the skin surrounding the left heel wound" the DON replied, "That's pretty simple, yes." The surveyor informed the DON that LPN #5 did not use skin prep during the left pressure ulcer wound care. The DON said the nurse should have used skin prep as ordered by the physician. The surveyor asked, "What is the purpose of using skin prep" she replied, "To help keep the dressing in place and also used for skin protection."

The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the findings.

The facility's policy titled) Skin and Wound care Guideline (Revised-September 2014).

Wound and Dressing Care include but not limited to:
-Dressing/treatment orders: Follow the physician's order for the type and frequency of treatment.

Definitions:
*A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony

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F 686	Continued From page 50 prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) . *Calcium alginate is a sterile primary dressing that can be cut to fit wounds with moderate to heavy exudate while maintaining a moist wound environment (woundsource.com). *Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/).	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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 interview, clinical	F 689		

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F 689	Continued From page 51 record review and facility document review, it was determined that facility staff failed to implement interventions to reduce the potential for accidents/hazards for one of 36 residents in the survey sample, Resident #6. For Resident #6, facility staff failed to ensure her fall mat was placed on the floor while she was in bed per physician's order to prevent injuries. The findings include: Resident #6 was admitted to the facility on 6/1/2015 with diagnoses that included but were not limited to Chronic Kidney Disease Stage 3, high blood pressure, type two diabetes, hypothyroidism and Bipolar disorder. Resident #6's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 4/22/19. Resident #6 was coded as requiring extensive assistance from one staff member with toileting, personal hygiene and dressing; and extensive assist with two plus staff member with bed mobility and transfers. Review of Resident #6's current July 2019 POS (Physician Order Summary), revealed the following orders: "Fall mat at bedside, in place when resident is in bed..." This order was initiated on 5/30/18. Review of Resident #6's comprehensive care plan dated 6/4/15 and revised 5/3/19 documented the following for her falls: "(Name of Resident #6) is at risk for injury, multiple risk factors related to deconditioning, psychoactive drug use, bladder incontinence, bowel incontinence, functional problem related r/t (related to) hx (history) R	F 689	F 689 1. Resident #6 has been discharged from the facility 2. Residents who have physician's orders for fall mats have the potential to be affected. 3. The Director of Nursing or designee will educate the nursing staff on implementing physician's orders, specifically related to the placement of fall mats. 4. The Director of Nursing or designee will audit/observe residents with physician's orders for fall mats to ensure the fall mats are in place as ordered. This audit will be completed 5x a week for 3 months. The results of these audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete by 8/19/19	

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F 689	Continued From page 52	F 689		

(right) ankle fracture. Goal: (Name of Resident #6) will have no fall related injuries through next review. Interventions: "Fall matt (sic) to bedside (Date Initiated: 5/31/2019)."

On 7/9/19 at 12:44 p.m., an observation was made of Resident #6. She was lying in bed on her back. A fall mat was not observed to be at the side of the bed. At this time Resident #6 had asked this writer to get the nurse so she could be readjusted in bed.

On 7/9/19 at 1:49 p.m., an observation was made of Resident #6. She was lying in bed on her right side. A fall mat was not observed to be at the side of the bed.

On 7/10/19 at 8:15 a.m., a blue fall mat was observed to be on the right side of her bed while the resident was in bed.

On 7/10/19 at 8:57 a.m., Resident #6 was observed up in bed eating breakfast with her over bed table in front of her. The base of the over bed table was to the right of Resident #6. The fall mat was folded up at the foot of her bed.

On 7/10/19 at 9:57 a.m., CNA (certified nursing assistant) #1, (Resident #6's) aide, removed her breakfast tray and walked out of Resident #6's room. Resident #6's over bed table was pushed off to the right of Resident #6's bed. CNA #1 did not come back to put the fall mat back down.

On 7/10/19 at 10:10 a.m., and 10:25 a.m., Resident #6 was observed lying in bed without her fall mat in place.

