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	495266	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANOVER HEALTH AND REHABILITATION CENTER	8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111

(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 7/14/19 through 7/16/19, and 8/5/19 through 8/7/19. Corrections are required for compliance with 42 CFR Part 483.73 Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by:	E 022		9/21/19

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

Electronically Signed | 08/29/2019

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E 022	Continued From page 1 Based on staff interview and facility documentation review, the facility staff failed to have policies and procedures for how it will provide a means to shelter in place for residents, staff, and volunteers. The Findings included: On 7/16/19 the facility's Emergency Preparedness Plan was reviewed with the Administrator (Employee A). The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures for how it will provided a means to shelter in place for residents, staff, and volunteers. During the review the Administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 022	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. There were no untoward affects to patients related to this policy. 2. All patients have the potential to be affected by this practice. 3. Staff Development Coordinator (SDC) or Designee will educate on policy for shelter in place. 4. The Administrator will complete a random monthly review of the Emergency Preparedness program to ensure that there are policies and procedures for shelter in place. 5. Date of Compliance is September 21st, 2019.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be	E 024		9/21/19

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E 024	Continued From page 2 reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have policies and procedures for the use of volunteers and other staffing strategies. The Findings included: On 7/16/19 the facility's Emergency Preparedness Plan was reviewed with the Administrator (Employee A). The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures for the use of volunteers and other staffing strategies.	E 024	1. There were no untoward affects to patients related to this policy. 2. All patients have the potential to be affected by deficient practice. 3. SDC or Designee will educate staff on policy for use of volunteers in an emergency. 4. The Administrator will complete a random monthly review of the Emergency Preparedness program to ensure that there are policies and procedures for use of volunteers and other staffing strategies. 5. Date of Compliance is September	

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E 024	Continued From page 3 During the review the Administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 024	21st, 2019.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have policies and procedures to describe the facility's role in providing care and treatment at	E 026	1. No untoward affects to patients related to policy for alternate care sites under a 1135 waiver. 2. All patients have the potential to be	9/21/19

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E 026	Continued From page 4 alternate care sites under a 1135 waiver. The Findings included: On 7/16/19 the facility's Emergency Preparedness Plan was reviewed with the Administrator (Employee A). The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures to describe the facility's role in providing care and treatment at alternate care sites under a 1135 waiver. During the review the Administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 026	affected by deficient practice. 3. SDC or Designee will educate staff on policy describing role of facility providing care at alternative sites. 4. The Administrator will complete a random monthly review of the Emergency Preparedness program to ensure that there are policies and procedures for roles under waiver into Emergency Preparedness Plan. 5. Date of Compliance is September 21st, 2019	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by:	E 032		9/21/19

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E 032	Continued From page 5 Based on staff interview and facility documentation review, the facility staff failed to ensure that the emergency preparedness communication plan included primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. The Findings included: On 7/16/19 the facility's Emergency Preparedness Plan was reviewed with the Administrator (Employee A). The review showed that the facility's emergency preparedness communication plan did not include primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies. During the review the Administrator stated that she was not able to locate the missing items. No further information was provided by the facility.	E 032	1. No untoward affects to patients related to policy for Emergency Preparedness Communication Plan.. 2. All patients have the potential to be affected by deficient practice. 3. SDC or Designee will educate staff on Emergency Preparedness Communication Plan. 4. The Administrator will complete a random monthly review of the Emergency Preparedness program to ensure that there are policies and procedures for Emergency Preparedness Communication plan including alternate and primary means of communication. 5. Date of Compliance is September 21st, 2019.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/14/19 through 7/16/19 and 8/5/19 through 8/7/19. An extended survey was conducted 8/6/19 - 8/7/19. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Six complaints were investigated during the survey. The Life Safety Code survey report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 46 Resident reviews.	F 000		

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F 000	Continued From page 6 On 8/6/2019, Immediate Jeopardy was identified in the following areas: Freedom from Abuse, Neglect, and Exploitation (F600) at a scope and severity level four, pattern. After abatement on 8/7/19, it was lowered to a level three pattern; Comprehensive Resident Centered Care Plans (F658) at a scope and severity level four, pattern. After abatement on 8/7/19, it was lowered to a level three, pattern; Quality of Care (F686) at a scope and severity level four, pattern. After abatement on 8/7/19, it was lowered to a level three, pattern; Nursing Service (F726) at a scope and severity level four, pattern. After abatement on 8/7/19, it was lowered to a level three, pattern and; Administration, (F841) at a scope and severity level four, pattern. After abatement on 8/7/19, it was lowered to a level three, pattern.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		9/21/19

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F 550	Continued From page 7 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to maintain dignity for 5 residents (Resident #35, Resident #101, Resident #91, Resident #57, and Resident #402) in a sample size of 46 residents.	F 550	1. Resident # 35 □ practice has been corrected., resident # 101 □ no longer resides in center, #402 no longer resides in center Resident # 91 - unacceptable practice of untimely toileting and review of incontinence products was completed, and resident # 57 □ Resident with inappropriate practice of maintaining	

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F 550	Continued From page 8 The findings included: 1. For Resident #35, the facility staff stood over her while assisting with her breakfast meal on 07/16/2019. Resident #35 was admitted to the facility on 07/07/2014. Diagnoses for Resident #35 included but are not limited to heart failure, diabetes, post-right hip hemi-arthroplasty, dementia, anxiety, and depression. Resident #35's Minimum Data Set (an assessment protocol) just prior to the fall with an Assessment Reference Date of 01/12/2018 was coded as an annual assessment. Resident #35's Brief Interview for Mental Status was not completed but Cognitive Skills for Daily Decision-making were coded as severely impaired. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive assistance from staff and 2+ person physical assist for support. Balance during transitions was coded as not steady. On 07/16/19 at 08:20 AM, Certified Nursing Assistant F (CNA F) was observed standing over Resident #35 on the right side of the bed for approximately 10 minutes while assisting Resident #35 to eat breakfast. There was also an unoccupied chair available on the right side of the bed directly behind CNA F. After CNA F left Resident #35's room, she was asked if she usually stands while feeding residents. CNA F stated, "With [Resident #35] I do because it's easier for me to see her." On 07/16/2019 at approximately 9:10 AM, the	F 550	privacy when given care was corrected. C.N.A F re-educated on appropriate feeding practice. 2. All patients are at risk for the deficient practice. 3. SDC or Designee will educate all staff related to dignity and privacy, feeding, response to call bells and timely toileting. 4. The DON or Designee will Review 10% of patients who are continent to determine the appropriate use of products, three times a week for 2 weeks, then weekly for 2 weeks than monthly x 2 then through QAPI process. The DON or Designee will Review 10% of patients being fed for appropriate techniques, 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process The DON or Designee will Review Rounds 3x a week to ensure appropriate dignity and privacy are maintained. 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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DON was notified of findings and stated, "We do not stand when feeding residents" to maintain dignity. A request for the facility policy on feeding residents was requested and the DON stated they did not have a policy.

On 07/16/2019 at approximately 7:45 PM, the administrator and DON had no further information or documentation to offer.

2. For Resident #101, the facility staff left her in stained clothing after meals.

Resident #101, a 90-year old female, was admitted to the facility on 03/23/2018. Diagnoses included but not limited to dementia.

Resident #101's most recent Minimum Data Set with an Assessment Reference Date of 06/29/2019 was coded as an annual assessment. The Brief Interview for Mental Status was coded as a 5 out of possible 15 indicative of severe cognitive impairment. Functional status for eating was coded as requiring supervision from staff and one person physical assist for support.

On 07/14/2019 at 4:21 PM, Resident #101 was observed in her room wearing a green shirt with a large stain on it.

On 07/14/2019 at 4:53 PM, Resident #101 was observed sitting on her bed fully dressed wearing a green shirt with a large stain on the front of it. The stain color had a pinkish tinge to it. The stain was from the lower chest to the waist region and extended out to beyond bilateral midclavicular lines. When asked about how the stain got there,

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Resident #101 looked down at her shirt and touched the stain and stated she didn't know. When asked if her shirt was wet, Resident #101 stated "No."

On 07/15/2019 at 8:32 AM, Resident #101 was observed fully dressed sitting in a chair in her room. Her lower shirt and a portion of her upper pants by the right hip region appeared wet. There was a small area of brown dried food on her left upper pant leg.

On 07/16/2019 at approximately 9:10 AM, the DON was notified of findings and conceded it's a dignity issue.

3. For Resident #91, the facility staff failed to respond to her requests for assistance to the rest room in a timely fashion. Also, Resident #91 was continent and wearing a brief due to delays in prompt assistance.

Resident #91, an 86-year old female, was admitted to the facility on 06/25/2019. Diagnoses included but not limited to history of fall with intertrochanteric fracture, cerebral vascular accident, hypertension, diabetes, and generalized muscle weakness.

Resident #91's most recent Minimum Data Set with an Assessment Reference Date of 07/02/2019 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 14 out of possible 15 indicative of intact cognition. Functional status for toileting was coded as requiring extensive assistance from staff and a one-person physical

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assist for support. Urinary continence was coded as occasionally incontinent (occurring less than 7 times in the 7-day look-back period).

On 07/14/2019 at 3:40 PM, Resident #91 was observed in her room seated in her chair. When asked if she had any concerns about the care she received at the facility, Resident #91 stated that she had recently experienced urinary urgencies and burning when urinating. Resident #91 stated she call staff to request assistance going to the restroom but "they walk past as though they don't see me." Resident #91 stated she is not able to "hold it" for very long and ends up urinating in brief due to the delay in assistance. When asked if she needed to wear a brief at home, Resident #91 stated "No" and denied any history with incontinence except her recent hospitalization she would sometimes have "accidents." When asked how it made her feel to be wearing a brief, she stated it was aggravating but she was glad she was wearing a brief because it's better than "sitting in it" waiting for staff to come help. Resident #91 stated she would prefer it if staff would just come and help her to the restroom.

On 07/15/2019 at approximately 1:30 PM, Certified Nursing Assistant D (CNA D) was interviewed. When asked about Resident #91's urinary continence status, CNA D stated that Resident #91 is incontinent at night but she is continent during the day. When asked how she knew Resident #91 was incontinent at night, CNA D stated that Resident #91's brief is always wet in the morning. When asked how frequently she offers toileting assistance to [Resident #91], CNA D stated "we make A.M. [morning] rounds and P.M. [afternoon/evening] rounds." When asked

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how frequently in an 8-hour shift, CNA D stated, "Twice."

On 07/15/2019 at approximately 2:00 PM, Registered Nurse A (RN A), unit manager, was asked about Resident #91's urinary continence status. RN A stated Resident #91 is able to make her needs known but stated Resident #91 has some incontinent episodes, usually in evenings. RN A went on to say that Resident #91 told her before that "she's had urgencies and can't hold it." When asked how frequently she should be offered toileting assistance, RN A stated "Every hour." When told CNA D stated she is offered toileting assistance twice a shift, RN A stated, "I think she should ask more often than twice a shift."

On 07/15/2019 at approximately 3:15 PM, Resident #91 was observed in her room sitting up in her wheelchair visiting with her husband. Resident #91's husband verified Resident #91 did not use a brief at home but had some accidents while in the hospital. Resident #91's husband stated he has witnessed his wife call for assistance and would "wait and wait" for someone to come. When asked when that occurred, he couldn't remember the day. When asked how long his wife waited, he stated, "20-30 minutes."

On 07/16/19 at approximately 9:15 AM, an interview with the DON was conducted. When DON was notified of findings, she stated the standard is to check on residents every 2 hours and offering toileting assistance. The DON went on to say that just because someone may have episodes of incontinence during the night does not mean they are always incontinent and this

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requires education for nurses and CNA's. When asked about the expectation for answering call lights, the DON stated that when the call bell rings, we expect someone to go in and answer it in 3-5 minutes to let them know someone will be in to provide the care. If it is a non-clinical person, they leave the light engaged so that they know that they (the residents) need care.

On 07/16/19 at approximately 11:55 AM, a copy of call light logs for the past three weeks was requested and the facility staff provided a copy of call light logs ranging from 07/01/2019 through 07/15/2019. Employee Q, Maintenance department, stated they can only get 15 days of call logs from the call light company. From 07/01/2019 through 07/15/2019, Resident #91's call bell was activated 10 times. There were 5 instances where the duration was longer than 5 minutes. The average call duration was 5.32 minutes. The longest wait time was 22.35 minutes on 07/12/2019.

On 07/16/2019 at approximately 3:55 PM, the DON provided a facility copy of a policy entitled, "Shift Responsibilities for CNA." In Section 4, it was documented "Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the license nurse of any pertinent patient findings (reddened skin, etc.)." The policy did not address the frequency of making rounds to offer toileting assistance.

On 07/16/2019 at approximately 7:45 PM, the administrator and DON stated they had no further documentation of information to offer.

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4. For Resident # 57 the facility staff failed to ensure the Resident was provided privacy and dignity when providing care.

Resident #57, an 81 year old man admitted to the facility on 1/25/19 with diagnoses of but not limited to acute kidney failure, muscle weakness, gout and hereditary Lymphedema. The Resident's most recent MDS codes resident as having BIMS (Brief Interview of Mental Status) of 14 indicating mild cognitive impairment. The resident was coded as needing extensive assist and 1 person physical assist for transfers.

On 7/14/19 at approximately 5:30 PM Resident #57 was observed sitting in his wheelchair at the entrance to the West Wing dining room. The DON, ADON, as well as CNA I and CNA J were observed each had one of Resident #57's extremities and were re-positioning him in his wheelchair in full view of the Residents and visitors in the dining room and hallway. Resident # 57 was observed without the leg rests to his wheelchair wearing non-slip socks without shoes. The CNA held his feet up while the ADON pushed the wheelchair into the dining room.

At 6:39 PM an interview was conducted with the Residents family members, who stated that the staff couldn't find the leg rests to his chair. They also stated that earlier he had been put in the chair using the Hoyer lift. The Hoyer lift sling was still in the wheelchair under the Resident.

The family stated that the staff usually get him up in the chair and back to bed using the lift. They stated they felt the staff were unprofessional repositioning their father in the chair by using four

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F 550	Continued From page 15 staff in the hall in front of the dining room. The family stated that the Resident's leg was accidentally bumped into the table by the staff, however no one apologized or asked if the Resident was ok. On 7/16/19 at 9:30 AM in an interview with the DON asked about how Resident #57 should be repositioned in the chair she stated that she gathered the number of staff it would take to assist in moving the Resident up in the chair. When asked why the Resident did not have foot rests on his wheelchair she stated "I cannot speak to why there were no foot rests on the wheelchair but we have changed out wheelchairs to give him one that is better for his positioning." On 7/16/19 during the end of day meeting the Administrator was made aware and no further information was provided 5. Resident #402 reported that on 5/28/19 staff failed to respond to her request for toileting assistance, causing her to have to use the food service dome to urinate.	F 550		

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Resident #402 was admitted to the facility on 5/28/19. Diagnoses for Resident #402 included but are not limited to displaced trimalleolar fracture of left lower leg, sprain of unspecified ligament of right ankle, muscle weakness, history of falling, and hypothyroidism.

Review of a hospital discharge summary dated 5/28/19 revealed Resident #402 "will be NWB [non-weight bearing] on left for 6 weeks." This indicated the Resident would require assistance with activities of daily living such as toileting.

Review of Resident #402's entire clinical record reveal no nursing notes, assessment data, or CNA [certified nursing assistant] documentation to indicate the Resident was assisted with any ADL's [activities of daily living, such as bathing, dressing, toileting, etc.] during her stay.

On 7/15/19 the facility administrator provided a "Service Concern Report" which revealed that Resident #402's spouse called the facility on 5/29/19 and reported Resident #402 was told to use an incontinence brief.

On 7/15/19 at 4:50pm an interview was conducted with CNA G who stated she was assigned to Resident #402 on 5/28/19 and did recall Resident #402 using the food service dome to urinate in. CNA G stated she had assisted Resident #402 to use the bedpan shortly after Resident #402 arrived to the facility at approximately 3-4pm.

On 7/15/19 Employee C, maintenance director was requested to provide call bell logs for Room 402 on 5/28/19.

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F 550	Continued From page 17 On 7/15/19 at 5:51pm the maintenance director advised that call bell logs were only available for the past 15 days and would not be able to be retrieved for 5/28/19. On 07/16/19 at approximately 9:15 AM, an interview with the DON was conducted. When asked about the expectation for answering call lights, the DON stated that when the call bell rings, we expect someone to go in and answer it in 3-5 minutes to let them know someone will be in to provide the care. If it is a non-clinical person, they leave the light engaged so that they know that they (the residents) need care. No further information was provided.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to have reasonable accommodation of resident needs for three Residents (Resident #95, Resident #101, and Resident 91) in a survey sample of 46 Residents. The findings included: 1. Resident #95 was not provided a wheel chair	F 558	1. Resident # 95 □ no longer resides in the center. Resident # 101 □ no longer resides in center. Resident # 91 □ unacceptable practice of untimely toileting and incontinence products practice corrected. 2. All residents are at risk for deficient practice of reasonable accommodations.	9/21/19

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F 558	Continued From page 18 large enough to accommodate him. Resident #95 was admitted to the facility on 6/19/19. On 7/15/19 at approximately 2:30pm Resident #95 was observed in therapy sitting in a w/c. It was observed that Resident #95's sides were protruding through the openings in the side of the w/c. When Resident #95 was asked if he was comfortable he stated, "no, not really." Employee J, Physical therapy assistant (PTA) was asked if the chair was adequate for Resident #95 and the PTA stated, "it is a little small." Upon request of this writer the therapist was asked the width of the w/c Resident #95 was in and it was labeled as 22 inches wide and the therapist confirmed this. On 7/14/19 at approximately 4:45pm during an interview with Resident #95 and his spouse it was discussed that the facility provided wheelchair (w/c) isn't wide enough to accommodate him. The spouse stated, "they told me not to bring his w/c from home because they may lose some of the parts. He is in the largest one they have and his personal w/c is larger than 26." On 7/15/19 at 3:47pm Resident #95 was observed in his room, laying in bed. At the bedside was a w/c measuring 26" wide. On 7/15/19 at 3:56pm Employee J, Physical Therapy Assistant stated, "I put him in a wider chair and better cushion and he looked better." No further information was provided.	F 558	3. SDC or Designee will educate nursing staff on reasonable accommodations. SDC will review with nursing staff appropriate meal tray set up. 4. The DON or Designee will Review 10% of patients who are continent to ensure timely toileting and appropriate use of incontinence products, if needed for three times a week for 2 weeks, then weekly for 2 weeks than monthly x 2 then through QAPI process 5.Date of Compliance is September 21st , 2019.	