On 7/10/19 at 10:40 a.m., LPN (Licensed

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F 689	Continued From page 53 Practical Nurse) #2, Resident #6's nurse was observed entering Resident #6's room with her Morphine. LPN #2 exited her room shortly after. This surveyor made an observation at 10:45 a.m., that Resident #6's blue fall mat was now on the floor to her right side. On 7/10/19 at 10:47 a.m., an interview was conducted with LPN #2. When asked if she had just put Resident #6's fall mat back down on the floor, LPN #2 confirmed that she did. When asked if it had been on the floor earlier that morning, LPN #2 stated that it was originally on the floor and that the staff usually pick it up when they deliver Resident #6's meal trays. LPN #2 stated that the over bed table cannot move on top of the fall mat and they have to remove the mat. When asked if staff should be placing the fall mat back down once Resident #6 has finished her meals, LPN #2 stated that it should be. When asked if Resident #6 was a fall risk, LPN #2 stated that Resident #6 used to be a high fall risk but that she had not had any falls in some time. LPN #2 stated the mat was a preventive measure to prevent injury from falls especially while the resident received a blood thinner. On 7/11/19 at 10:27 a.m., an interview was conducted with CNA (certified nursing assistant) #1, Resident #6's aide. CNA #1 confirmed that she was assigned to Resident #6 on 7/10/19 and that she had probably had been the aide that removed her breakfast tray. When asked the process (what staff should do), if they see a fall mat that is folded up in a resident's room and the resident is in bed, CNA #1 stated that she would put the fall mat back on the ground. CNA #1 was told about the observations made on 7/10/19. CNA #1 confirmed that she should have put the	F 689		

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F 689	Continued From page 54 fall mat back down once Resident #6 had completed her meal. When asked how CNAs know what things each resident needs in place such as fall mats, devices etc. CNA #1 stated that she will get report from the nurse or she can look at a nursing Kardex for each resident. Review of Resident #6's current nursing Kardex revealed that it did not address fall mats. Review of Resident #6's clinical record revealed that her last recorded fall was on 9/28/18 with a minor injury. The care plan was updated with the following intervention: "Encourage resident to eat up in W/C (wheelchair) for meals." Further review of Resident #6's clinical record revealed that her last fall risk assessment was conducted on 9/28/18. The risk assessment did not have a scoring system to determine her risk for falls. On 7/11/19 at 5:05 p.m., administrative staff member (ASM) #1, the administrator, ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Resident Safety," did not address the above concern. No further information was presented prior to exit.	F 689		
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 with professional standards of practice, the	F 698		

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F 698	Continued From page 55 comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to communicate an ongoing assessment for one resident (Resident #1) of 36 residents in the survey sample for monitoring of complications after dialysis treatment; and failed to check weights on Resident #1. The facility staff failed to communicate an ongoing assessment with the dialysis center for Resident #1 who attended outpatient dialysis three days per week on Monday, Wednesday and Friday. The facility staff failed to obtain weights on Resident #1 when she returned from dialysis on most days. The findings included: Resident #1 was originally admitted to the facility on 04/19/17. Diagnoses 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 at an outpatient dialysis center. The current Minimum Data Set (MDS) a Quarterly assessment with an Assessment Reference Date (ARD) of 01/24/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, under section	F 698	F 698 1. Resident #1 has a Dialysis Communication book and a physician's order to be weighed when returning from dialysis. 2. All Dialysis patients in the facility have the potential to be affected by this practice. 3. The Director of Nursing or designee will educate the Licensed Nursing staff on following physician's orders and appropriate communication with the dialysis center regarding the facility's patients. A communication note book will be provided to each dialysis resident to take to dialysis. This will be used as a communication tool between the dialysis center and the facility. In the event that the note book is not complete upon return from the dialysis center, the Licensed Nurse will contact the dialysis center to receive any necessary information and document that information in the resident's medical record.	

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F 698	Continued From page 56 (O) for Special Treatments, Procedures and Programs, the resident was coded for dialysis. Resident #1's Care Plan included: weigh per protocol and as needed. Use aseptic technique and universal precautions. Resident #1's physician orders contained the following orders: (1) Dialysis on Monday, Wednesday and Friday. (2) If bleeding occurs from the dialysis site apply pressure and call 911 as needed. (3) Monitor Dialysis port for signs and symptoms of infection for every shift. (4) Obtain weights upon return from dialysis. Notify MD if 3+ lbs is noted one time a day every Monday, Wednesday and Friday. (5) Dialysis return assessment in the evening every Monday, Wednesday and Friday. A review of Resident #1's weights for the Month of May showed the following: 05/01/19 resident weighed 106 lbs. 05/14/19 resident weighed 103.4 lbs. 05/16/19 resident weighed 105.5. 05/20/19 resident weighed 108.2 lbs. A review of Resident #1's weight for the Month of June showed the following: 06/19/19 resident weighed 106.4 lbs. No other weighs were recorded for the month of June. A review of Resident #1's weight for the Month of July showed the following: 07/05/19 resident weighed 105 lbs. 07/10/19 resident weighed 105.5 lbs. No other weights were obtained. An interview was conducted with Licensed	F 698	4. The Director of Nursing or designee will audit the dialysis communication book for each resident for appropriate content and correspondence 3x a week for 3 months. Additionally, the Director of Nursing or designee will audit each dialysis patient's weight upon return from dialysis 3x a week for 3 months. The results of these audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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F 698	Continued From page 57 Practical Nurse (LPN) #5 on 07/11/2019 at approximately 9:45 am. She was asked if she could view Resident #1's Dialysis Communication Book. LPN #1 stated that she would have to get permission from the resident because she has her communication book with her at all times. The communication sheet listed that resident was receiving dialysis at (Name) Dialysis Center on Monday, Wednesday and Fridays at 11:00 AM. There were no communication notes from 7/10/19. The last communication notes in the book were dated 06/07/19-06/10/19. LPN #5 stated that resident is attending a new facility as of Monday because she was disruptive to other residents. She had to change dialysis centers. Resident told nurse she left the communication sheet in the transportation van. LPN #5 was asked what should have been done. She said "They should have called the dialysis place and received the notes." An interview was conducted with LPN #5 (Licensed Practical Nurse) Unit Manager (East Wing) on 07/11/19 at approximately 5:20 PM. She stated that the resident will refuse to be weighed sometimes. LPN #5 was asked what should have been done. She said that when the resident returns after dialysis the 3-11 (PM) shift should document resident's weight because she usually returns to the facility between 4:30 PM and 5:00 PM. and if she refuses to be weighed her POA (Power of Attorney/responsible party) should be called. On 07/11/19 at approximately, 3:14 PM a briefing was held with the Administrator, Director of Nursing, the Regional Director of Clinical Services. The administrator stated "We should have communicated with the dialysis center by	F 698		

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F 698	Continued From page 58 telephone or fax." On 07/11/19 at approximately 7:30 PM an interview was conducted with Resident #1 concerning staff obtaining her weights when she returns from dialysis. Resident was asked if she was refusing being weighed when she comes back from dialysis. She stated "No," "That's a lie." She was also asked if she gives staff her communication book to keep for her when she returns from dialysis. She stated "No." "because they lost it one time." "I keep it myself." On 07/11/19 at approximately 7:35 PM the following Certified Nursing Assistants (CNAs) were interviewed concerning weighing resident when she returns from dialysis. CNA #2 was asked if resident #1 is assigned to her when resident returns from dialysis and does she obtain resident weights. She stated "No." CNA #5 stated "I normally work the 11 (PM)-7 (AM) shift; If I come in early, no one tells me to weigh her." CNA #6 stated "When (Resident #1) come in from dialysis I get her vital signs and weigh her. I record the vital signs and her weight on a piece of paper with the date, time and give the information to the nurse to record in the system." The facility's policy titled Hemodialysis Care Policy-Effective date-June 16, 2017. -Policy statement: The licensed nursing staff will use the following criteria as part of the patient/resident's comprehensive assessment to determine whether or not to proceed with care planning. Risks and complications unique to each patient/ resident will be documented on the individualized plan of care. The general	F 698		