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2. For Resident #101, the facility staff failed set up her tray and cut up her meat in a timely fashion.

Resident #101, a 90-year old female, was admitted to the facility on 03/23/2018. Diagnoses included but not limited to dementia.

Resident #101's most recent Minimum Data Set with an Assessment Reference Date of 06/29/2019 was coded as an annual assessment. The Brief Interview for Mental Status was coded as a 5 out of possible 15 indicative of severe cognitive impairment. Functional status for eating was coded as requiring supervision from staff and one person physical assist for support.

On 07/15/2019 at 5:18 PM, Resident #101 was observed awake in bed lying on top of her covers wearing a hospital gown. The head of the bed was elevated approximately 60 degrees and her dinner was in front of her on the tray table. The meat was not cut up. There was also stewed tomatoes, mashed potatoes, and strawberries on the tray, all uneaten. Resident #101 was babbling incoherently and picked up a full cup of iced tea (approximately 250 ml) and spilled the entire contents of the glass all over the left side of her hospital gown, sheets, and floor. This surveyor alerted staff and an aide entered the room to clean up the spill.

On 07/15/2019 at approximately 5:50 PM, an interview with Certified Nursing Assistant E (CNA E) was conducted. CNA E verified she was assigned to care for Resident #101. When asked about feeding assistance for Resident #101, she

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stated it was limited. CNA E stated that Resident #101 needs help opening things but she doesn't need someone with her all the time. When asked if she tends to spill food on herself, CNA E stated, "Yes." When asked about the process for delivering trays, CNA E stated that whoever delivers the tray also prepares it like opening things or cutting meat.

On 07/15/19 at 5:58 PM, this surveyor and CNA E entered Resident #121's room. CNA E looked at Resident #101's tray and then began cutting up the meat. CNA E verified it was beef burgundy. She went on to say that [Resident #101] may have told whoever delivered the tray that she could cut her own meat.

On 07/16/2019 at approximately 9:10 AM, an interview with the DON was conducted. When asked about expectation of staff for one person physical assist, she stated that means staff provide assistance with set up and opening things and may need to support to initiate eating.

On 07/16/2019 at approximately 7:45 PM, the administrator and DON stated they had no further information or documentation to offer.

3. For Resident #91, the facility staff failed to respond to her requests for assistance to the rest room in a timely fashion. Also, Resident #91 was continent and wearing a brief due to delays in prompt assistance.

Resident #91, an 86-year old female, was admitted to the facility on 06/25/2019. Diagnoses included but not limited to history of fall with

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intertrochanteric fracture, cerebral vascular accident, hypertension, diabetes, and generalized muscle weakness.

Resident #91's most recent Minimum Data Set with an Assessment Reference Date of 07/02/2019 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 14 out of possible 15 indicative of intact cognition. Functional status for toileting was coded as requiring extensive assistance from staff and a one-person physical assist for support. Urinary continence was coded as occasionally incontinent (occurring less than 7 times in the 7-day look-back period).

On 07/14/2019 at 3:40 PM, Resident #91 was observed in her room seated in her chair. When asked if she had any concerns about the care she received at the facility, Resident #91 stated that she had recently experienced urinary urgencies and burning when urinating. Resident #91 stated she call staff to request assistance going to the restroom but "they walk past as though they don't see me." Resident #91 stated she is not able to "hold it" for very long and ends up urinating in brief due to the delay in assistance. When asked if she needed to wear a brief at home, Resident #91 stated "No" and denied any history with incontinence except her recent hospitalization she would sometimes have "accidents." When asked how it made her feel to be wearing a brief, she stated it was aggravating but she was glad she was wearing a brief because it's better than "sitting in it" waiting for staff to come help. Resident #91 stated she would prefer it if staff would just come and help her to the restroom.

On 07/14/2019 at approximately 5:15 PM, the

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clinical record was reviewed. The admission assessment dated 06/25/19 at 12 p.m. under the header "GU/Bladder (Genitourinary/Bladder)", it was documented "Non-distended bladder." Other options available on the list that were not selected were: continent of bladder; incontinent of bladder; pain on urination; nocturia; catheter utilized. Excerpts of a nurse's note dated 06/30/2019 at 1:19 p.m. documented, "Resident has c/o [complained of] burning and dysuria notified on-call NP [nurse practitioner] [name], n.o. [nurse order] to obtain u/a and c&s [urinalysis and culture and sensitivity]." "Resident also has an n.o. to start Macrobid 100mg p o b i d x 7 days [by mouth twice a day for 7 days] which was started from the stat box, also has n.o. for Pyridium 100 mg p.o. tid prn x 3 days [by mouth three times a day as needed for 3 days] which has been ordered."

On 07/15/2019 at approximately 1:30 PM, Certified Nursing Assistant D (CNA D) was interviewed. When asked about Resident #91's urinary continence status, CNA D stated that [Resident #91] is incontinent at night but she is continent during the day. When asked how she knew [Resident #91] was incontinent at night, CNA D stated that [Resident #91]'s brief is always wet in the morning. When asked how frequently she offers toileting assistance to [Resident #91], CNA D stated "we make A.M. [morning] rounds and P.M. [afternoon/evening] rounds." When asked how frequently in an 8-hour shift, CNA D stated, "Twice."

On 07/15/2019 at approximately 2:00 PM, Registered Nurse A (RN A), unit manager, was asked about Resident #91's urinary continence status. RN A stated [Resident #91] is able to

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make her needs known but stated [Resident #91] has some incontinent episodes, usually in evenings. RN A went on to say that [Resident #91] told her before that "she's had urgencies and can't hold it." When asked how frequently she should be offered toileting assistance, RN A stated "Every hour." When told CNA D stated she is offered toileting assistance twice a shift, RN A stated, "I think she should ask more often than twice a shift."

On 07/15/2019 at approximately 3:15 PM, Resident #91 was observed in her room sitting up in her wheelchair visiting with her husband. Resident #91's husband verified Resident #91 did not use a brief at home but had some accidents while in the hospital. Resident #91's husband stated he has witnessed his wife call for assistance and would "wait and wait" for someone to come. When asked when that occurred, he couldn't remember the day. When asked how long his wife waited, he stated, "20-30 minutes."

On 07/16/19 at approximately 9:15 AM, an interview with the DON was conducted. When DON was notified of findings, she stated the standard is to check on residents every 2 hours and offering toileting assistance. The DON went on to say that just because someone may have episodes of incontinence during the night does not mean they are always incontinent and this requires education for nurses and CNA's. When asked about the expectation for answering call lights, the DON stated that when the call bell rings, we expect someone to go in and answer it in 3-5 minutes to let them know someone will be in to provide the care. If it is a non-clinical person, they leave the light engaged so that they

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F 558	Continued From page 24 know that they (the residents) need care. On 07/16/19 at approximately 11:55 AM, a copy of call light logs for the past three weeks was requested and the facility staff provided a copy of call light logs ranging from 07/01/2019 through 07/15/2019. Employee Q, Maintenance department, stated they can only get 15 days of call logs from the call light company. From 07/01/2019 through 07/15/2019, Resident #91's call bell was activated 10 times. There were 5 instances where the duration was longer than 5 minutes. The average call duration was 5.32 minutes. The longest wait time was 22.35 minutes on 07/12/2019. On 07/16/2019 at approximately 3:55 PM, the DON provided a facility copy of a policy entitled, "Shift Responsibilities for CNA." In Section 4, it was documented "Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the license nurse of any pertinent patient findings (reddened skin, etc.)." The policy did not address the frequency of making rounds to offer toileting assistance. On 07/16/2019 at approximately 7:45 PM, the administrator and DON stated they had no further documentation of information to offer.	F 558		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		9/21/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff neglected to provide goods and services to prevent and promote the healing of pressure ulcers for one resident (Resident #5) in a survey sample of 46 Residents, resulting in harm for Resident #5. Immediate Jeopardy was identified on 8/6/19 at 6:17pm and the facility was notified. After verification, Immediate Jeopardy was abated on 8/7/19 at 6:55pm and the scope and severity was lowered to level three, isolated. The findings included; 1. For Resident #5, the facility staff neglected to provide treatments, including a working air mattress for pressure a pressure ulcer. The pressure ulcer worsened from a stage 2 ulcer to a stage 4 ulcer which was identified by surveyors while onsite, resulting in harm. Resident #5 was admitted to the facility on 1-29-19. Diagnoses included; vertigo, chronic kidney disease, dementia, benign prostatic	F 600	1. Resident # 5 □ No longer resides in the facility. 2. All residents with pressure ulcers are at risk for deficient practice. Any specialty air mattress will be observed for proper functionality. 3. SDC or Designee will educate licensed staff on wound care policy and providing appropriate treatment for pressure ulcers. 4. DON or designee will review all pressure ulcers to ensure accuracy of assessment and appropriate treatment 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process. Any specialty air mattress will be observed for proper functionality 3 X week for 2 weeks, then weekly for 2 weeks, the monthly x @ through the QAPI process 5. Date of Compliance is September 21st, 2019.	

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hypertrophy, stroke, hypertension, congestive heart failure. and chronic Foley catheter.

Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-26-19. The Resident was coded with mild cognitive impairment, and no aberrant behaviors. Resident #5 required extensive assistance to total dependence on one to two staff members, for activities of daily living care. The Resident was coded as not having any pressure ulcers at the assessment time, nor on admission. The Resident had a long standing Foley catheter (urine drainage) due to an obstruction, and was incontinent of bowel. The Resident was coded as at risk for pressure sores.

On 7-14-19, at 3:30 p.m., the first observation and interview of Resident #5 was conducted during initial tour of the facility. The Resident was found laying on a specialty mattress (Genesis II, a low air loss mattress), and the air motor was bogging down and humming, and not infusing air into the mattress. The mattress was flat, hard, and solid, with no air in it. The Resident was laying partially on his left side, and a Foley catheter was noted to be draining dark yellow urine with white sediment in it. The Resident was able to speak and make his needs known, and was found to be oriented to person, time, place and situation. The Resident stated he was thirsty and wanted water. There were 6 water "Sippie" non-spillable cups on the over-bed table which were all empty. The bedside table was 3 feet from the bed and the Resident could not reach it. Staff were notified.

A second observation of Resident #5 was

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conducted on 7-15-19 at 4:30 p.m., and the Resident was sleeping in bed on his back. The over-bed table was found to be exactly as the last observation, and the bed was deflated with the motor still humming, but not infusing air. The air mattress was replaced on 7-16-19.

A third observation occurred on 7-16-19 at 11:30 a.m., with Licensed practical nurse C (LPN C), and Certified nursing assistant N (CNA N). The nurse removed the bandage from the Resident's coccyx. The 4 inch by 4 inch single bandage had a solid center in it which was a tan telfa like non-adherent 2 inch by 2 inch square. The outer circumference of the square bandage was surrounded by a boarder of adherent malleable stretchy tape, reminiscent of Band-Aid fabric. There was no packing or medicated cream in the hollow wound. Immediately after removing the dressing a green purulent discharge was seen. The wound was circular, and deep with full muscle tissue loss and bone protrusion clearly visualized and palpated by the nurse. The wound had undermined and tunneled circumferentially around, only under the circular rolled wound edges. There was also noted yellow tan slough and black necrotic tissue inside the wound, and silvery white fascia could be seen covering the coccygeal bone protrusion. The LPN measured the wound with a long cotton swab and a wound measuring disposable paper tape. She measured the cotton swab after it was laid on the wound, and placed in the wound for an accurate measurement. The wound measured 2 centimeters (cm) long, 1.5 cm wide, and 1.5 cm deep. The exterior wound edges were rolled (epibole). The Resident was pre-medicated with pain medication and stated he felt no pain as the wound was measured.

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Review of the weekly skin assessment sheets since admission "PCC Skin & Wound - Total Body Skin Assessment" documents revealed all (including the initial) were completed by LPN's. The findings showed from 1-29-19 until 6-24-19 staff document that the resident had no new wounds however, on 4-29-19, another type of assessment document was initiated and performed by all LPN staff, "Skin and Wound Evaluation V 5.0". These documents were started for a "new Pressure wound stage 2 on the Resident's sacrum" and was described as being treated with povidone iodine after cleaning with normal saline, and no dressing. The wound measured 3 cm long x 1.3 cm wide, no depth, and healable. None of these documents were completed after this initial one until 1 month later, on 5-27-19. On 5-27-19 the next "Skin and Wound Evaluation V 5.0" document occurred one month after the first one on 4-29-19. The document describes the sacrum wound as stage 2 unchanged, healable, and documents the measurements of the wound as 1.1 cm long x 0.5 cm wide, and no depth. The treatment remains the same. No eschar, no debridement, no dressing.

On 6-24-19 staff pin pointed and documented the "Coccyx" portion of the sacrum, instead of just stating sacrum, stage 2 pressure ulcer 1.3 cm long x 0.9 cm wide, no depth, Normal saline, and now, cover with foam dressing. Healable. No eschar, No debridement. A Left buttock and a right buttock were found as "New areas" on 6-24-19, however, had nothing to do with the continuing Sacrum/Coccyx wound according to nursing staff.

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No assessments by staff described a stage 4 pressure ulcer, and no assessments were completed from 7-14-19. through 7-16-19, until the surveyor found the stage 4 pressure ulcer on 7-16-19.

All of the assessments, including the initial assessment, were completed by LPN's.

Physician's orders and Medication and Treatment Administration Records (MAR's/TAR's) were reviewed and revealed no physicians order for prevention of pressure sores from bowel incontinent episodes such as an incontinence barrier cream. Only the following 4 orders appeared after the pressure sore developed for the sacral coccyx acquired pressure ulcer treatment;

1. Ordered 4-29-19 start 4-29-19 discontinued 7-8-19 Clean open area to sacrum with normal saline and apply betadine twice per day at morning and bedtime. No dressing. No change to this order occurred after 2.5 months without healing.

2. Ordered 6-3-19 start 6-4-19 discontinued 7-9-19 Clean wound with normal saline & apply Vasolex ointment to coccyx wound topically once per day & as needed with allevyn dressing.

3. Ordered 7-10-19 start 7-10-19 discontinued 7-16-19 Cleanse sacrum/coccyx with normal saline apply intrasite gel (hydrogel water gel to keep wound bed moist) and cover with coversite once every day.

4. Ordered 7-16-19 start 7-17-19 Cleanse sacral wound with saline, apply iodoform (iodine

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impregnated gauze for packing into a hole) and cover area with coversite one time per day, after the examination by surveyors and an LPN, and was not ordered to be administered until the following day (7-17-19) further delaying care.

Review of the MAR/TAR's revealed that the pressure sore treatments that were ordered as above, were not administered on 5/18, 5/24, 6/4, 6/10, 6/20, 6/26, 7/8, and 7/9/19. No nursing notes reveal the reason for the omissions.

It is of note to mention that the "Vasolex" ointment ordered on 6-3-19 was a debridement agent. Debridement is the removal of dead and damaged tissue from a wound. This can be completed by surgical/cutting out removal, or chemical enzyme/liquefying of dead tissue to remove it. Resident #5's "skin wound evaluation" documents on that date show no necrotic/dead tissue in need of debridement.

An interview was conducted via telephone with the Resident's physician and all surveyors present on 7-16-19 at 6:45 p.m. The doctor stated he had seen the Resident on 7-15-19 between the hours of 7:00 a.m., to 8:00 a.m. He stated that he was aware the Resident had a wound, and had reviewed the recent nursing notes which stated the Resident had a stage 2 pressure sore, and so in his progress note dated 7-15-19, he wrote a stage 2 sacral decubitus. The nursing notes were reviewed from the doctor's previous visit of 6-22-19, none stated the Resident had a stage 2 decubitus ulcer. The doctor was informed that an RN surveyor had assessed the wound this morning (7-16-19), and he was asked if he had been made aware of the findings. He stated "No." The doctor was asked

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if he evaluated the wound, and he stated "it looked like a stage 2 when I saw him, but I was interested in the shingles, my focus was not the wound." The surveyors asked if he could describe the wound, and he stated "it was on his coccyx area."

The doctor was asked if a debridement agent would be used for a stage 2 decubitus ulcer which had no eschar, and he stated "No.", The doctor went on to say, "but he has been in failing health for several months with heart disease which is an obvious factor for skin integrity, and we don't need to aggressively treat as the prognosis is poor."

The doctor stated that the Resident was also losing weight and nutrition was an issue, with mineral loss. The doctor was asked why minerals and supplements had not been ordered as a replacement to mitigate this, and if that would be of value. The doctor stated yes it would be of value, but due to his age and failing health the Resident was supportive care at this stage and his overall prognosis was poor.

The physician was asked why a Resident, regardless of age, who was ambulatory and recovering from a hospitalization and receiving aggressive occupational and physical therapy within the past few months would not be treated for a pressure wound. The doctor repeated "I didn't go into the detail of the wound, and chose to look at the nursing notes. The doctor was asked why none of his progress notes discuss evaluation of the wound until this last note yesterday, and he responded that the Resident's "prognosis was poor, and I thought he had shingles, but probably just heat rash, I was not

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there to see the decubitus."

The DON was requested to supply surveyors with all policies for skin assessments and pressure ulcers. The DON, and Corporate RN supplied 2 facility policies on skin assessments and pressure ulcers. They are as follows;

1. "Pressure ulcers Manual" - "Skin Assessment" Skin assessments will be completed for all patients. A licensed nurse will ensure that the skin risk assessment is done upon admission, and quarterly thereafter. A skin assessment will also be completed upon re-entry to the center (i.e., after ER visit, dialysis, etc.) The weekly skin assessment will be completed thereafter. Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs.

2. "Pressure ulcers Manual" - "Pressure Ulcer monitoring &" A licensed nurse will assess patients for the presence of pressure ulcers: if a pressure ulcer is present, the nurse will evaluate for complications. Provide pain management prior to pressure ulcer treatment as indicated. The wound record will be completed weekly by a licensed nurse for any patient with pressure ulcers. There will be a wound record for each site.

Guidance is provided for the staging of pressure ulcers by the National Pressure Ulcer Advisory Panel (NPUAP), and is as follows;

NPUAP announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury FOR IMMEDIATE RELEASE April 13, 2016.

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Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 4 Pressure Injury:
If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness stage 4 pressure injury. Do not use (deep tissue pressure injury) DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

In summary, for Resident #5, the physician ordered treatments were not administered, assessments of skin, and the wound were not completed for 1 month, and the wound was identified by surveyors as a stage 4 pressure ulcer, when staff were still documenting a stage 2 wound. Orders were received for debridement of the wound on 6-3-19, when documents say there was nothing to debride. No supplements were ordered for wound healing. The physician did not evaluate the wound. The air mattress that was

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being used was not in working order for 3 days. The wound was initially identified as a stage 2 wound which progressed to a stage 4 wound, without staff identifying it.

The Administrator, DON, and the Registered Nurse (RN) Regional Consultant were made aware of the harm level deficiency at the end of day debrief on 7-16-19. No further information was supplied by the facility.

The facility presented the following plan to remove the Immediate Jeopardy:

F600
Identification of those residents in which the center staff was negligent in providing care and treatment to a wound resulting in deterioration, and harm to resident.

1) Resident #5 is currently out of center. Dr. [name redacted] notified on 8.6.19 of negligence related to assessment, improper treatment, delay in initiating and implementing orders, and deterioration of wound resulting in hospitalization.

2) All patients admitted to center will have Skin and Wound Assessment completed by Registered Nurse

How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice:

A. Education provided to registered nursing staff concerning wound identification on admission, assessment of wounds related to staging,

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F 600	Continued From page 35 appropriate treatment and/or intervention needed to prevent further deterioration. All Registered nurses will have education prior to next scheduled shift. This is validated through return demonstration utilizing the Skills Validation for "Skin and Pressure ulcer prevention and management." B. Weekly wound rounds will be completed by DON, UM , MD and/ or MD extender will document in clinical record in physician notes and nursing wound evaluation .	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to implement their abuse policies for 1 resident (Resident #8) in a sample size of 46 residents. The findings included:	F 607	1. Resident # 8 □ fall investigation is complete. 2. All residents are at risk for injury of unknown origin. 3. SDC or Designee will educate all staff on abuse and neglect policy, specific to injuries of unknown origin. 4. DON or Designee will review all incident reports weekly 3x a week for 2	9/21/19

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F 607	Continued From page 36 For Resident #8, the facility staff failed to implement their Abuse/Neglect Policy. Resident #8 is 76 year old female who was admitted to the facility on 08/29/2016 with diagnoses including but not limited to stroke, muscle weakness, and vascular dementia without behavioral disturbance. Resident #8's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/2019 was coded as a Quarterly review. Resident #8 was coded with a Brief Interview of Mental Status (BIMS) score of "6" out of possible 15, indicating severely impaired cognition. On 07/14/19 at approximately 4:45 pm during initial tour of the facility, Resident #8 was observed lying quietly in bed sleeping. She had large purple bruising around both of her eyes and and a bruise above her right eyebrow with a small, scabbed over laceration on the right eyebrow. An interview with Resident #8 was attempted, however she opened her eyes but did not engage in conversation. On 07/16/19, a clinical record review was performed. A Progress Note dated 6/30/2019 at 04:45 read: "CNA reported resident was lying on the floor. Resident was noted lying on the floor in the hallway in front of her wheelchair. Resident stated she did not know how she fell but replied yes when asked if she fell asleep." and another Progress Note dated 7/12/2019 at 03:04 read: "Called to room by CNA found resident wrapped up in covers laying on floor between the beds on the right side".	F 607	weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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On 07/16/19 at approximately 2:28 PM, an interview with the Administrator (Employee A) and the Director of Nursing (DON, Employee B) was conducted. The Administrator stated, "we did not do an investigation or report anything because the nurse notes state that the resident was found wrapped up in blankets on the floor so she must have fallen". The DON stated, "I remember this incident because it was just this past week, she was found wrapped up in blankets on the floor next to her bed so the nurse determined that she had to have fallen out of bed". When asked if there were any witnesses to the "fall", the DON replied, "No, not to my knowledge".

On 07/16/19, a facility policy entitled, "Nursing Policies and Procedures, Abuse/Investigative Reporting, Injuries of Unknown Origin, policy #102" (effective date 11/4/16) was reviewed. The Policy Statement read: "Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the Center Administrator". The "Procedure" subheading, item #7 read, "The Director of Nursing is responsible for immediately notifying the Administrator of the injury of unknown origin. An initial report to the State Agency will be initiated".

Both the Administrator and DON confirmed that they felt the incidents, on 6/30/19 and 7/12/19, were "falls" and not injuries of unknown origin despite the lack of witnesses on both occasions, and therefore did not implement the facility Abuse/Neglect Policy for injuries of unknown origin.

COMPLAINT DEFICIENCY

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to report injuries of unknown origin to the state agency for 2 residents (Resident #35, Resident #8) in a sample size of 46 residents.	F 609	1. Resident # 35 □ No corrective action needed, any future bruise will be addressed per policy. Resident # 8 □ No corrective action needed, any future injury of unknown origin will be addressed per policy. 2. All residents are at risk for the	9/21/19

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F 609	Continued From page 39 The findings included: 1. For Resident #35, the facility staff failed to report to the state agency injuries of multiple bruises all over her body on 03/26/2018 and a non-displaced hip fracture on 03/27/2018. Resident #35 was admitted to the facility on 07/07/2014. Diagnoses for Resident #35 included but are not limited to heart failure, diabetes, post-right hip hemi-arthroplasty, dementia, anxiety, and depression. Resident #35's Minimum Data Set (an assessment protocol) just prior to the fall with an Assessment Reference Date of 01/12/2018 was coded as an annual assessment. Resident #35's Brief Interview for Mental Status was not completed but Cognitive Skills for Daily Decision-making were coded as severely impaired. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive assistance from staff and 2+ person physical assist for support. Balance during transitions was coded as not steady. On 07/14/19 at 6:00 PM, in the course of the complaint investigation, the clinical record was reviewed. Excerpts of an SBAR [Situation, Background, Assessment, Recommendation] note written by Licensed Practical Nurse (LPN E) dated 3-26-18 at 5:37 a.m. documented, "Resident noted to have multiple bruises in different locations of her body." "Resident was noted with multiple bruises on her body, face, left and right arm, left lower extremity, multiple fingers and bilateral hands. Resident is unable to give a description due to dementia. Resident cries out in	F 609	deficient practice. 3. SDC or Designee will educate all staff and include investigation / report all injuries of unknown origin. 4. The DON or Designee will review all incident reports weekly 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019. .	

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pain when right leg was lifted. [Physician name] made aware. New order received for pelvic x-ray. Voice message left for daughter, [name] to call facility. Recommendations: Two persons assist during care."

A nurse's note written by LPN E dated 3-27-18 at 7:30 a m documented, "Off going charge nurse reported resident had bruising on her "right leg". During examination of resident with charge nurse, it was noted that resident's right hip/leg had rotated inward. Faint bruising was noted to outer aspect of resident's right upper leg. Resident has been turned and repositioned during the night. Resident will frown when being repositioned or turned. [Physician's name] was made aware and examined resident. New order received to transfer resident to transfer to [sic] emergency room for evaluation and more x-rays. Voice message left for daughter [daughter's name] to call facility. Vital Signs 97.2 [temperature]-60[pulse]-18[respirations] 134/76 [blood pressure]. O2 saturation 95% (RA) [room air]. [Ambulance company name] notified of need for transportation. Resident was transferred to [Medical Center name] via [ambulance company name]."

A nurse's note written by Registered Nurse B (RN B) dated 3-27-18 at 2:37 p.m. it was documented, "...At 2 p.m. [daughter's name] called this facility and stated that the hospital physician informed her that Resident has a fracture to right hip. Will follow-up for further information."

An excerpt of the hospital computed tomography [CT] report dated 03/27/19 at 10:28 AM documented under "Finding: The bones are severely osteopenic." An excerpt of the note

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documented under "Impression: 1. Nondisplaced incomplete fracture in the lateral cortex at the base of the right femoral greater trochanter."

The skin assessment documentation was reviewed. A skin assessment dated 03/06/2018 in the "Notes" section documented "scattered bruising bil [bilateral] arms." A skin assessment dated 3/13/2018 documented in the "Notes" section "Bruises bil [bilateral] arms and legs." A skin assessment dated 3/20/2018 documented in the "Notes" section "Skin is dry and intact." A skin assessment dated 3-27-2018 documented in the "Notes" section, "Bruise left side of face bruising to bilateral arms and bilateral legs."

On 07/15/19 at approximately 11:35 AM, a copy of all investigations for March 2018 timeframe was requested. The facility provided an incident report, a diagram of bruising sites, two employee written statements and a copy of the hospital discharge instructions. The administrator stated that Resident #35 did not have a fall in March of 2018.

The incident report completed by LPN E was dated 04/02/2018 at 5:24 AM. Under the header "Incident Description" it was documented, "Resident was noted to have bruise on left corner of her mouth. Resident was assessed in bruises were noted on several fingers on bilateral hands, inner aspect of arm just below armpit, outer aspect of right arm above elbow, skin tear to ring finger on right hand. Resident is unable to give description due to advance [sic] dementia." Under the header "Predisposing Environmental Factors" "furniture" was selected. Under the header "Predisposing Physiological Factors" "confused, incontinent, impaired memory, Other" were

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selected. Under the header "Predisposing Situation Factors", "siderails up" was selected. Under the header "Other info [information]" it was documented "Resident is total care, combative with care."

On the diagram of bruising sites, it was labeled there was bruising on the left side of face and neck, inner aspect of right arm, inner aspect of left arm, bruise on right posterior [back of the arm] elbow, bruises on all fingers of both hands, bruise on anterior leg below the knee (shin) and left foot, bruise on inner aspect of right lower leg, and scattered bruising on lateral [outer] aspect of right lower leg."

A written statement by Certified Nursing Assistant L [CNA L] dated 3-25-18 documented, "I had [Resident #35] on my caseload as a 3-24-2018. I went into her room and changed her twice. I didn't see any marks or brusies [sic] while changing her." A handwritten statement by CNA M dated 3-26-18 documented, "I, [CNA M], did rounds when I came onto shift to ensure res [residents] were breathing/safe. At 2 a.m. I started rounds I did not notice anything on [Resident #35's room number/bed] face but am unsure if bruise was already there due to only using limited light. Resident was a little aggressive hitting my hand but nothing too much or alarming due to getting report and staff stating resident screams and fights."

On 07/16/2019 at approximately 2:00 PM, an interview with the administrator and DON was conducted. The DON stated she was not working at the facility at the time of the incident. The DON stated the certified nursing assistant working the night of the incident and unit manager at the time

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of the incident were no longer working at the facility. When the DON was presented with the diagram of bruising sites and the bruising patterns and asked about expectations for staff response, the DON stated she would want to investigate to keep [Resident #35] safe and have more information such as the color of the bruises to determine if some were old vs. new. She also stated she would be concerned due to the amount of bruising. The administrator and DON conceded a thorough investigation was not done and it should have been reported to the state agency as an injury of unknown origin.

The facility staff provided a copy of their policy manual entitled, "Abuse/Neglect/Misappropriation/Crime." Under the policy entitled, "Initial Reporting Guidelines" in Section 2, it was documented, "Injuries of unknown origin (injuries not witnessed or patient can't state what happened) should be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the State Survey Agency." Under the policy entitled "Reporting Requirements/Investigations" in Section 1, it is documented, "Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of Resident property, the administrator will immediately report to the state agency, but not later than two hours after the allegation is made, if the events that caused the allegation involves abuse or results and serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury." In Section 2 it was documented, "The administrator and/or Director of Nursing will

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immediately initiate a thorough internal investigation of the alleged suspected occurrence. The investigative protocol will include, but not limited to, collecting evidence, interviewing alleged victims and Witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations."

On 07/16/2019 at approximately 7:45 PM, the administrator and DON had no further information or documentation to offer.

2. For Resident #8, the facility staff failed to report an injury of unknown origin.

Resident #8 is 76 year old female who was admitted to the facility on 08/29/2016 with diagnoses including but not limited to stroke, muscle weakness, and vascular dementia without behavioral disturbance.

Resident #8's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/2019 was coded as a Quarterly review. Resident #8 was coded with a Brief Interview of Mental Status (BIMS) score of "6" out of possible 15, indicating severely impaired cognition.

On 07/14/19 at approximately 4:45 pm during initial tour of the facility, Resident #8 was observed lying quietly in bed sleeping. She had large purple bruising around both of her eyes and and a bruise above her right eyebrow with a small, scabbed over laceration on the right eyebrow. An interview with Resident #8 was attempted, however she opened her eyes but did

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not engage in conversation.

On 07/16/19, a clinical record review was performed. A Progress Note dated 6/30/2019 at 04:45 read: "CNA reported resident was lying on the floor. Resident was noted lying on the floor in the hallway in front of her wheelchair. Resident stated she did not know how she fell but replied yes when asked if she fell asleep." and another Progress Note dated 7/12/2019 at 03:04 read: "Called to room by CNA found resident wrapped up in covers laying on floor between the beds on the right side".

On 07/16/19 at approximately 2:28 PM, an interview with the Administrator (Employee A) and the Director of Nursing (DON, Employee B) was conducted. The Administrator stated, "we did not do an investigation or report anything because the nurse notes state that the resident was found wrapped up in blankets on the floor so she must have fallen". The DON stated, "I remember this incident because it was just this past week, she was found wrapped up in blankets on the floor next to her bed so the nurse determined that she had to have fallen out of bed". When asked if there were any witnesses to the "fall", the DON replied, "No, not to my knowledge".

On 07/16/19, a facility policy entitled, "Nursing Policies and Procedures, Abuse/Investigative Reporting, Injuries of Unknown Origin, policy #102" (effective date 11/4/16) was reviewed. The Policy Statement read: "Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the Center Administrator". The "Procedure" subheading, item #7 read, "The

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F 609	Continued From page 46 Director of Nursing is responsible for immediately notifying the Administrator of the injury of unknown origin. An initial report to the State Agency will be initiated". Both the Administrator and DON confirmed that they felt the incidents, on 6/30/19 and 7/12/19, were "falls" and not injuries of unknown origin despite the lack of witnesses on both occasions, and therefore did not file any reports.	F 609		
F 610 SS=D	COMPLAINT DEFICIENCY Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility	F 610	1. Resident # 35 □ No corrective action needed, any future bruise will be addressed per policy.	9/21/19

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F 610	Continued From page 47 staff failed to investigate injuries of unknown origin for 2 residents (Resident #35, Resident #8) in a sample size of 46 residents. The findings included: 1. For Resident #35, the facility staff failed to investigate when she presented with injuries of multiple bruises all over her body on 03/26/18 and a non-displaced hip fracture on 03/27/2018. Resident #35 was admitted to the facility on 07/07/2014. Diagnoses for Resident #35 included but are not limited to heart failure, diabetes, post-right hip hemi-arthroplasty, dementia, anxiety, and depression. Resident #35's Minimum Data Set (an assessment protocol) just prior to the fall with an Assessment Reference Date of 01/12/2018 was coded as an annual assessment. Resident #35's Brief Interview for Mental Status was not completed but Cognitive Skills for Daily Decision-making were coded as severely impaired. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive assistance from staff and 2+ person physical assist for support. Balance during transitions was coded as not steady. On 07/14/19 at 6:00 PM, in the course of the complaint investigation, the clinical record was reviewed. Excerpts of an SBAR [Situation, Background, Assessment, Recommendation] note written by Licensed Practical Nurse (LPN E) dated 3-26-18 at 5:37 a.m. documented, "Resident noted to have multiple bruises in different locations of her body." "Resident was	F 610	Resident # 8 □ No corrective action needed, any future injury of unknown origin will be addressed per policy. 2. All residents are at risk for the deficient practice. 3. SDC or Designee will educate all staff and include investigation / report all injuries of unknown origin. 4. The DON or Designee will review all incident reports 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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noted with multiple bruises on her body, face, left and right arm, left lower extremity, multiple fingers and bilateral hands. Resident is unable to give a description due to dementia. Resident cries out in pain when right leg was lifted. [Physician name] made aware. New order received for pelvic x-ray. Voice message left for daughter, [name] to call facility. Recommendations: Two persons assist during care."

A nurse's note written by LPN E dated 3-27-18 at 7:30 a m documented, "Off going charge nurse reported resident had bruising on her "right leg". During examination of resident with charge nurse, it was noted that resident's right hip/leg had rotated inward. Faint bruising was noted to outer aspect of resident's right upper leg. Resident has been turned and repositioned during the night. Resident will frown when being repositioned or turned. [Physician's name] was made aware and examined resident. New order received to transfer resident to transfer to [sic] emergency room for evaluation and more x-rays. Voice message left for daughter [daughter's name] to call facility. Vital Signs 97.2 [temperature]-60[pulse]-18[respirations] 134/76 [blood pressure]. O2 saturation 95% (RA) [room air]. [Ambulance company name] notified of need for transportation. Resident was transferred to [Medical Center name] via [ambulance company name]."

A nurse's note written by Registered Nurse B (RN B) dated 3-27-18 at 2:37 p.m. it was documented, "...At 2 p.m. [daughter's name] called this facility and stated that the hospital physician informed her that Resident has a fracture to right hip. Will follow-up for further information."

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An excerpt of the hospital computed tomography [CT] report dated 03/27/19 at 10:28 AM documented under "Finding: The bones are severely osteopenic." An excerpt of the note documented under "Impression: 1. Nondisplaced incomplete fracture in the lateral cortex at the base of the right femoral greater trochanter."

The skin assessment documentation was reviewed. A skin assessment dated 03/06/2018 in the "Notes" section documented "scattered bruising bil [bilateral] arms." A skin assessment dated 3/13/2018 documented in the "Notes" section "Bruises bil [bilateral] arms and legs." A skin assessment dated 3/20/2018 documented in the "Notes" section "Skin is dry and intact." A skin assessment dated 3-27-2018 documented in the "Notes" section, "Bruise left side of face bruising to bilateral arms and bilateral legs."

On 07/15/19 at approximately 11:35 AM, a copy of all investigations for March 2018 timeframe was requested. The facility provided an incident report, a diagram of bruising sites, two employee written statements and a copy of the hospital discharge instructions. The administrator stated that Resident #35 did not have a fall in March of 2018.

The incident report completed by LPN E was dated 04/02/2018 at 5:24 AM. Under the header "Incident Description" it was documented, "Resident was noted to have bruise on left corner of her mouth. Resident was assessed in bruises were noted on several fingers on bilateral hands, inner aspect of arm just below armpit, outer aspect of right arm above elbow, skin tear to ring finger on right hand. Resident is unable to give description due to advance [sic] dementia." Under

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the header "Predisposing Environmental Factors" "furniture" was selected. Under the header "Predisposing Physiological Factors" "confused, incontinent, impaired memory, Other" were selected. Under the header "Predisposing Situation Factors", "siderails up" was selected. Under the header "Other info [information]" it was documented "Resident is total care, combative with care."