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F 698	Continued From page 59 guidelines and emergency guidelines The goal should provide: 1. The specialized care needed. 2. Maintain patency of the shunt/central line. 3. Prevent infection or medical complications. Plan of Care Protocol: Pre and post dialysis weight for every visit provided by dialysis center. The above issues were addressed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/11/19 at approximately 3:14 PM. No additional information was presented.	F 698		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interviews and facility documentation review, the facility staff failed for one (Resident #181) of 36 residents in the survey sample, to assist with transportation arrangements in order to attend an appointment with an outside physician. The findings included: The facility staff failed to ensure Resident #181 attended her scheduled physician appointment on 07/09/18. Resident #181 was admitted to the facility on 07/02/18. Being the resident was no longer in the facility a closed record review was conducted. Diagnoses for Resident #181 included but not	F 745		

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F 745	Continued From page 60 limited to Atherosclerotic Heart Disease, Cerebral Infarction (stroke) and Chronic COPD. The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #181's Admission Evaluation coded Resident #181 as alert and oriented x 4. Under ADL/Mobility for level of functioning included the following: the assist of two with ambulation, toileting and transfers, assist of one with bed mobility, bathing and dressing for Activities of Daily Living care. Review of Resident #181's hospital discharge summary dated 07/02/18 included the following doctor's appointment: Follow up with Dr. (Name) to discuss *WATCHMAN device on 07/09/18 at 1:00 p.m. Review of Resident #181's clinical record was conducted 07/09/19 at approximately 12:22 p.m. and revealed the following information: "Resident had an appointment today, family came and resident stated to cancel appointment. Resident had not set up transportation." An interview was conducted with Licensed Practical Nurse (LPN) #5 (Unit Manager on East) on 07/10/19 at approximately at 9:00 a.m., LPN #5 stated, "The facility's admitting nurse should have reviewed Resident #181's discharge summary for any upcoming appointments." She explained the nurse is to complete the Transportation Form for appointments then give the completed form to Social Services (SS). SS is to set up transportation for the resident. The LPN said the resident is not responsible for making their own transportation; the Social Worker (SW) is responsible for making the residents transportation arrangements.	F 745	F 745 1. Resident #181 was discharged from the facility 2. All residents with scheduled appointments have the potential to be affected. 3. The Director of Nursing, or designee will educate the Licensed Nursing staff of identifying Physicians appointments on the hospital discharge summary, scheduling the appointments and completing a transportation request that will be given to the Social Services department. 4. The Director of Nursing or designee will review all new admissions for scheduled appointments. The Director of Nursing or designee will audit the appointment date/time, transportation request completed and given to social services. This audit will be completed Monday- Thursday, with Friday, Saturday and Sunday being completed on Monday for 3 months. The results of these audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be completed 8/19/19	

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F 745	Continued From page 61 On 07/11/19 at approximately 9:10 a.m., an interview was conducted with the Social Worker. The SW reviewed Resident #181's hospital discharge. After he reviewed the hospital discharge the SW stated, "Resident #181 had a scheduled appointment follow up with Dr. (Name) to discuss watchman device on 07/09/18 at 1:00 p.m." He said "The nurse should have given me a completed transportation request form for Resident #181 whether the family was taking the resident or not." He said they would have followed up with the family to make sure transportation arrangements were made and that the resident should have never missed her physician appointment. The Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the findings. Definitions: *WATCHMAN device is a permanent, one-time implant designed to keep harmful blood clots from entering your blood stream and potentially causing a stroke (uchealth.org). Complaint deficiency.	F 745		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		