On the diagram of bruising sites, it was labeled there was bruising on the left side of face and neck, inner aspect of right arm, inner aspect of left arm, bruise on right posterior [back of the arm] elbow, bruises on all fingers of both hands, bruise on anterior leg below the knee (shin) and left foot, bruise on inner aspect of right lower leg, and scattered bruising on lateral [outer] aspect of right lower leg."

A written statement by Certified Nursing Assistant L [CNA L] dated 3-25-18 documented, "I had [Resident #35] on my caseload as a 3-24-2018. I went into her room and changed her twice. I didn't see any marks or brusies [sic] while changing her." A handwritten statement by CNA M dated 3-26-18 documented, "I, [CNA M], did rounds when I came onto shift to ensure res [residents] were breathing/safe. At 2 a.m. I started rounds I did not notice anything on [Resident #35's room number/bed] face but am unsure if bruise was already there due to only using limited light. Resident was a little aggressive hitting my hand but nothing too much or alarming due to getting report and staff stating resident screams and fights."

On 07/16/2019 at approximately 2:00 PM, an interview with the administrator and DON was

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conducted. The DON stated she was not working at the facility at the time of the incident. The DON stated the certified nursing assistant working the night of the incident and unit manager at the time of the incident were no longer working at the facility. When the DON was presented with the diagram of bruising sites and the bruising patterns and asked about expectations for staff response, the DON stated she would want to investigate to keep [Resident #35] safe and have more information such as the color of the bruises to determine if some were old vs. new. She also stated she would be concerned due to the amount of bruising. The administrator and DON conceded a thorough investigation was not done and it should have been reported to the state agency as an injury of unknown origin.

The facility staff provided a copy of their policy manual entitled, "Abuse/Neglect/Misappropriation/Crime." Under the policy entitled, "Initial Reporting Guidelines" in Section 2, it was documented, "Injuries of unknown origin (injuries not witnessed or patient can't state what happened) should be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the State Survey Agency." Under the policy entitled "Reporting Requirements/Investigations" in Section 1, it is documented, "Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of Resident property, the administrator will immediately report to the state agency, but not later than two hours after the allegation is made, if the events that caused the allegation involves abuse or results and serious bodily injury, or not later than 24 hours if the

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events that caused the allegation do not involve abuse and do not result in serious bodily injury." In Section 2 it was documented, "The administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged suspected occurrence. The investigative protocol will include, but not limited to, collecting evidence, interviewing alleged victims and Witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations."

On 07/16/2019 at approximately 7:45 PM, the administrator and DON had no further information or documentation to offer.

2. For Resident #8, the facility staff failed to investigate an injury of unknown origin.

Resident #8 is 76 year old female who was admitted to the facility on 08/29/2016 with diagnoses including but not limited to stroke, muscle weakness, and vascular dementia without behavioral disturbance.

Resident #8's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/2019 was coded as a Quarterly review. Resident #8 was coded with a Brief Interview of Mental Status (BIMS) score of "6" out of possible 15, indicating severely impaired cognition.

On 07/14/19 at approximately 4:45 pm during initial tour of the facility, Resident #8 was

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observed lying quietly in bed sleeping. She had large purple bruising around both of her eyes and a bruise above her right eyebrow with a small, scabbed over laceration on the right eyebrow. An interview with Resident #8 was attempted, however she opened her eyes but did not engage in conversation.

On 07/16/19, a clinical record review was performed. A Progress Note dated 6/30/2019 at 04:45 read: "CNA reported resident was laying on the floor. Resident was noted lying on the floor in the hallway in front of her wheelchair. Resident stated she did not know how she fell but replied yes when asked if she fell asleep." and another Progress Note dated 7/12/2019 at 03:04 read: "Called to room by CNA found resident wrapped up in covers laying on floor between the beds on the right side".

On 07/16/19 at approximately 2:28 PM, an interview with the Administrator (Employee A) and the Director of Nursing (DON, Employee B) was conducted. The Administrator stated, "we did not do an investigation or report anything because the nurse notes state that the resident was found wrapped up in blankets on the floor so she must have fallen". The DON stated, "I remember this incident because it was just this past week, she was found wrapped up in blankets on the floor next to her bed so the nurse determined that she had to have fallen out of bed". When asked if there were any witnesses to the "fall", the DON replied, "No, not to my knowledge".

On 07/16/19, a facility policy entitled, "Nursing Policies and Procedures, Abuse/Investigative Reporting, Injuries of Unknown Origin, policy #102" (effective date 11/4/16) was reviewed. The

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F 610	Continued From page 54 Policy Statement read: "Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the Center Administrator". The "Procedure" subheading, item #7 read, "The Director of Nursing is responsible for immediately notifying the Administrator of the injury of unknown origin. An initial report to the State Agency will be initiated" and item #8 read, "Investigative protocols will be immediately initiated...". Both the Administrator and DON confirmed that they felt the incidents, on 6/30/19 and 7/12/19, were "falls" and not injuries of unknown origin despite the lack of witnesses on both occasions, and therefore did not perform any investigations.	F 610		
	COMPLAINT DEFICIENCY			
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 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	F 623		9/21/19

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F 623	Continued From page 55 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; (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	F 623		

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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
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).

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F 623	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to notify Ombudsman of a transfer to hospital for one Resident (Resident #79) in a survey sample of 46 residents. The findings included: Resident #79, was admitted to the facility on 4/19/19 with a readmission date of 6/24/19. Review of Resident #79's clinical record revealed that on 6/9/19 the Resident was transferred to a hospital. Resident #79 was admitted to the hospital. Review of Resident #79's entire clinical record revealed no indication that the ombudsman was made aware of the Resident's transfer/discharge. On 7/15/19 an interview was conducted with the Director of Nursing (DON) and she stated, "nursing notifies the ombudsman." Verification of this notification was requested. On 7/16/19 when the verification of the ombudsman notification was requested again, the DON stated, "I have nothing." No further information was provided.	F 623	1. Resident # 79 □ Notified Ombudsman of transfer to Emergency Room. 2. All residents who discharge to the hospital are ask risk for deficient practice. 3. SDC or Designee will educate DON, Director of Discharge Planning and Admissions department on requirements of Ombudsman notification related to transfer to hospital. 4. DON or Designee will review all transfer to hospital to ensure notification of Ombudsman. Audit 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		9/21/19

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F 645	Continued From page 58 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 645		

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F 645	Continued From page 59 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for 8 residents (Resident #503, #87, #502, #203, #254, #252, #253, and #48) of the survey sample of 46 to ensure a Preadmission Screening and Resident Review (PASARR) was conducted prior to admission to the nursing facility. The Findings included: 1. For Resident # 503, the Preadmission Screening and Resident Review (PASARR) was not completed prior to admission to the facility.	F 645	1. Resident # 503 no longer resides in facility, # 203 no longer resides in facility, #87 no longer resides in facility, #503 no longer resides in facility, # 254 no longer resides in facility, #252 no longer resides in facility. #48 PASSAR was complete. 2. All new admission are risk for deficient practice 3. Administrator or designee will educate the discharge planner on review and completion of PASARR prior to patient□s admission to center. 100% of all current residents reviewed for completion and accuracy.	

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F 645	Continued From page 60 Resident # 503 was a 92 yr old female admitted to the facility on 6/28/2019 with diagnoses of but not limited to Major Depressive Disorder. Resident # 503's most recent (Minimum Data Set) MDS was an Admission Assessment with an (Assessment Reference Date) ARD of 7/12/2019. The MDS coded her has having a (Brief Interview of Mental Status) BIMS Score of 15 out of 15, indicating no cognitive impairment. Review of the clinical record revealed that the PASARR was signed on 6/28/2019, the day of admission, by the facility's Discharge Planning Director. Review of the document for Resident # 503 revealed the Preadmission Screening and Resident Review (PASARR) was dated the day of admission to the facility and documented "yes" to the question "Does the individual have a serious mental illness (MI) ?. The question should be answered "yes" only if all three of the qualifying questions were answered "yes". Those three questions were answered "no", indicating no serious mental illness. On 7/15/2019 at 9 a.m., an interview was conducted with the Administrator and the Corporate Consultant (Employee E). The Administrator was asked when a Resident should have a PASARR completed. She stated that it was a part of the admission process. The Administrator stated that the facility had been completing the screening once the residents were admitted to the facility if the hospital did not send it in the discharge papers. The Corporate Consultant stated they recently learned that the PASARR screening should happen prior to	F 645	4. The DON or designee will audit 20% of new admission to ensure PASARR was completed prior to patient admission to center 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process. 5. Date of Compliance is September 21st, 2019.	

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admission and it should occur during the pre-admission process.

On 7/16/20019 at 10:48 a.m., an interview was conducted with the Discharge Planning Director (Employee P) who stated she or her assistant would complete the PASARR once the resident was admitted to the facility if the hospital did not send it. Employee P stated she just learned that the form needed to be completed before the resident was admitted to the facility. Employee P was informed that the question regarding mental illness was answered "yes". Employee P stated that was an error and the PASARR form should be filled out correctly for each resident.

No further information was provided.

2. For Resident # 87, the Preadmission Screening and Resident Review (PASARR) was not initiated prior to admission to the facility.

Resident # 87's original date of admission was 6/3/2019 and readmitted on 7/9/2019 with diagnoses of but not limited to: Right hip replacement, acute embolism and thrombosis, and Hypertension.

Resident #87's most recent MDS (Minimum Data Set) Assessment was a 30 day Assessment with an ARD (Assessment Reference Date) of 7/1/2019 from the original admission. The MDS coded Resident # 87 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating no cognitive impairment.

On 7/15/2019, review of the clinical record

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revealed the PASARR Level I screening was completed on the day of the original admission by the facility's Discharge Planning Director (Employee P).

On 7/15/2019 at 9 a.m., an interview was conducted with the Administrator and the Corporate Consultant (Employee E). The Administrator was asked when a Resident should have a PASARR completed. She stated that it was a part of the admission process. The Administrator stated that the facility had been completing the screening once the residents were admitted to the facility if the hospital did not send it in the discharge papers. The Corporate Consultant stated they recently learned that the PASARR screening should happen prior to admission and it should occur during the pre-admission process.

On 7/16/20019 at 10:48 a.m., an interview was conducted with the Discharge Planning Director (Employee P) who stated she or her assistant would complete the PASARR once the resident was admitted to the facility if the hospital did not send it. Employee P stated she just learned that the form needed to be completed before the resident was admitted to the facility.

No further information was provided.

3. For Resident # 502, the facility staff failed to obtain a PASARR screening prior to admission and did not complete the form in its entirety.

Resident # 502 was admitted to the facility on 7/9/2019 with diagnoses of but not limited to:

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Acute Hemorrhagic Anemia, Malignant Neoplasm of the Colon, Colectomy, Bradycardia, Hypertension and Hypokalemia.

There was no Minimum Data Set (MDS) done because it was too early to obtain the assessment. The admission nursing assessment. indicated no cognitive impairment; the resident required assistance with activities of daily living.

Review of the clinical record revealed that the PASARR was signed on 7/9/2019, the day of admission, by the facility's Discharge Planning Director. The PASARR form was not completed entirely. Question # 5 was not answered about whether or not Resident # 502 needed to be referred for a Level II evaluation. Neither "option a" indicating to refer for a Level II nor "option b" indicating no referral needed were checked.

On 7/15/2019 at 9 a.m., an interview was conducted with the Administrator and the Corporate Consultant (Employee E). The Administrator was asked when a Resident should have a PASARR completed. She stated that it was a part of the admission process. The Administrator stated that the facility had been completing the screening once the residents were admitted to the facility if the hospital did not send it in the discharge papers. The Corporate Consultant stated they recently learned that the PASARR screening should happen prior to admission and it should occur during the pre-admission process.

On 7/16/20019 at 10:48 a.m., an interview was conducted with the Discharge Planning Director (Employee P) who stated she or her assistant

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would complete the PASARR once the resident was admitted to the facility if the hospital did not send it. Employee P stated she just learned that the form needed to be completed before the resident was admitted to the facility.

No further information was provided.

4. For Resident # 203, the Preadmission Screening and Resident Review (PASARR) was not initiated prior to admission to the facility.

Resident #203, was a 78 year old male admitted to the facility on 6/20/2018. Diagnoses included but were not limited to: acute sacral fractures, progressive osteoporosis, and history of falls.

Resident #203's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #203 was coded as having a BIMS (brief interview of mental status) score of "12" out of a possible 15, or moderate cognitive impairment. Resident # 203 was also coded as requiring limited to extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, locomotion, and toileting. Resident # 203 was assessed as frequently incontinent of bowel and bladder.

Review of the clinical record was conducted on 7/15/19 and revealed the PASARR Level I screening was completed six days after admission by the facility's Discharge Planning Director (Employee P). The PASARR was dated 6/26/18. Resident # 203 was admitted on

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F 645	Continued From page 65 6/20/18. On 7/15/2019 at 9 a.m., an interview was conducted with the Administrator and the Corporate Consultant (Employee E). The Administrator was asked when a Resident should have a PASARR completed. She stated that it was a part of the admission process. The Administrator stated that the facility had been completing the screening once the residents were admitted to the facility if the hospital did not send it in the discharge papers. The Corporate Consultant stated they recently learned that the PASARR screening should happen prior to admission and it should occur during the pre-admission process. On 7/16/20019 at 10:48 a.m., an interview was conducted with the Discharge Planning Director (Employee P) who stated she or her assistant would complete the PASARR once the resident was admitted to the facility if the hospital did not send it. Employee P stated she just learned that the form needed to be completed before the resident was admitted to the facility. No further information was provided. 5. For Resident # 254 the facility staff failed to obtain a LEVEL I PASARR prior to admission to the facility. Resident #254, a 32 year old man admitted to the facility on 7/3/19 with diagnoses of but not limited to traumatic injuries sustained in MVA (motor vehicle accident) subdural hemorrhage, major	F 645		

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laceration of the liver, fracture of superior rim of left pubis, fracture of lumbosacral spine and pelvis. Resident #254 is a new admission and therefore does not yet have an MDS (Minimum Data Set) however is non-weight bearing due to injuries sustained in MVA.

On 7/15/19 during the clinical record review it was noted that Resident #254 had the following entry in the Nursing Progress Notes:

"7/4/19 10:06 AM - Discharge Planning Progress Notes- Level I PASRR [sic] was conducted internally using the available diagnostic and medical information from the hospital's admitting / discharging documentation. The said document is not uploaded in PCC."

On 7/16/19 at 10:48 AM an interview was conducted with the Social Worker when asked what the process is for PASARR completion she explained that it should be completed before the Resident enters the facility by hospital or referring agency.

She further elaborated that when a Resident does not have a Level I PASARR completed when they prior to admission then it is done "in house" after they arrive.

On 7/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

On 7/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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6. For Resident #252 the facility failed to obtain a LEVEL I PASARR prior to admission to the facility.

Resident #252, a 61 year old woman admitted to the facility on 7/12/19 with diagnoses of but not limited to major depressive disorder, COPD (Chronic Obstructive Pulmonary Disease), and Diabetes. Resident #252 is a new admission and therefore does not yet have an MDS (Minimum Data Set).

On 7/15/19 during the clinical record review it was noted that Resident #252 had the following entry in the Nursing Progress Notes:

"7/12/19 10:06 AM - Discharge Planning Progress Notes- Level I PASRR [sic] was conducted internally using the available diagnostic and medical information from the hospital's admitting / discharging documentation. The said is now uploaded in PCC."

On 7/16/19 at 2:33 PM an interview was conducted with the Social Worker when asked what the process is for PASARR completion she explained that it should be completed before the Resident enters the facility by hospital or referring agency.

She further elaborated that when a Resident does not have a Level I PASARR completed when they prior to admission then it is done "in house" after they arrive.

On 7/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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7. For Resident # 253 the facility failed to obtain a LEVEL I PASARR prior to admission to the facility.

Resident #253, 65 year old woman admitted to the facility on 7/10/19 with diagnoses of but not limited to major depressive disorder, muscle weakness, and anxiety disorder. Resident #254 is a new admission and therefore does not yet have an MDS (Minimum Data Set).

On 7/15/19 during the clinical record review it was noted that Resident #254 had the following entry in the Nursing Progress Notes:

"7/10/19 5:39 PM - Discharge Planning Progress Notes- Level I PASRR [sic] was not provided by the transferring hospital. The Level I PASRR was conducted internally using the available diagnostic and medical information from the hospital's admitting / discharging documentation. The said is now uploaded in PCC [Point Click Care - computer program for electronic medical records]."

On 7/16/19 at 2:33 PM an interview was conducted with the Social Worker when asked what the process is for PASARR completion she explained that it should be completed before the Resident enters the facility by hospital or referring agency.

She further elaborated that when a Resident does not have a Level I PASARR completed when they prior to admission then it is done "in house" after they arrive.

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On 7/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

8. For Resident #48, the facility staff failed to obtain a PASARR (Preadmission Screening and Annual Resident Review) prior to admission on 09/10/2019.

Resident #48, a 99-year old female, was admitted to the facility on 09/10/2016. Diagnoses included but not limited to dementia and depression.

Resident #48's most recent Minimum Data Set with an Assessment Reference Date of 06/14/2019 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 4 out of possible 15 indicative of severe cognitive impairment.

On 07/15/2019 at approximately 10:30 AM, the clinical record was reviewed. The PASARR was completed on the same day of admission to the facility, 09/10/2019, and signed by Employee P, the Discharge Planner.

On 07/16/2019 at approximately 10:50 AM, an interview with Employee P was conducted. When asked about the expectation for the PASARR, Employee P stated that PASARR's should be completed by the transferring facility and "We should have it before they enter, even on the weekends."

On 07/16/2019 at approximately 7:45 PM, the administrator and DON had no further

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F 645	Continued From page 70 documentation or information to offer.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		9/21/19

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F 656	Continued From page 71 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, the facility staff failed to develop a comprehensive care plan for oxygen use for one Resident (Resident #58) in a survey sample of 46 residents. For Resident #58 the facility staff failed to develop a careplan to include poor oxygen saturation and use of oxygen. The findings included; Resident #58 was admitted to the facility on 4/19/19. The Resident's diagnoses included but were not limited to: cerebral infarction due to embolism of right middle cerebral artery and obstructive sleep apnea. On 7/14/19 at approximately 4:30pm during initial tour, Resident #58 was observed at his bedside, sitting in a wheelchair visiting with his spouse. Resident #58 was connected to a portable oxygen cylinder, which was on the back of his wheel chair and had a nasal cannula in his nose to deliver the oxygen. It was observed that the O2 cylinder was reading in the red zone, which indicated it was empty. On 7/14/19 at 4:40pm LPN F was approached and asked to come check Resident #58's oxygen (O2) saturation. LPN F accompanied this writer	F 656	1. Resident # 58 □ Care Plan updated to include oxygen therapy. 2. All patients receiving oxygen are at risk for incomplete care-plan. 3. The Nurse Educator or Designee will educate Licensed Nurses on updating and review of care plan per center policy related to oxygen delivery. 4. The DON or Designee will review three different residents with oxygen therapy to ensure care plan is up to date and accurate, 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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F 656	Continued From page 72 to Resident #58's room and checked his O2 saturation. LPN F stated, "it is 85-97, the highest I got was 97. I'm going to check his orders." LPN F was asked to look at the O2 cylinder and LPN F stated, "he needs a new tank, that's what is going on." During multiple observations of Resident #58 from 7/14/19-7/16/19, Resident #58 was observed with oxygen on via nasal cannula. Review of Resident #58's physician orders revealed an order that read, "Oxygen at (2) liters per minute via nasal cannula every shift." Review of Resident #58's careplan reveals no indication of the need for oxygen and inability to maintain oxygen saturation independently. On 07/16/19 at 08:49 AM an interview was conducted with the DON, she acknowledged she would expect the use of oxygen to be on the careplan. No further information was provided.	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.	F 657		9/21/19

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F 657	Continued From page 73 (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 observation, Resident interview, spouse interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for 2 Residents (#58 and #79) in the survey sample of 46 Residents. The findings included: 1. For Resident #58 the facility staff failed to review and revise the careplan to remove the use of a cervical collar which was no longer being used. Resident #58 was admitted to the facility on 4/19/19. The Resident's diagnoses included but were not limited to: cerebral infarction due to embolism of right middle cerebral artery and obstructive sleep apnea.	F 657	1. Resident # 58 and # 79 □ Care Plan has been reviewed and revised. Nursing and therapy staff will be re-educated on following resident□s individualized care-plan related to cervical collar, anticoagulant therapy and wound care. 2. All residents receiving anticoagulant, wound care and use of cervical collar are at risk. 3. The SDC or Designee will educate Licensed Nurses on updating and reviewing care plans related to anticoagulant therapy, wound care, and use of cervical collar. 4. The DON or Designee will review 10% resident care plans who receive, anticoagulant therapy and wound care and utilizer cervical collar 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process.	

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F 657	Continued From page 74 On 7/14/19 at approximately 4:30pm during initial tour, Resident #58 was observed at his bedside, sitting in a wheelchair visiting with his spouse. Resident #58 was observed with no cervical collar in use. During multiple observations of Resident #58 from 7/14/19-7/16/19, Resident #58 was observed in bed as well as in the wheel chair and no cervical collar was in use. Review of Resident #58's physician orders revealed no orders for the use of a cervical collar. Review of Resident #58's careplan revealed and entry dated 6/27/19 that read "Cervical collar". No further information was provided. 2a. For Resident #79 the facility staff failed to review and revise the careplan to include the current use of an anticoagulant. Resident #79, was admitted to the facility on 4/19/19 with a readmission date of 6/24/19. Review of Resident #79's current physician orders for July revealed an order change for Eliquis on 7/3/19. The current order read, "Eliquis Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for anticoagulant." Review of Resident #79's careplan revealed a careplan anticoagulant use that was resolved on 7/3/19. No further information was provided.	F 657	5. Date of Compliance is September 21st, 2019.	

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F 657	Continued From page 75 2b. For Resident #79 the facility staff failed to review and revise the careplan to include the current development of a wound. Resident #79, was admitted to the facility on 4/19/19 with a readmission date of 6/24/19. Review of Resident #79's clinical record revealed a skin & wound evaluation dated 6/24/19 that indicated that Resident #79 has a stage II pressure wound to her sacrum measuring 0.8 x 1.6 x 0.7 cm. Another skin & wound evaluation was presented, dated 7/10/19 that indicated the sacral wound remains a stage II wound with the following measurements: 0.8 x 1.2 x 0.9 cm. Review of Resident #79's current careplan revealed a entry created on 4/21/19 and revised on 7/4/19 which stated "potential for skin impairment d/t [due to] decrease mobility, frequent incontinence, DM [diabetes], oxygen use. Resident #79's actual wound status was not indicated. No further information was provided.	F 657		
F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §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:	F 658		9/21/19

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F 658	Continued From page 76 Based on observation, staff interview, facility documentation review, clinical record review, and during the course of a complaint investigation the facility staff failed to ensure professional standards of quality were met for eight Residents (Resident #5, #72, #63, #503, #87, #203, #74, #54) in a survey sample of 46 residents. This resulted in harm for Resident #5. The findings included: Immediate Jeopardy was identified on 8/6/19 at 6:17pm and the facility was notified. After verification, Immediate Jeopardy was abated on 8/7/19 at 6:55pm and the scope and severity was lowered to level three, isolated. The findings included; 1. For Resident #5, the facility staff failed to identify wounds, accurately assess wounds, obtain and implement appropriate treatment orders. Resident #5 was admitted to the facility on 1-29-19. Diagnoses included; vertigo, chronic kidney disease, dementia, benign prostatic hypertrophy, stroke, hypertension, congestive heart failure. and chronic Foley catheter. Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-26-19. The Resident was coded with mild cognitive impairment, and no aberrant behaviors. Resident #5 required extensive assistance to total dependence on one to two staff members, for activities of daily living care. The Resident was coded as not having any pressure ulcers at the	F 658	1. Resident # 5 □ Patient no longer resides in facility. The patients air mattress was changed. The Physician consulted with the family and received options for further treatment and ultimately decided to discharge to the Hospital. Resident #72 □ Physician was notified no untoward affects to patient Resident # 63 □ No longer resides at facility. Resident # 503 □ Patient no longer resides in facility. Resident # 87 □ No longer resides at facility. Resident # 203 □ Patient no longer resides at facility. Resident # 74 □ No longer resides in facility. Resident # 54 □ Physician was notified no untoward affects to patient 2. 2a) All residents with pressure ulcers are at risk for deficient practice All resident who receive medication are at risk All residents are at risk for physician order treatment not being completed per order. 3.SDC or designee will educate licensed staff on providing appropriate treatment for pressure ulcers and review of wound care policy. SDC designee will educate licensed nursing on medication administration and availability SDC or designee will educate licensed nurse on following physician orders for	

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F 658	Continued From page 77 assessment time, nor on admission. The Resident had a long standing Foley catheter (urine drainage) due to an obstruction, and was incontinent of bowel. The Resident was coded as at risk for pressure sores. At area M-0100 through M-1200 under the MDS skin conditions section of the assessment, the Resident was coded to be at risk for pressure ulcers, had no pressure ulcers, and had no other skin problems such as rashes, and or moisture associated skin damage. On 7-16-19 at 11:30 a.m., an observation of wound treatment for Resident #5 was conducted with Licensed practical nurse C (LPN C), and Certified nursing assistant N (CNA N). The nurse removed the bandage from the Resident's coccyx. The 4 inch by 4 inch single bandage had a solid center in it which was a tan telfa like non-adherent 2 inch by 2 inch square. The outer circumference of the square bandage was surrounded by a boarder of adherent malleable stretchy tape, reminiscent of Band-Aid fabric. There was no packing or medicated cream in the hollow wound. Immediately after removing the dressing a green purulent discharge was seen. The wound was circular, and deep with full muscle tissue loss and bone protrusion clearly visualized and palpated by the nurse. The wound had undermined and tunneled circumferentially around, only under the circular rolled wound edges. There was also noted yellow tan slough and black necrotic tissue inside the wound, and silvery white fascia could be seen covering the coccygeal bone protrusion. The LPN measured the wound with a long cotton swab and a wound measuring disposable paper tape. She measured the cotton swab after it was laid on the	F 658	treatment of surgical wounds. 4. DON or designee will review all pressure ulcers to ensure accuracy of assessment and appropriate treatment 3x a week for 2 weeks, than weekly for 2 weeks than monthly x 2 through QAPI process The DON or designee will conduct MAR/TAR audits ensure timely medication administration and availability 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process The DON or designee will audit 10% of surgical wound to ensure physician ordered treatment in place. Weekly 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process. 5. Date of compliance September 21st 2019	

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wound, and placed in the wound for an accurate measurement. The wound measured 2 centimeters (cm) long, 1.5 cm wide, and 1.5 cm deep. The exterior wound edges were rolled (epibole). The Resident was pre-medicated with pain medication and stated he felt no pain as the wound was measured.

Nursing progress notes were reviewed from wound identification to the time of survey. No notes describe any pressure ulcer identification, treatments, assessments for pressure ulcers, or changes to the care plan for Resident #5 after the first identification of the wound on 4-29-19. The initial note described the pressure injury as a red bruise with open skin, and the skin evaluation document of 4-29-19 gave further measurements.

Review of the weekly skin assessment sheets since admission "PCC Skin & Wound - Total Body Skin Assessment" documents revealed all (including the initial) were completed by LPN's. The findings were as follows;

1-29-19 - no new wounds
2-5-19 - no new wounds
2-12-19 - no new wounds
2-19-19 - no new wounds
2-26-19 - no new wounds
3-5-19 - no new wounds
3-13-19 - no new wounds
3-25-19 -no new wounds
4-1-19 - no new wounds
4-8-19 -no new wounds
4-15-19 -no new wounds
4-22-19 -no new wounds
From 4-22-19 through 5-26-19, no weekly skin checks were completed.

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5-27-19 -no new wounds
6-3-19 -no new wounds
6-10-19 -no new wounds
6-17-19 - no new wounds
6-24-19 - 2 new wounds (left and right buttocks)
7-1-19 -no new wounds
7-8-19 -no new wounds
7-15-19 -no new wounds.

On 4-29-19, another type of assessment document was initiated and performed by all LPN staff, "Skin and Wound Evaluation V 5.0". These documents were started for a "new Pressure wound stage 2 on the Resident's sacrum" and was described as being treated with povidone iodine after cleaning with normal saline, and no dressing. The wound measured 3 cm long x 1.3 cm wide, no depth, and healable. None of these documents were completed after this initial one until 1 month later, on 5-27-19. The Rest of these particular assessment documents follow below in chronological order:

On 5-27-19 the next "Skin and Wound Evaluation V 5.0" document occurred one month after the first one on 4-29-19. The document describes the sacrum wound as stage 2 unchanged, healable, and documents the measurements of the wound as 1.1 cm long x 0.5 cm wide, and no depth. The treatment remains the same. No eschar, no debridement, no dressing.

On 6-3-19 Sacrum stage 2 pressure ulcer 1.7 cm long x 0.5 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-10-19 sacrum stage 2 pressure ulcer 1.9 cm long x 0.5 cm wide, no depth, same

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treatment. Healable. No eschar, No debridement, no dressing.

On 6-17-19 sacrum stage 2 pressure ulcer 1.2 cm long x 0.6 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-24-19 staff pin pointed and documented the "Coccyx" portion of the sacrum, instead of just stating sacrum, stage 2 pressure ulcer 1.3 cm long x 0.9 cm wide, no depth, Normal saline, and now, cover with foam dressing. Healable. No eschar, No debridement. A Left buttock and a right buttock were found as "New areas" on 6-24-19, however, had nothing to do with the continuing Sacrum/Coccyx wound according to nursing staff.

On 7-2-19 coccyx stage 2 pressure ulcer 1.4 cm long x 0.2 cm wide, no depth, same treatment. Healable. No debridement, No eschar.

On 7-8-19 coccyx stage 2 pressure ulcer 1.5 cm long x 0.5 cm wide, no depth, same treatment. Healable, Deteriorating. No debridement, No eschar.

On 7-9-19 (one day later) the last assessment documented coccyx stage 2 pressure ulcer 1.2 cm long x 0.6 cm wide, no depth, Eschar 20%, deteriorating, healable, treatment; normal saline and enzymatic debridement (ordered 6-3-19).

It is notable to mention that betadine (2 times per day) and Vasolex (1 time per day) were ordered to be completed simultaneously and were signed as administered simultaneously, however, the dressing would have to be removed twice daily for

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this to occur.

No assessments by staff described a stage 4 pressure ulcer, and no assessments were completed from 7-14-19. through 7-16-19, until the surveyor found the stage 4 pressure ulcer on 7-16-19.

All of the assessments, including the initial assessment, were completed by LPN's.

Physician's orders and Medication and Treatment Administration Records (MAR's/TAR's) were reviewed and revealed no physicians order for prevention of pressure sores from bowel incontinent episodes such as an incontinence barrier cream. Only the following 4 orders appeared after the pressure sore developed for the sacral coccyx acquired pressure ulcer treatment;

1. Ordered 4-29-19 start 4-29-19 discontinued 7-8-19 Clean open area to sacrum with normal saline and apply betadine twice per day at morning and bedtime. No dressing. No change to this order occurred after 2.5 months without healing.

2. Ordered 6-3-19 start 6-4-19 discontinued 7-9-19 Clean wound with normal saline & apply Vasolex ointment to coccyx wound topically once per day & as needed with allevyn dressing.

3. Ordered 7-10-19 start 7-10-19 discontinued 7-16-19 Cleanse sacrum/coccyx with normal saline apply intrasite gel (hydrogel water gel to keep wound bed moist) and cover with coversite once every day.

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4. Ordered 7-16-19 start 7-17-19 Cleanse sacral wound with saline, apply iodoform (iodine impregnated gauze for packing into a hole) and cover area with coversite one time per day, after the examination by surveyors and an LPN, and was not ordered to be administered until the following day (7-17-19) further delaying care.

Review of the MAR/TAR's revealed that the pressure sore treatments that were ordered as above, were not administered on 5/18, 5/24, 6/4, 6/10, 6/20, 6/26, 7/8, and 7/9/19. No nursing notes reveal the reason for the omissions.

The DON was requested to supply surveyors with all policies for skin assessments and pressure ulcers. The DON, and Corporate RN supplied 2 facility policies on skin assessments and pressure ulcers. They are as follows;

1. "Pressure ulcers Manual" - "Skin Assessment" Skin assessments will be completed for all patients. A licensed nurse will ensure that the skin risk assessment is done upon admission, and quarterly thereafter. A skin assessment will also be completed upon re-entry to the center (i.e., after ER visit, dialysis, etc.) The weekly skin assessment will be completed thereafter. Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs.

2. "Pressure ulcers Manual" - "Pressure Ulcer monitoring &" A licensed nurse will assess patients for the presence of pressure ulcers: if a pressure ulcer is present, the nurse will evaluate for complications. Provide pain management prior to pressure ulcer treatment as indicated. The wound record will be completed weekly by a

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licensed nurse for any patient with pressure ulcers. There will be a wound record for each site.

Guidance is provided for the staging of pressure ulcers by the National Pressure Ulcer Advisory Panel (NPUAP), and is as follows;

NPUAP announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury FOR IMMEDIATE RELEASE April 13, 2016.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury:
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant (fat) adiposity can develop deep wounds. Undermining and tunneling may

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occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

Stage 4 Pressure Injury:
If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness stage 4 pressure injury. Do not use (deep tissue pressure injury) DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

On 7-16-19, Resident #5's care plan was reviewed and revealed the following 2 entries of importance; 1. Resistive to care, and 2. Skin care plan.

1. FOCUS "Resident and wife are resistive to care." instituted 5-7-19, with an intervention for "Explain to (Resident spouse name) some interventions she is using may be harmful and cause more problems with skin integrity.... continues to use own equipment and use of sheepskin which will add moisture." The Corporate RN (corp RN) was asked how a woman who walks with a cane could apply sheepskin to a hospital bed with her husband in it. The Corp RN replied "yes, we put it on the bed, but the wife insisted." No nursing progress notes, physician progress notes, nor the MDS describe the Resident as refusing care.

2. On 5-1-19, and 5-2-19 new focuses were added with no additions after that date. A planned focus area included; "the Resident has a

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pressure ulcer with potential for pressure ulcer development, administer treatments as ordered, and monitor for effectiveness...",

Per Lippincott Manual of Nursing Practice, 11th edition, page 150 the nursing standard reads, "assess for risk factors for pressure ulcer development and alter those factors, 2. Assess skin of the older adult frequently for the development of pressure ulcers. 3. Stage the ulcer so appropriate treatment can be started."

In summary, for Resident #5, the physician ordered treatments were not administered, assessments of skin, and the wound were not completed for 1 month, and the wound was identified by surveyors as a stage 4 pressure ulcer, when staff were still documenting a stage 2 wound. Staff signed that they completed 2 conflicting wound treatment orders simultaneously. The wound was initially identified as a stage 2 wound which progressed to a stage 4 wound, without staff identifying it.

The Administrator, DON, and the Registered Nurse (RN) Regional Consultant were made aware of the harm level deficiency at the end of day debrief on 7-16-19. No further information was supplied by the facility.

2. For Resident #72, the facility staff failed to administer insulin as scheduled.

Resident #72, an 81 year old female, was admitted to the facility on 6/22/2019. Her diagnoses included but are not limited to diabetes, high blood pressure, and generalized weakness.

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On 7/15/19 at approximately 10:20, Resident #72 expressed concerns stating, "the nurses can be slow giving me my scheduled medicines, I take insulin for my diabetes".

On 7/15/19, clinical record review was conducted for Resident #72 and an excerpt from the care plan read, "The resident has Diabetes Mellitus, the resident will have no complications related to diabetes...diabetes medication as ordered by doctor". The signed physician orders dated 6/24/19 read, "Basaglar Kwikpen Solution Pen-injector 100 unit/ml (Insulin Glargine), inject 8 units subcutaneously one time a day for diabetes". Her dose was scheduled to be given at 9:00 AM each morning.

A Medication Administration Audit Report for the previous week was requested and provided by facility staff. Resident #72 received Insulin Glargine as follows:
7/9/19, time scheduled 9:00 AM, time administered 10:49 AM
7/11/19, time scheduled 9:00 AM, time administered 10:42 AM
7/12/19, time scheduled 9:00 AM, time administered 11:46 AM
7/13/19, time scheduled 9:00 AM, time administered 11:44 AM
7/14/19, time scheduled 9:00 AM, time administered 10:56 AM
7/15/19, time scheduled 9:00 AM, time administered 10:14 AM

On 7/16/19 at approximately 9:50 AM, the Director of Nursing (DON, Employee B) was interviewed and stated, "the facility expectations for med pass include [medication to be given] one

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hour before and one hour after [the] scheduled time". When asked about the possible outcomes if insulin is not given as ordered at the scheduled time, she stated, "if the resident does not receive the ordered insulin as scheduled at the correct times, it could cause an elevation in the blood sugar levels and that could cause ketoacidosis [a diabetic emergency]".