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F 880	Continued From page 62 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880	1. CNA #1 for resident #33 was educated on the Infection Control policy on 7/31/19. The LPN for resident #21 was educated on the Infection Control policy on 7/10/19. The facility reviewed the Infection Prevention and Control Policy on 7/16/19. 2. All residents in the facility have the potential to be affected by this practice. 3. The Director of Nursing or designee will educate all staff on the Infection Prevention and Control policy. Additionally, Licensed Nurses will be educated on Infection control practice during treatments. Annually the facility QAPI committee will review the Infection Prevention and Control policy and amend the policy as necessary. This annual review will be documented in the committee's minutes. 4. The Director of Nursing or designee will conduct random Infection Control rounds/audits 3xa week for 3 months. The Director of Nursing or designee will observe/audit wound treatments 3x a week for 3 months. The results of these audits will be reported to the facility's QAPI committee for discussion and necessary revision. 5. Corrective action will be complete on 8/19/19	

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F 880	Continued From page 63 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain infection control practices for two of 36 residents in the survey sample (Residents #33 and #21); and facility staff failed to ensure annual review of the infection control policies. 1. For Resident #33, facility staff failed to maintain infection control practices during breakfast on 7/10/19. 2. The facility staff failed to ensure infection control measures were implemented during wound care to Resident #21's left heel pressure ulcer.	F 880		

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F 880	Continued From page 64	F 880		

3. The facility staff failed to ensure the Infection Prevention & Control policy was reviewed annually.

The findings include:

1. Resident #33 was admitted to the facility on 10/6/18 and readmitted on 11/20/18 with diagnoses that included but were not limited to high blood pressure, heart failure, muscle weakness, and hypothyroidism. Resident #33's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/15/19. Resident #33 was coded as being intact in cognitive function scoring 13 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #33 was coded as requiring limited assistance with meals.

On 7/10/19 at 9:00 a.m. observation of breakfast was conducted in the resident rooms. At 9:06 a.m., CNA #1 was observed walking out of room 617 and then to the meal cart. CNA #1 grabbed the meal tray for Resident #33 and walked into her room. At 9:07 a.m., CNA #1 placed her meal tray in front of Resident #33 and removed the lid off the plate. CNA #1 then walked out of Resident #33's room and walked up the hall to room 614. At 9:08 a.m., CNA #1 walked out of room 612 with a white towel in her hand. CNA #1 then walked into Resident #33's room, placed the towel over Resident #33's shirt and began cutting up Resident #33's meal. CNA #1 was also not observed to wash or sanitize her hands in between going in and out of all three rooms.

On 7/11/19 at 10:27 a.m., an interview was

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conducted with CNA #1. When asked how to maintain infection control going in and out of resident rooms, CNA #1 stated that she would sanitize or wash her hands after leaving a room and prior to starting care and/or assisting the next resident. When asked if it was okay to grab a towel from a residents room to be used on another resident, CNA #1 stated that was never okay to do. When asked if she could recall the above observation, CNA #1 stated, "Honestly I don't recall." CNA #1 then stated, "I know that is cross contamination. I know you can't do that."

On 7/11/19 at 5:05 p.m., administrative staff member (ASM) #1, the administrator, ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Infection Control," did not address the above concerns.

No further information was presented prior to exit.
2. Resident #21 was originally admitted to the facility on 03/29/19. Diagnosis for Resident #21 included but are not limited to *Type II Diabetes Mellitus. Resident #21's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 05/04/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #21 extensive assistance of two with personal hygiene, extensive assistance of one with bathing, toilet use, dressing and bed mobility for Activities of Daily Living care. Under section M-skin condition was coded for pressure ulcer care.