Review of the facility's policy entitled, "6.0 General Dose Preparation and Medication Administration" (revision date 01/01/13), under subheading "Procedure", item 5.4 read, "Administer medications within timeframes specified by facility policy".

COMPLAINT DEFICIENCY

3. For Resident # 63, the facility staff failed to document the administration of medications as ordered by the physician.

Resident #63, an 83 year old, was admitted to the facility on 5/28/2019. Diagnoses included but were not limited to Hyperlipidemia, occlusion and stenosis of the right middle cerebral artery, Aphasia following cerebral infarction and Dysphagia.

The most current Minimum Data Set (MDS) assessment was a 30 day Admission assessment with an assessment reference date (ARD) of 6/23/2019. Resident # 63 was coded with a Brief Interview of Mental Status score of 7 out of 15 indicating severe cognitive impairment. She required extensive to total assistance of one to two staff persons with activities of daily living.

Review of the July 2019 Medication

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Administration Record revealed missing documentation of medications including:
Amlodipine 10 milligrams give one tablet via PEG (Percutaneous Endoscopic Gastrostomy) tube one time per day
7/13/19 at 9 a.m.

Aspirin 325 milligrams give one tablet via PEG (Percutaneous Endoscopic Gastrostomy) tube one time per day
7/13/19 at 9 a.m.

Baclofen 5 milligrams give one tablet via PEG (Percutaneous Endoscopic Gastrostomy) tube one time per day
7/13/19 at 9 a.m.

Hydralazine 100 milligrams give one tablet via PEG (Percutaneous Endoscopic Gastrostomy) tube three times per day
7/13/19 at 8 a.m. and 7/13/19 at 2 p.m.

Losartan 100 milligrams give one tablet via PEG (Percutaneous Endoscopic Gastrostomy) tube one time per day
7/13/19 at 9 a.m.

Enteral Feed Order every shift Check and record residuals every shift 7/6/19-day shift, 7/9/19-day shift, 7/13/19- day shift

Enteral Feed Order every shift flush tube with 20-30 milliliters of water before and after administration of medication pass
7/6/19-day shift, 7/9/19-day shift, 7/13/19- day shift

Review of the July 2019 Treatment Administration Record revealed missing documentation of

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administration including:

Enteral Feed Order every evening shift Check and record residuals every shift 7/5/19-evening shift, 7/10/19 evening shift

Anchor Feeding tube every shift 7/5/19-evening shift, 7/9/19-day shift, 7/10/19- evening shift

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

The Director of Nursing (DON) cited Lippincott as its Nursing professional guidance used by the facility. The DON stated the expectation was that medications should be administered within one hour before or after the scheduled time.

"Fundamentals of Nursing, by Lippincott"cited as the facility nursing practice reference stated "The physician is responsible for directing medical

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treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration.....
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation
" Document administration AFTER giving the ordered medication.
" Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug...."

Reference: Nursing 2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 7/16/2019.

The Administrator and DON were notified of the

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issue at the end of day meeting on 7/15/19. The Director of Nursing (DON) stated the expectation was that nurses would administer medications as ordered by the physician. The DON (director of nursing) stated that she was newly employed since 7/1/2019 and had identified the failure of the staff to ensure medications were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

No further information was provided.

4. For Resident # 503, the facility staff failed to administer medications timely as ordered by the physician.

Resident # 503 was a 92 year old female admitted to the facility on 6/28/2019 with diagnoses of but not limited to Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Heart Failure and Chronic Kidney Disease Stage 3.

Resident # 503's most recent (Minimum Data Set) MDS was an Admission Assessment with an (Assessment Reference Date) ARD of 7/12/2019. The MDS coded her has having a (Brief Interview of Mental Status) BIMS Score of 15 out of 15, indicating no cognitive impairment.

During the initial tour of the facility on 7/14/2019 at 3:40 p.m., Resident # 503 complained that her breathing treatments and medications often were

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given late. Also, Resident # 503 stated medications scheduled for 7/13/2019 at 9 a.m. were not administered until 11 a.m.

Review of the July 2019 MAR (Medication Administration Record) revealed documentation that all of the medications were administered on time. Review of the nurses notes revealed no documentation that any medications were administered late.

On 7/15/2019 at 2:15 p.m., an interview was conducted with the Director of Nursing and the Corporate Consultant (Employee I) who both stated copy of the Medication Administration Audit Report was requested from the Corporate Consultant (Employee I) who stated he would try to obtain the report.

Review of the Medication Admin Audit Report confirmed the 9:00 a.m. medications scheduled for 7/13/2019 at 9:00 a.m. were administered at 11:08 a.m. as Resident # 503 stated. Those medications were:
Lisinopril 5 milligrams give 5 milligrams by mouth one time a day
Spiriva HandiHaler Capsule 18 micrograms one capsule inhale orally one time a day

Potassium Chloride ER (Extended Release) Tablet 20 milliequivalents give one tablet by mouth one time a day

Omeprazole Delayed Release 20 milligrams give one capsule by mouth one time a day

Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters one vial inhale orally two times a day

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Further review of the Medication Admin Audit report revealed other medications administered late:
Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters one vial inhale orally two times a day
Scheduled 7/8/2019 at 9:00 p.m., Administered 7/8/19 at 10:26 p.m.

Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters one vial inhale orally two times a day
Scheduled 7/11/2019 at 9 p.m., Administered 7/11/19 at 10:43 p.m.

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g. (example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

The Director of Nursing (DON) cited Lippincott as its Nursing professional guidance used by the

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facility. The DON stated the expectation was that medications should be administered within one hour before or after the scheduled time.

"Fundamentals of Nursing, by Lippincott"cited as the facility nursing practice reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration.....
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation
" Document administration AFTER giving the ordered medication.
" Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug...."

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Reference: Nursing 2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 7/16/2019.

The Administrator and DON were notified of the issue at the end of day meeting on 7/15/19. The Director of Nursing (DON) stated the expectation was that nurses would administer medications as ordered by the physician. The DON (director of nursing) stated that she was newly employed since 7/1/2019 and had identified the failure of the staff to ensure medications were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

No further information was provided.

5. For Resident # 87, the facility staff failed to ensure the administration of medications timely as ordered by the physician.

Resident # 87's original date of admission was 6/3/2019 and readmitted on 7/9/2019 with diagnoses of but not limited to: Right hip replacement, acute embolism and thrombosis, and Hypertension.

Resident #87's most recent MDS (Minimum Data Set) Assessment was a 30 day Assessment with an ARD (Assessment Reference Date) of 7/1/2019 from the original admission. The MDS

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coded Resident # 87 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating no cognitive impairment.

During the initial tour of the facility on 7/14/2019 at 3:40 p.m., Resident # 87 complained that her medications often were given late. Also, Resident # 87 stated medications scheduled for 7/13/2019 at 9 a.m. were not administered until after 10 a.m.

Review of the July 2019 MAR (Medication Administration Record) revealed documentation that all of the medications were administered on time. Review of the nurses notes revealed no documentation that any medications were administered late.

On 7/15/2019 at 2:15 p.m., an interview was conducted with the Director of Nursing and the Corporate Consultant (Employee I) who both stated copy of the Medication Administration Audit Report was requested from the Corporate Consultant (Employee I) who stated he would try to obtain the report.

Review of the Medication Admin Audit Report confirmed the 9:00 a.m. medications scheduled for 7/13/2019 at 9:00 a.m. were administered between 10:11 and 10:21 a.m. as Resident # 87 stated.

Further review revealed other medications administered late:
Acetaminophen 500 milligrams give two tablets by mouth for pain-Scheduled 7/13/19 at 8 a.m., administered at 10:18 a.m.

Acetaminophen 500 milligrams give two tablets

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by mouth for pain-Scheduled 7/14/19 at 8 a.m., administered at 9:39 a.m.

Docusate Sodium 100 milligrams give one capsule by mouth -scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Fish Oil 500 milligrams one capsule by mouth-scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Metoprolol Extended Release 200 milligrams give one tablet by mouth-scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Olmesartan 40 milligrams give one tablet by mouth-scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Tramadol 50 milligrams give two tablets by mouth -scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Apixaban 5 milligrams give one tablet by mouth -scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Cetirizine 10 milligrams give one tablet by mouth-scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Allopurinol 100 milligrams give one tablet by mouth-scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

Furosemide 20 milligrams give one tablet by mouth-scheduled 7/15/19 at 9:00 am, administered at 11:25 a.m.

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Tramadol 50 milligrams give 2 tablets by mouth -scheduled 7/9/19 at 9 p.m., administered 7/10/19 at 11:53 p.m.

Apixaban 5 milligrams give one tablet by mouth -scheduled 7/10/19 at 5:00 p.m., administered 7/10/19 at 9:52 p.m.

Acetaminophen 500 milligrams give two tablets by mouth-scheduled 7/11/19 at 4:00 p.m., administered at 5:59 p.m.

Tramadol 50 milligrams give 2 tablets by mouth -scheduled 7/11/19 at 9:00 p.m., administered at 10:40 p.m.

Acetaminophen 500 milligrams give two tablets by mouth-scheduled 7/13/19 at 4:00 p.m., administered at 5:38 p.m.

Acetaminophen 500 milligrams give two tablets by mouth-scheduled 7/14/19 at 4:00 p.m., administered at 5:24 p.m.

The facility policy "General Dose Preparation and Medication Administration stated:
4.1.1 Verify each a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule.
4.1.2 Confirm that the MAR reflects the most recent medication order.....

5.4 Administer medications within timeframe specified by Facility policy
6.1 Document necessary medication administration/treatment information (e.g.

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(example) when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms."

The Director of Nursing (DON) cited Lippincott as its Nursing professional guidance used by the facility. The DON stated the expectation was that medications should be administered within one hour before or after the scheduled time.

"Fundamentals of Nursing, by Lippincott"cited as the facility nursing practice reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
Rights of Medication Administration.....
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation

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F 658	Continued From page 100 " Document administration AFTER giving the ordered medication. " Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug...." Reference: Nursing 2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 7/16/2019. The Administrator and DON were notified of the issue at the end of day meeting on 7/15/19. The Director of Nursing (DON) stated the expectation was that nurses would administer medications as ordered by the physician. The DON (director of nursing) stated that she was newly employed since 7/1/2019 and had identified the failure of the staff to ensure medications were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration. No further information was provided. 6. For Resident # 203, the facility staff failed to ensure the Antibiotic eyedrops, Ciprofloxacin 0.3 % eye drops and Cipro 500 milligrams tablets were administered as ordered by the physician. Resident #203, was a 78 year old male admitted	F 658		

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to the facility on 6/20/2018. Diagnoses included but were not limited to: acute sacral fractures, progressive osteoporosis, and history of falls.

Resident #203's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #203 was coded as having a BIMS (brief interview of mental status) score of "12" out of a possible 15, or moderate cognitive impairment. Resident # 203 was also coded as requiring limited to extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, locomotion, and toileting. Resident # 203 was assessed as frequently incontinent of bowel and bladder.

Review of the clinical record was conducted on 7/15/19.

The Nurses Notes revealed documentation of green drainage from left eye on 6/25/18 at 15:34 (3:34 PM).

A new order was written for Ciprofloxacin 0.3 % eye drops, 2 drops in both eyes every 8 hours for 5 days.

Review of the June 2018 Medication Administration Record revealed an order written: 6/25/18 at 3:24 PM-Ciprofloxacin Solution 0.3 % instill 2 drops in both eyes every 8 hours for infection X 5 days related to conjunctivitis until 6/30/18. Scheduled Midnight, 8 AM, and 4 PM daily. Documentation revealed the eye drops were not available for administration on 6/26/18. The first dose was administered on 6/27/18 at midnight.

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Review of the Pharmacy Proof of Delivery invoices revealed the Ciprofloxacin Solution 0.3 % eye drops were not delivered to the facility until 6/26/18 at 9:26 PM. It was over 30 hours after the order was written before the medication was delivered to the facility. The medication was discontinued on 6/30/18. Therefore, Resident # 203 did not receive the antibiotic eye drops for 5 days. He received them for 4 days 6/27-6/30/18. There was no documentation the physician was notified.

Further review of the July 2018 Medication Administration Record (MAR) revealed orders:

6/28/18 at 4:55 PM-Cipro 500 milligrams give one tablet by mouth two times a day for 7 days, scheduled at 9 AM and 6 PM-Discontinue date of 7/5/18. The first dose was given on 6/28/18 at 6 PM. There was one dose that was not administered on 6/30/18 at 6 PM because the medication was "unavailable" according to the nurses notes.

On 7/16/19,an interview was conducted with the Assistant Director of Nursing regarding the documentation about the antibiotics. The ADON reviewed the Medication Administration Records and nurses notes. The ADON stated that the nurses should have given all of the doses of the antibiotics. The ADON also stated the physician should have been notified if any doses were missed. The ADON stated nurses should ensure the full course of all medications are administered.

On 7/16/19 at 11 AM, an interview was conducted with the Corporate Consultant (Employee I) who

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stated nurses are expected to administer medications as ordered by the physician. Employee I stated the antibiotic, Cipro, was available in the Stat box. A copy of the Stat Box contents and the Pharmacy Proof of Delivery report were requested.

Review of the facility's Stat Box contents revealed there was Cipro 250 milligrams-quantity 6 tablets available in the box.

Review of the Pharmacy Proof of Delivery invoices revealed the Ciprofloxacin 500 milligrams tablets quantity 14 were delivered to the facility on 6/28/18 at 9:38 PM.

"Fundamentals of Nursing, by Lippincott"cited as the facility nursing practice reference stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

The Administrator and DON were notified of the issue at the end of day meeting on 7/16/19. The Director of Nursing (DON) stated the expectation was that the Pharmacy would ensure medications would be available for nurses to administer as ordered by the physician. The DON stated the nurses were The Director of Nursing (DON) stated the expectation was that nurses would administer medications as ordered by the physician. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

No further information was provided.

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F 658	Continued From page 104 COMPLAINT DEFICIENCY 7. For Resident #74 the facility staff failed to follow professional standards with following physician orders for wound care. Resident #74 was admitted to the facility on 6/22/19. His diagnoses included but were not limited to: sepsis, encounter for surgical aftercare following surgery of the circulatory system. Resident #74 had a prior history of an infected AV graft on his left arm. On 07/15/19 at 03:23 PM Resident #74 was observed with a border bandage on his left arm. On the bandage the following was written: "7/13/19 JS 3-11" On 7/16/19 at 11:25am Resident #74 was observed with a border dressing on his left arm. Written on the bandage was, "7/13/19 JS 3-11" Review of Resident #74's clinical record revealed a nursing note on 6/22/19 at 13:53 that read, "admission skin check, dialysis AV graft to the right upper arm with tape and gauze noted and left elbow wound from an old AV graft that got infected." Review of Resident #74's treatment administration record (TAR) revealed an order, with an order date of 6/23/19 and a d/c [discontinue] date of 7/14/19, that read, "wound care to the left old AV graft site: cleanse with 1/4 strength dakins solution, pack wound beds with saline soaked gauze loosely, cover with dry gauze and wrap with kling, secure with tape or	F 658		

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stretch netting. to be done daily and prn soilage [sic] or dressing dislodgement. every evening shift for old left AV graft wound site." The border dressing observed on Resident #74's left arm which was dated 7/13/19 was not the ordered treatment for the site on 7/13/19.

Review of the TAR for July 2019 revealed that the above stated order had not been carried out on 6 occasions/days from July 1-13, as ordered by the physician.

Review of the physician orders for Resident #74 revealed an order with a date of 7/4/19 that read, "wound care to the left old AV graft site: cleanse with NS [normal saline] cover with foam boarder [sic] dressing daily every evening shift for old left AV graft wound site."

Review of the TAR for July revealed that this ordered treatment had not been completed on 7/14/19 as ordered. It had been signed off on 7/15/19 as being completed despite observation of the border dressing on 7/16/19 with the bandage dated 7/13/19.

On 7/16/19 at 4:45pm LPN B was asked to read the orders for Resident #74's left arm, LPN B stated, "cleanse with NS [normal saline] daily and cover with foam border dressing daily." LPN B then accompanied the surveyor to the dining room, she observed Resident #74's bandage on his left arm. Upon exit of the dining room LPN B was asked what she saw and LPN B stated, "it looks like it was last changed 7/13. You are asking if I see anything wrong with it not being changed in 3 days, yes I do."

On 7/16/19 the Director of Nursing (DON) was

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asked her expectation regarding caring out physician orders, the DON stated, "I expect them to be carried out as ordered."

The DON stated their nursing standards of practice is, Lippincott. According to Lippincott Manual of Nursing Practice 10th edition, 2014. Under the header "Standards of Practice", it was documented on Table 2.1 entitled, "Common legal claims for departure from standards of care" included "Failure to implement a physician's, advanced practice nurse's, or physician's assistant's order properly or in a timely fashion."

COMPLAINT DEFICIENCY.

8. For Resident # 54, the facility staff failed to administer physician ordered, and scheduled medications in a timely manner.

Resident #51 was a 71 year old who was admitted to the facility on 5/26/17. Resident #54's diagnoses included Chronic Heart Failure, Dementia, Depression, Asthma, Diabetes Mellitus Type 2, and Constipation.

The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 3/12/19 was reviewed. Resident #54 was coded as having a Brief Interview of Mental Status Score of 10, indicating moderately impaired cognition.

On 7/16/19 a review was conducted of Resident #54's clinical record. The signed physician orders for the medications, and Medication Administration Records (MAR) were reviewed for

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the month of July. According the MAR, the following medications were administered approximately 2 hours late:

Abilify Tablet 15 MG was scheduled for 7/16/19 at 9:00 A.M., and administered on 7/16/19 at 11:04 A.M.

Docusate Sodium Tablet was scheduled for 7/16/19 at 9:00 A.M., and administered on 7/16/19 at 11:06 A.M.

Linagliptin 5 MG was scheduled for 7/16/19 at 9:00 A.M., and administered on 7/16/19 at 11:07 A.M.

Atenolol Tablet 25 MG was scheduled for 7/16/19 at 9:00 A.M., and administered on 7/16/19 at 11:05 A.M.

On 7/16/19 a review was conducted of facility documentation, revealing a Medication Administration policy dated 1/1/13. An excerpt read, "Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..."

No further information was received.

The facility presented the following plan to remove the Immediate Jeopardy:

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Center failed to ensure professional standards of care resulting in development of and or

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F 658	Continued From page 108 worsening of pressure areas for Resident #5. A. Resident #5 is currently out of center. Dr. [redacted] notified on 8.6.2019 of negligence related to assessment, improper treatment, delay in initiating and implementing orders, and deterioration of wound resulting in hospitalization. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: A) Registered Nursing staff educated in correct identification, wound staging, and appropriate treatments for initial assessment before there next scheduled shift. .All licensed staff will be educated on re-evaluation of wounds, appropriate treatments, and notification to registered nurse and physician or extender if wound deterioration is suspected prior to next scheduled shift. B) Weekly wound rounds will be completed by DON, UM, MD and/ or MD extender and documented in the clinical record in physician notes and nursing wound evaluation.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679		9/21/19

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F 679	Continued From page 109 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to maintain activity participation for one resident (Resident #35) in a sample size of 46 residents. The findings included: Resident #35 was admitted to the facility on 07/07/2014. Diagnoses for Resident #35 included but are not limited to heart failure, diabetes, post-right hip hemi-arthroplasty, dementia, anxiety, and depression. Resident #35's Minimum Data Set (an assessment protocol) just prior to the fall with an Assessment Reference Date of 01/12/2018 was coded as an annual assessment. Resident #35's Brief Interview for Mental Status was not completed but Cognitive Skills for Daily Decision-making were coded as severely impaired. Resident #35's care plan was reviewed. A Focus on the care plan created on 8/2/2016 and revised on 5/22/2019 documented, "The resident is dependent on staff for meeting emotional intellectual physical and social needs. Resident independently plays with baby dolls for sensory stimulation." The goal associated with this Focus documented, "The resident will participate in 1:1 activities 2-6 times weekly until next review date to enhance social, cognitive, & emotional needs. Interventions associated with this Focus documented, "Ensure that activities are	F 679	1. Resident # 35 □ Activities plan revised and covered for an appropriate number of activities established 2. All residents are at risk who receive one on one activities. 3. SDC or Designee will educate activities staff appropriate individualized activities per resident cognitive status 4. DON or designee will perform 100% audit regarding one on one activities and re-assessed for active participation, 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is August 27th, 2019.	

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F 679	Continued From page 110 compatible with mental capabilities and known interest in preferences; Adapt activities as needed to be age appropriate. Honor resident's preferred activities such as baby dolls, pet therapy, gardening, music, spiritual/church, family visits, watching TV & news, and sensory stimulation. Provide meaningful 1:1 activities such as reading to resident, sensory stimulation, pet therapy, gardening, music and social/religious visits." A review of Resident number #35's Activity participation documentation demonstrated that there were 16 encounters with activities 02/05/2018 through 03/20/2018. However, there were 6 encounters with activities 04/03/2018 through 05/15/2018. On 07/16/2019 at approximately 7:45 PM, the administrator and DON had no further information or documentation to offer.	F 679		
F 686 SS=J	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.	F 686		9/21/19

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F 686	Continued From page 111 This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, spouse interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to perform services to prevent and promote the healing of pressure ulcers for six residents (Resident #5, #19, #155, #156, #62, #79) in a survey sample of 46 Residents, resulting in harm for Resident #5. Immediate Jeopardy was identified on 8/6/19 at 6:17pm and the facility was notified. After verification, Immediate Jeopardy was abated on 8/7/19 at 6:55pm and the scope and severity was lowered to level three, isolated. The findings included; 1. For Resident #5, the facility staff failed to provide ordered treatments, monitoring for worsening of the ulcer for an acquired potentially avoidable stage 4 pressure ulcer. The staff then failed to change the treatment of the ulcer as it worsened from a stage 2 ulcer to a stage 4 ulcer which was identified by surveyors while onsite, resulting in harm. Resident #5 was admitted to the facility on 1-29-19. Diagnoses included; vertigo, chronic kidney disease, dementia, benign prostatic hypertrophy, stroke, hypertension, congestive heart failure. and chronic Foley catheter. Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-26-19. The Resident was coded with mild cognitive impairment, and no aberrant behaviors.	F 686	1. Resident # 5 □ No longer resides in the facility. Resident #19 assessed by physician and appropriate treatment initiated, Resident #155 assessed by physician and appropriate treatment initiated, # 156 no longer resides in center, resident, #62 wound assessed by physician and no wound was present, #79 no longer resides in center. 2. All residents with pressure ulcers are at risk for deficient practice. 3. SDC or Designee will educate licensed staff on providing appropriate treatment for pressure ulcers and review of wound care policy. 4. DON or designee will review all pressure ulcers to ensure accuracy of assessment and appropriate treatment, 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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Resident #5 required extensive assistance to total dependence on one to two staff members, for activities of daily living care. The Resident was coded as not having any pressure ulcers at the assessment time, nor on admission. The Resident had a long standing Foley catheter (urine drainage) due to an obstruction, and was incontinent of bowel. The Resident was coded as at risk for pressure sores.

At area M-0100 through M-1200 under the MDS skin conditions section of the assessment, the Resident was coded to be at risk for pressure ulcers, had no pressure ulcers, and had no other skin problems such as rashes, and or moisture associated skin damage.

The only preventative measure for skin breakdown ordered by a physician, for the Resident, was a "ROHO" wheel chair cushion ordered 4-21-19 (3 months after admission) and the day before PT was discontinued. The cushion was signed as administered, and was observed in the Resident room in his wheel chair.

On 7-14-19, at 3:30 p.m., the first observation and interview of Resident #5 was conducted during initial tour of the facility. The Resident was found laying on a specialty mattress (Genesis II, a low air loss mattress), and the air motor was bogging down and humming, and not infusing air into the mattress. The mattress was flat, hard, and solid, with no air in it. The Resident was laying partially on his left side, and a Foley catheter was noted to be draining dark yellow urine with white sediment in it. The Resident was able to speak and make his needs known, and was found to be oriented to person, time, place and situation. The Resident stated he was thirsty

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and wanted water. There were 6 water "Sippie" non-spillable cups on the over-bed table which were all empty. The bedside table was 3 feet from the bed and the Resident could not reach it. Staff were notified.

A second observation of Resident #5 was conducted on 7-15-19 at 4:30 p.m., and the Resident was sleeping in bed on his back. The over-bed table was found to be exactly as the last observation, and the bed was deflated with the motor still humming, but not infusing air. The air mattress was replaced on 7-16-19.

A third observation occurred on 7-16-19 at 11:30 a.m., with Licensed practical nurse C (LPN C), and Certified nursing assistant N (CNA N). The nurse removed the bandage from the Resident's coccyx. The 4 inch by 4 inch single bandage had a solid center in it which was a tan telfa like non-adherent 2 inch by 2 inch square. The outer circumference of the square bandage was surrounded by a boarder of adherent malleable stretchy tape, reminiscent of Band-Aid fabric. There was no packing or medicated cream in the hollow wound. Immediately after removing the dressing a green purulent discharge was seen. The wound was circular, and deep with full muscle tissue loss and bone protrusion clearly visualized and palpated by the nurse. The wound had undermined and tunneled circumferentially around, only under the circular rolled wound edges. There was also noted yellow tan slough and black necrotic tissue inside the wound, and silvery white fascia could be seen covering the coccygeal bone protrusion. The LPN measured the wound with a long cotton swab and a wound measuring disposable paper tape. She measured the cotton swab after it was laid on the

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wound, and placed in the wound for an accurate measurement. The wound measured 2 centimeters (cm) long, 1.5 cm wide, and 1.5 cm deep. The exterior wound edges were rolled (epibole). The Resident was pre-medicated with pain medication and stated he felt no pain as the wound was measured.

Nursing progress notes were reviewed from wound identification to the time of survey. No notes describe any pressure ulcer identification, treatments, assessments for pressure ulcers, or changes to the care plan for Resident #5 after the first identification of the wound on 4-29-19. The initial note described the pressure injury as a red bruise with open skin, and the skin evaluation document of 4-29-19 gave further measurements. On 5-3-19 a care plan meeting was held and the Resident's spouse asked that the Resident be frequently changed and cleaned for bowel incontinence to prevent skin breakdown as her only concern. The Resident had a Foley catheter for urination. No other nursing progress notes document the pressure ulcer until 5-30-19 (one month later) which was documented by the Registered dietician because of weight loss.

Review of the weekly skin assessment sheets since admission "PCC Skin & Wound - Total Body Skin Assessment" documents revealed all (including the initial) were completed by LPN's. The findings were as follows;

1-29-19 - no new wounds
2-5-19 - no new wounds
2-12-19 - no new wounds
2-19-19 - no new wounds
2-26-19 - no new wounds
3-5-19 - no new wounds

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3-13-19 - no new wounds
3-25-19 -no new wounds
4-1-19 - no new wounds
4-8-19 -no new wounds
4-15-19 -no new wounds
4-22-19 -no new wounds
From 4-22-19 through 5-26-19, no weekly skin checks were completed.
5-27-19 -no new wounds
6-3-19 -no new wounds
6-10-19 -no new wounds
6-17-19 - no new wounds
6-24-19 - 2 new wounds (left and right buttocks)
7-1-19 -no new wounds
7-8-19 -no new wounds
7-15-19 -no new wounds.

On 4-29-19, another type of assessment document was initiated and performed by all LPN staff, "Skin and Wound Evaluation V 5.0". These documents were started for a "new Pressure wound stage 2 on the Resident's sacrum" and was described as being treated with povidone iodine after cleaning with normal saline, and no dressing. The wound measured 3 cm long x 1.3 cm wide, no depth, and healable. None of these documents were completed after this initial one until 1 month later, on 5-27-19. The Rest of these particular assessment documents follow below in chronological order:

On 5-27-19 the next "Skin and Wound Evaluation V 5.0" document occurred one month after the first one on 4-29-19. The document describes the sacrum wound as stage 2 unchanged, healable, and documents the measurements of the wound as 1.1 cm long x 0.5 cm wide, and no depth. The treatment remains the same. No eschar, no debridement, no dressing.

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On 6-3-19 Sacrum stage 2 pressure ulcer 1.7 cm long x 0.5 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-10-19 sacrum stage 2 pressure ulcer 1.9 cm long x 0.5 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-17-19 sacrum stage 2 pressure ulcer 1.2 cm long x 0.6 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-24-19 staff pin pointed and documented the "Coccyx" portion of the sacrum, instead of just stating sacrum, stage 2 pressure ulcer 1.3 cm long x 0.9 cm wide, no depth, Normal saline, and now, cover with foam dressing. Healable. No eschar, No debridement. A Left buttock and a right buttock were found as "New areas" on 6-24-19, however, had nothing to do with the continuing Sacrum/Coccyx wound according to nursing staff.

On 7-2-19 coccyx stage 2 pressure ulcer 1.4 cm long x 0.2 cm wide, no depth, same treatment. Healable. No debridement, No eschar.

On 7-8-19 coccyx stage 2 pressure ulcer 1.5 cm long x 0.5 cm wide, no depth, same treatment. Healable, Deteriorating. No debridement, No eschar.

On 7-9-19 (one day later) the last assessment documented coccyx stage 2 pressure ulcer 1.2 cm long x 0.6 cm wide, no depth, Eschar 20%,

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deteriorating, healable, treatment; normal saline and enzymatic debridement (ordered 6-3-19).

It is notable to mention that betadine (2 times per day) and Vasolex (1 time per day) were ordered to be completed simultaneously and were signed as administered simultaneously, however, the dressing would have to be removed twice daily for this to occur.

No assessments by staff described a stage 4 pressure ulcer, and no assessments were completed from 7-14-19. through 7-16-19, until the surveyor found the stage 4 pressure ulcer on 7-16-19.

All of the assessments, including the initial assessment, were completed by LPN's.

Physician's orders and Medication and Treatment Administration Records (MAR's/TAR's) were reviewed and revealed no physicians order for prevention of pressure sores from bowel incontinent episodes such as an incontinence barrier cream. Only the following 4 orders appeared after the pressure sore developed for the sacral coccyx acquired pressure ulcer treatment;

1. Ordered 4-29-19 start 4-29-19 discontinued 7-8-19 Clean open area to sacrum with normal saline and apply betadine twice per day at morning and bedtime. No dressing. No change to this order occurred after 2.5 months without healing.

2. Ordered 6-3-19 start 6-4-19 discontinued 7-9-19 Clean wound with normal saline & apply Vasolex ointment to coccyx wound topically once

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per day & as needed with allevyn dressing.

3. Ordered 7-10-19 start 7-10-19 discontinued 7-16-19 Cleanse sacrum/coccyx with normal saline apply intrasite gel (hydrogel water gel to keep wound bed moist) and cover with coversite once every day.

4. Ordered 7-16-19 start 7-17-19 Cleanse sacral wound with saline, apply iodoform (iodine impregnated gauze for packing into a hole) and cover area with coversite one time per day, after the examination by surveyors and an LPN, and was not ordered to be administered until the following day (7-17-19) further delaying care.

Review of the MAR/TAR's revealed that the pressure sore treatments that were ordered as above, were not administered on 5/18, 5/24, 6/4, 6/10, 6/20, 6/26, 7/8, and 7/9/19. No nursing notes reveal the reason for the omissions.

It is of note to mention that the "Vasolex" ointment ordered on 6-3-19 was a debridement agent. Debridement is the removal of dead and damaged tissue from a wound. This can be completed by surgical/cutting out removal, or chemical enzyme/liquefying of dead tissue to remove it. Resident #5's "skin wound evaluation" documents on that date show no necrotic/dead tissue in need of debridement.

An interview was conducted via telephone with the Resident's physician and all surveyors present on 7-16-19 at 6:45 p.m. The doctor stated he had seen the Resident on 7-15-19 between the hours of 7:00 a.m., to 8:00 a.m. He stated that he was aware the Resident had a wound, and had reviewed the recent nursing

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notes which stated the Resident had a stage 2 pressure sore, and so in his progress note dated 7-15-19, he wrote a stage 2 sacral decubitus. The nursing notes were reviewed from the doctor's previous visit of 6-22-19, none stated the Resident had a stage 2 decubitus ulcer. The doctor was informed that an RN surveyor had assessed the wound this morning (7-16-19), and he was asked if he had been made aware of the findings. He stated "No." The doctor was asked if he evaluated the wound, and he stated "it looked like a stage 2 when I saw him, but I was interested in the shingles, my focus was not the wound." The surveyors asked if he could describe the wound, and he stated "it was on his coccyx area."

The doctor was asked if a debridement agent would be used for a stage 2 decubitus ulcer which had no eschar, and he stated "No.", The doctor went on to say, "but he has been in failing health for several months with heart disease which is an obvious factor for skin integrity, and we don't need to aggressively treat as the prognosis is poor."

The doctor stated that the Resident was also losing weight and nutrition was an issue, with mineral loss. The doctor was asked why minerals and supplements had not been ordered as a replacement to mitigate this, and if that would be of value. The doctor stated yes it would be of value, but due to his age and failing health the Resident was supportive care at this stage and his overall prognosis was poor.

The physician was asked why a Resident, regardless of age, who was ambulatory and recovering from a hospitalization and receiving

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aggressive occupational and physical therapy within the past few months would not be treated for a pressure wound. The doctor repeated "I didn't go into the detail of the wound, and chose to look at the nursing notes. The doctor was asked why none of his progress notes discuss evaluation of the wound until this last note yesterday, and he responded that the Resident's "prognosis was poor, and I thought he had shingles, but probably just heat rash, I was not there to see the decubitus."

No changes to the Resident's diet were ever ordered from the time of admission. No dietary supplements, minerals, or protein for pressure ulcer formation, wound healing, was ever added or ordered for the Resident after admission, for the 6 month period.

Registered Dietician (RD) notes were reviewed and revealed that the RD evaluated the Resident twice in 6+ months. Those evaluations were on 5-16-19, and 5-30-19, and she made no recommendations.

The DON was requested to supply surveyors with all policies for skin assessments and pressure ulcers. The DON, and Corporate RN supplied 2 facility policies on skin assessments and pressure ulcers. They are as follows;

1. "Pressure ulcers Manual" - "Skin Assessment" Skin assessments will be completed for all patients. A licensed nurse will ensure that the skin risk assessment is done upon admission, and quarterly thereafter. A skin assessment will also be completed upon re-entry to the center (i.e., after ER visit, dialysis, etc.) The weekly skin assessment will be completed thereafter. Care

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plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs.

2. "Pressure ulcers Manual" - "Pressure Ulcer monitoring &" A licensed nurse will assess patients for the presence of pressure ulcers: if a pressure ulcer is present, the nurse will evaluate for complications. Provide pain management prior to pressure ulcer treatment as indicated. The wound record will be completed weekly by a licensed nurse for any patient with pressure ulcers. There will be a wound record for each site.

Guidance is provided for the staging of pressure ulcers by the National Pressure Ulcer Advisory Panel (NPUAP), and is as follows;

NPUAP announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury FOR IMMEDIATE RELEASE April 13, 2016.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive

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related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury:
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant (fat) adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

Stage 4 Pressure Injury:
If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness stage 4 pressure injury. Do not use (deep tissue pressure injury) DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

On 7-16-19, Resident #5's care plan was reviewed and revealed the following 2 entries of importance; 1. Resistive to care, and 2. Skin care plan.

1. FOCUS "Resident and wife are resistive to care." instituted 5-7-19, with an intervention for "Explain to (Resident spouse name) some interventions she is using may be harmful and cause more problems with skin integrity.... continues to use own equipment and use of sheepskin which will add moisture." The

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Corporate RN (corp RN) was asked how a woman who walks with a cane could apply sheepskin to a hospital bed with her husband in it. The Corp RN replied "yes, we put it on the bed, but the wife insisted." No nursing progress notes, physician progress notes, nor the MDS describe the Resident as refusing care.

2. On 5-1-19, and 5-2-19 new focuses were added with no additions after that date. All planned focuses are included as follows; "Focuses"-"Potential for further skin impairment", and the interventions were: Keep skin clean and dry, lotion to dry skin, peri care with incontinence episodes, pressure reduction mattress, Roho cushion in wheel chair, Ted hose as ordered (none were worn on the legs of the Resident during observations), weekly skin assessment, the Resident has a pressure ulcer with potential for pressure ulcer development, administer treatments as ordered, and monitor for effectiveness, devices ATMOS 9000 air mattress (the only 9000 air bed) & (the Resident was on a Genesis II mattress, which is a low air loss mattress while the ATMOS 9000 is an alternating pressure mattress), educate resident and family as to causes of skin breakdown (the Resident is a doctor) monitor nutritional status, provide supplements as ordered (none were ordered), position resident as needed, treat pain prior to treatment as needed to ensure the resident's comfort.

On 7-16-19 at the end of day meeting, facility staff were asked to show evidence of how Resident #5's wounds were unavoidable. They stated they had no further evidence to provide.