Resident #21's revised comprehensive care plan

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F 880	Continued From page 66 on 04/15/19 documented Resident #21 with area to left heel. The goal: resident will have intact skin, free from redness, blisters or discoloration by/through next review. Some of the intervention/approaches to manage goal included: administer treatments as ordered and monitor for effectiveness of treatment and update physician as needed and assess/document/report to physician as needed with changes in skin status. Review of Resident #21's July 2019 Treatment Administration Record (TAR) consisted of the following order: starting on 04/17/19-apply bilateral *prevalon boots while in bed every shift. On 07/10/19 at approximately 10:56 a.m., Resident #21 was observed lying in bed in supine position with prevalon boot to left heel. The LPN washed her hands x 18 seconds then donned a set of gloves. The LPN removed Resident #21's left heel from a prevalon boot; left pressure ulcer observed without a dressing with small amount of serosanguineous drainage present. The LPN placed the left foot back inside the prevalon boot. The LPN removed her gloves, used hand sanitizer, donned a new pair of gloves, removed the left heel from the prevalon boot, cleaned the wound x 2 with a saline soaked gauze, pat dry, then placed the left foot (left heel pressure ulcer without dressing) back inside the prevalon boot. The LPN cut a piece of Calcium Alginate to fit the left heel pressure ulcer wound. The LPN removed the left foot from the prevalon boot, placed the cut Calcium Alginate to the wound bed then covered with a dry adhesive dressing. The LPN removed her gloves then washed her hands x 19 seconds.	F 880		

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F 880	Continued From page 67 An interview was conducted with LPN #6 on 07/10/19 at approximately 2:50 p.m., who stated, "I should have not placed the left foot back inside the prevalon boot to prevent the potential spread of infection." She said the left heel should have elevated off the bed while wound care was being performed. On 07/10/19 at approximately 2:55 p.m., an interview was conducted with LPN #5 (Unit Manager on East). The LPN said placing the foot back inside the prevalon boot is an infection control problem. She said the wound is now contaminated from the boot so the wound should have been clean again before dressing the pressure ulcer. She said a barrier should have been put in place; the wound should not touch the bed or be placed back inside the prevalon boot. The LPN stated, "The boot is not clean so it can cause cross contamination." An interview was conducted with the Director of Nursing (DON) on 07/11/19 at approximately 5:25 p.m. The DON said the nurse should have never placed the left foot with the pressure ulcer back inside the prevalon boot after cleaning the wound. She said inside the prevalon boot is a contaminated surface. The DON said the nurse should have propped the foot with the boot or laid the foot on a clean surface or have an extra pair of hands to hold the foot while wound care was being performed. The DON said this is an infection control issue." The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the	F 880		

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findings.

The facility's policy titled (Infection Control-effective May 2015).
-Purpose: To protect residents and staff by preventing the spread of infection.

Definitions:

*A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)
.

*Prevalon boots give patients the most advanced protection against heel pressure ulcers and foot drop. Prevalon helps minimize pressure, friction and shear on your patient's feet, heels and ankles. By elevating the foot and separating the heel from the mattress, it delivers total heel pressure relief (http://www.sageproductsglobal.com/en/prevalon.cfm).

*Calcium alginate is a sterile primary dressing that can be cut to fit wounds with moderate to heavy exudate while maintaining a moist wound environment (woundsource.com).

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3. On 07/11/2019 at 5:00 p.m., an interview was conducted with the Director of Nursing (DON) to review the facility's Infection Prevention Control Program and observed that the Infection Prevention Control Prevention Program Policy was dated April 10, 2017 as the last date reviewed. The DON stated that she would speak to the Administrator to see if he had a copy of the policy that was dated more recent.

On 07/11/2019 at approximately 5:30 p.m., the DON was unable to provide any further documentation.

On 07/11/2019 at approximately 7:00 p.m., an interview was conducted with the Administrator and he was asked, "What are your expectations of the facility staff reviewing the facilities Infection Prevention Control Program Policy?" The Administrator stated, "The facility will review the policy immediately. I expect all policies to be reviewed annually or more often as needed."

The Administrator, Director of nursing and the Regional Director of Clinical Services was informed of the finding on 07/11/2019 at approximately 8:10 p.m. The facility did not present any further information about the finding.

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