In summary, for Resident #5, the physician

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ordered treatments were not administered, assessments of skin, and the wound were not completed for 1 month, and the wound was identified by surveyors as a stage 4 pressure ulcer, when staff were still documenting a stage 2 wound. Orders were received for debridement of the wound on 6-3-19, when documents say there was nothing to debride. No supplements were ordered for wound healing. The physician did not evaluate the wound, and staff signed that they completed 2 conflicting wound treatment orders simultaneously. The air mattress that was care planned was not the one in use, and mattress which was being used was not in working order for 3 days. The wound was initially identified as a stage 2 wound which progressed to a stage 4 wound, without staff identifying it.

The Administrator, DON, and the Registered Nurse (RN) Regional Consultant were made aware of the harm level deficiency at the end of day debrief on 7-16-19. No further information was supplied by the facility.

2. For Resident #19, facility staff failed to carry over wound treatment orders from the hospital, resulting in a delay in treatment. In addition, the wound worsened.

Resident #19 was admitted to the facility from the hospital on 05/08/2019. Resident #19's diagnoses included, but were not limited to: seizures, sepsis(1), right-sided hemiplegia(2), and congestive heart failure(3). Resident #19's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 05/14/2019. The Brief

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Interview for Mental Status (BIMS) scored Resident #19 at a 9, indicating moderate impairment. Resident #19 was coded as requiring total assistance of 1 person for toileting, and requiring extensive assistance of 1 person for other Activities of Daily Life (ADLs).

A review of Resident #19's medial record was conducted beginning on 08/05/2019. Resident #19 was admitted to the facility from the hospital on 05/08/2019.

A review of Resident #19's Hospital Discharge Summary revealed the following:
" ...Stage 3 Sacral (on the sacrum) ulcer POA (Present on admission) c/w (continue with) wound care."
A review of the Hospital discharge document entitled "DISCHARGE MEDICATIONS" revealed the following:
" ...iodine-sodium (IODINE) 2% external solution: Apply to affected area three (3) times daily. To left buttocks and sacral area."

The Assessment entitled "Admission Assessment/Screening V.1.2" dated 05/08/2019 at 1:49p.m. entered by Licensed Practical Nurse (LPN) B does not contain a section reviewing the skin. No documentation of a skin issue is noted in the section entitled "Other Concerns".

The Assessment entitled "PCC Skin and Wound - Total Body Skin Assessment" dated 05/08/2019 reveals no documentation of a wound.

A review of Resident #19's Physician Orders revealed the following orders:
Apply betadine to left buttock every day shift - start date 07/05/2019

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Apply EPC (cream) to buttocks every shift and with incontinent episodes every shift for skin protection - start date 07/23/2019
Clean left and right buttocks with NS (normal saline) apply betadine every shift for left and right buttocks open area - start date 07/29/2019
A discontinued order for Santyl(4) was noted as being initiated on 06/12/2019 and continuing until 07/01/2019.

A progress note entitled "Health Status Note" dated 06/10/2019 at 3:40p.m. by LPN G reads: "Resident was found to have an open area one[sic] the left buttock. In the same area that he usually does. Picture taken of area and RP (Responsible Party) [NAME] notified. N.O. (new orders) for prostat(5) and betadine. [RP NAME] is aware of the new orders as well. Betadine applied. Wedge cushion in placed[sic] and resident repositioned at q2h (every 2 hours). Temp 97.1, Resident remains on abt (antibiotic) therapy, 600cc (cubic centimeter) output noted yellow urine.

A progress note entitled "Skin/Wound Note" dated 06/10/2019 at 8:30p.m. by LPN A reads:
"Skin Assessment Complete. Findings:
Turgor: Good Elasticity
Skin Color:
Temperature: Warm (normal)
Moisture: Normal
Condition: Extremely Dry
New Wounds: 1"

An Assessment entitled "Skin & Wound Evaluation V5.0" dated 07/08/2019 at 8:47p.m. describes the following: The form contains several sections, where the staff member may select an option for each section from multiple

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choices. In the section entitled "Describe", the option "15. Pressure" is selected. In the section "Stage", the option "2. Stage 2: Partial thickness skin loss with exposed dermis" is selected. In the "Location", a free text box, contained the words "Left Buttock". In the section "Measurements", the following measurements are documented: Area: 1.2 cm2, Length: 0.9cm, Width: 2.1cm, Depth: Not Applicable, Undermining: Not applicable, Tunneling: Not applicable. No description of the wound bed is made.

On the morning of 08/06/2019, an observation of Resident #19's wound was made by this surveyor and Employee B, the Director of Nursing (DON). The wound stretched horizontally across both buttocks, roughly midway down the buttock. No dressing was in place. On the left buttock, the wound bed was obscured by tan/yellow slough (dead tissue, usually cream or yellow in color). The portion of the wound on the right buttock consisted of red, moist, abraded looking skin.

Employee B documented her assessment of the wound in a Skin/Wound note dated 08/06/2019 at 4:59p.m.: "skin assessment of wound to right and left buttock. Left buttock noted to be UTS (unable to stage) with 90% thick adherent slough to wound bed 10% on the edges of the wound noted dark brown necrotic tissue. Periwound intact irregular edges noted to wound bed. Right buttock UTS noted to be improving dark red tissue noted with irregular edges, periwound intact."

Resident #19's primary Physician was Employee L, the Medical Director. Surveyors request copies of all notes Employee L made of his visits to see Resident #19. None of Employee L's notes refer

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to a skin condition or pressure wound. Employee L was not available for interview during the 8/5/19 - 8/7/19 portion of the survey.

On 8/7/19 at 9:14am, an interview was conducted with Employee O, another facility Physician and the Acting Medical Director in Employee L's absence, in the conference room. When asked about skin assessments; he replied: "I do not do a full skin exam, when they shower and look at their skin, they would determine that. I cover 6 different facilities and it's just not physically possible. I go by their assessment unless they say come look at this wound, then I look at it."

The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 08/07/2019. No further documentation was provided.

3. For Resident #155, facility staff failed to assess the resident and initiate treatment for pressure wounds upon admission, resulting in a delay in treatment. In addition, the wound worsened.

Resident #155 was admitted to the facility on 07/29/2019. His diagnoses included but were not limited to: atrial fibrillation (6), hypertension (elevated blood pressure), and muscle weakness. Resident #155's most recent MDS Assessment was an Entry Assessment with an ARD of 07/29/2019. The Entry MDS did not have the BIMS or ADL Assessment completed.

Resident #155 had a "Skin/Wound Evaluation V5.0" Assessment dated 07/29/2019 at 6:42p.m. by LPN I. This assessment described a Stage 3

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pressure ulcer with 30% slough.

A Review of Resident #155's Physician Orders dated 08/05/2019 revealed an order for: "Santyl Ointment 250 UNIT/GM (Collagenase) Apply to sacrum topically every evening shift for decubitus related to RASH AND OTHER NONSPECIFIC SKIN ERUPTION (R21) clean sacral ulcer with NS, apply scant amount of Santyl ointment with light drsg (dressing) q (every) evening.

No order was noted for an alternative/specialty air mattress.

Resident #155's Comprehensive Care Plan revealed a Focus of: "actual skin impairment pressure ulcer to coccyx (tailbone)"

This focus had a "created on" date of 08/02/2019 and a "revision date" of 08/04/2019.

No orders related to wound care with an earlier start date were found.

On the morning of 08/06/2019, an observation of Resident #155's wound was conducted by this surveyor and Employee B, the DON. Resident #155's wound was observed with a slough-filled base with red borders. The wound was covered with a clear plastic "opsite" style dressing over gauze. The dressing was clean but was not dated.

Employee B documented her observation in a "Skin/Wound" note dated 08/06/2019 at 4:57p.m. The note states: "assessment of residents [sic] coccyx wound assessed today noted stage 3 to coccyx with 50% slough to wound bed periwound

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intact. Will continue with current treatment plan."

A review of the facility document entitled "Pressure Ulcer Treatment Guidance" revealed the following under the heading for "Pressure Ulcers - Unstageable": "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, black) in the wound bed."

Resident #155's primary Physician was Employee L, the Medical Director. Surveyors request copies of all notes Employee L made of his visits to see Resident #155. None of Employee L's notes refer to a skin condition or pressure wound. Employee L was not available for interview during the 8/5/19 - 8/7/19 portion of the survey.

On 8/7/19 at 9:14am an interview was conducted with Employee O, another facility Physician and the Acting Medical Director in Employee L's absence, in the conference room. When asked about skin assessments; he replied: "I do not do a full skin exam, when they shower and look at their skin, they would determine that. I cover 6 different facilities and it's just not physically possible. I go by their assessment unless they say come look at this wound, then I look at it."

The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 08/07/2019. No further documentation was provided.

4. For Resident #156, facility staff failed to carry over wound treatment orders from the hospital, resulting in a delay in treatment. In addition, the

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wound worsened.

Resident #156 was admitted to the facility on 07/26/2019. His diagnoses included but were not limited to: discitis (inflammation of the discs of the spine), muscle weakness, hypertension, and chronic kidney disease (7). Resident #156's most recent MDS Assessment was an Admission/5 Day Assessment with an ARD of 08/02/2019. The BIMS scored Resident #156 at a 14, indicating little to no impairment. Resident #156 was coded as requiring extensive assistance of 1 person for bed mobility, transfers, and dressing; and requiring extensive setup assistance for ambulation, eating, and personal hygiene.

A review of Resident #156's medical record was conducted beginning on 08/05/2019. It was noted that Resident #156 was admitted to the facility from the hospital on 07/26/2019.

Resident #156's hospital Discharge Documentation revealed, under "Discharge Wound Care Instructions": "Therahoney(8) Gel and Silicone foam dressing to sacral area/buttocks - change daily after cleansing with saline."

An Admission Note dated 07/26/2019 at 4:03p.m. describes numerous small abrasions to Resident #156's arms and legs but does not describe a wound to the sacrum/buttocks.

A "Skin/Wound" note dated 07/29/2019 at 10:21a.m. by Employee K, the Assistant Director of Nursing (ADON) states: "New Admission Skin Assessment completed, resident with scattered old scabs to bilateral arms and feet, and small abrasion to Left knee, all of which are open to air.

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Resident has a vascular area to right great toe 1.5cm x .5cm no drainage noted. Resident also has a DTI (deep tissue injury) 6cm x 2.1 treatment in place. Resident is educated to the importance of off loading pressure to his sacrum, verbalizes understanding."

A review of Resident #156's Physician Orders dated 08/05/2019 reveals no orders for treatment of the sacral wound.

A Review of Resident #156's Comprehensive Care Plan reveals a Focus entitled "The Resident has an actual pressure ulcer sacrum and right toe development r/t (related to) immobility." The focus has a "Created On" of 08/04/2019 and a "Revision on" of the same date.

On the morning of 08/06/2019, this surveyor observed Resident #156's wound with the DON. The wound displayed eschar and slough to the base of the wound, with tunneling at the 12 o'clock to 1 o'clock position.

Employee B, the DON, documented her observation in a Skin/Wound Note dated 08/06/2019 at 5:04p.m.: "assessed resident wound to sacrum noted 75% black Eschar from 3 o'clock to 6 o'clock of wound bed 25% slough noted around wound edges. Edges of wound irregular tunneling noted at 12 o'clock. Will continue with current treatment plan."

Resident #155's primary Physician was Employee L, the Medical Director. Surveyors request copies of all notes Employee L made of his visits to see Resident #155. None of Employee L's notes refer to a skin condition or pressure wound. Employee L was not available for interview during the 8/5/19

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F 686	Continued From page 133 - 8/7/19 portion of the survey. On 8/7/19 at 9:14am, an interview was conducted with Employee O, another facility Physician and the Acting Medical Director in Employee L's absence, in the conference room. When asked about skin assessments; he replied: "I do not do a full skin exam, when they shower and look at their skin, they would determine that. I cover 6 different facilities and it's just not physically possible. I go by their assessment unless they say come look at this wound, then I look at it." The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 08/07/2019. No further documentation was provided. 1. Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. They cause poor blood flow, which deprives your body's organs of nutrients and oxygen. In severe cases, one or more organs fail. In the worst cases, blood pressure drops and the heart weakens, leading to septic shock. - https://medlineplus.gov/sepsis.html 2. Hemiplegia, paralysis of the muscles of the lower face, arm, and leg on one side of the body. - https://www.britannica.com/science/hemiplegia 3. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It	F 686		

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means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. - https://medlineplus.gov/heartfailure.html

4. This product is used to help the healing of burns and skin ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help antibiotics to work better and speed up your body's natural healing process. - https://www.medicinenet.com/collagenase_oint-topical/article.htm

5. Prostat is a high protein liquid nutrition supplement. - https://www.medline.com/product/Pro-Stat-Sugar-Free-Liquid-Protein-Nutritional-Supplement/Z05-PF11003

6. An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. - https://medlineplus.gov/atrialfibrillation.html

7. Chronic kidney disease (CKD) means that your kidneys are damaged and can't filter blood as they should. This damage can cause wastes to build up in your body. It can also cause other problems that can harm your health. Diabetes and high blood pressure are the most common causes of CKD. - https://medlineplus.gov/chronickidneydisease.html

8. TheraHoney Gel Honey Dressing has high sugar level that helps promote autolytic debridement of necrotic tissue, a moist wound

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healing environment and rapidly reduces wound odor. - https://www.healthproductsforyou.com/p-therahoney-wound-gel-honey-dressing.html

5. For Resident # 62 the facility staff failed to follow their "Pressure Ulcer Treatment Guide" and applied barrier cream to a pressure ulcer instead of a Hydrocolloid dressing.

Resident #62 a 76 year old woman admitted to the facility on 1/28/18 with diagnoses of but not limited to Cerebral infarction (stroke) affecting left side, Hemiplegia and Hemiparesis following stroke, Diabetes and heart failure.

Resident #62's most recent MDS (minimum Data Set) with an ARD (Assessment Reference Date) of 6/24/19 coded Resident as being extensive assistance with physical assistance of 1 person for bathing, and dressing and for bed mobility, transfer and toileting she is coded as total dependence staff assistance of 2. Resident was coded as having a (Brief Interview of Mental Status) BIMS of 15.

On 8/5/19 during clinical record review it was discovered that Resident # 62 had a pressure ulcer to her sacrum.

On 8/5/19, observed Resident #62's sacral wound long with RN A (the unit manager). The Resident was in bed dressed in hospital gown, incontinence brief was removed and wound was found to be an open area to sacrum, uncovered by a dressing. When asked what she would consider this wound she stated it looked like "Sheering kind of wound opening up the top layer

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of skin." When asked if the Care Plan had been updated to reflect this she indicated that it had been.

According to the TAR (Treatment Administration Record) and the Physicians order the resident had been given an order on 8/1/19 at 12:43 AM for Calmoseptine (wound barrier cream) to sacrum "Apply to sacrum every shift for open area on sacrum until healed"

The Resident care plan read:

Focus:
The resident has a sacral pressure ulcer. Created on 9/12/17 with a revision on date of 8/2/19.

Goal:
Resident's will Pressure Ulcer [sic] will show signs of healing and remain free from infection by/ through review date: Created on 9/12/17. Revision on 8/2/19. Target date 10/29/19.

Interventions:
Administer treatments as ordered and monitor for effectiveness. Created on 9/12/17. Revision on 8/2/19

Monitor nutritional status. Provide supplements as ordered. Monitor intake and record Created on 9/12/17 Revision on 8/2/19

Position Resident as needed created 9/12/17 Revision on 8/2/19
RESOLVED- Report dressing not intact during care to nurse- Created on 9/12/17 Revision on 12 /11/17 RESOLVED- 12/11/17

RESOLVED - Treat pain prior to treatment as

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needed to ensure resident's comfort Created on 9/12/17 RESOLVED 12/11/17

On 8/5/19 at approximately 4:00 PM in an interview was conducted with RN A. When asked if the care plan had been updated to include the current pressure area she stated that it should be updated and correct.

On 8/5/19 at approximately 4:35 PM an interview was conducted with the DON, when asked about the treatments for wounds she stated that all the "Treatment Carts" have a "Pressure Ulcer Treatment Guide" which shows pictures of the types of wounds and the appropriate treatments for each one. When asked if all nurses and physicians had access and were aware of this, she indicated that they had all seen it and were aware.

According to the facility "Treatment Guide" copy provided to the surveyors, with the type of wound Resident # 62 had, the nursing staff should use Hydrocolloid dressing, foam dressing, and petroleum based non-adherent dressing, transparent film or alginate cover with secondary dressing.

On 8/6/19 at approximately 4:15 an interview with the Corporate RN employee I was conducted and he also stated that open areas should be covered with a dressing.

On 8/7/19 at approximately 8:45 AM an interview was conducted with Employee O (Acting Medical Director), and when shown the "Pressure Ulcer Treatment Guide" and asked was he familiar with the document he stated that he was not and had not seen it before. When asked if a stage II

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wound would be an open area he said "Yes you are correct." When asked if the Pressure Ulcer Treatment guide was correct when it states a Hydrocolloid dressing or another kind of protective dressing should be applied he stated " Yes that is right an open wound needs a dressing." When asked if a Barrier Cream would be appropriate for an open wound he stated that it would not. He stated it is impossible for me to check everyone's skin I rely on the Nurses for that. They will tell me if I need to look at someone. He also stated that "Dr. (Medical Director Employee L name redacted) usually handles the wounds as he is wound certified."

On 8/7/19 during the end of day meeting the Administrator was made aware and no information was provided.

6. For Resident # 79 the facility staff failed to provide appropriate care and treatment to treat a pressure ulcer. Resident #79 had an order for her pressure ulcer dressing to be changed every three days but also had an order for Desitin paste to be applied to the pressure ulcer twice each day. In addition the pressure ulcer worsened.

Resident #79 a 78 year old woman originally admitted to the facility on 4/19/19 with diagnoses of but not limited to Chronic Obstructive Pulmonary Disease, Dementia with behaviors, Urinary Tract Infection, Chronic Kidney Disease, HTN, and muscle weakness.

On 8/5/19, during clinical record review, it was discovered that Resident #79 had a Stage 2 sacral pressure discovered on readmission from

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hospital stay.

The "Skin and Wound Evaluation" dated 5/31/19 read:
A. Describe:
1. Type: 15 Pressure
15 a -Stage:
2. Stage 2: Partial thickness skin loss with exposed dermis
22. Location: Sacrum
23. Acquired:
2. - Present on Admission

B. Measurements -Area: 0.1 cm2 Length-0.5 cm Width - 0.4 cm

The rest of skin assessment was left blank and notifications boxes were not checked for Practitioner or Responsible Party.

Skin and wound assessment dated 6/24/19 shows progression of wound (wound increased in size).

1. Type - 15 Pressure
15 a -Stage:
2. Stage 2: Partial thickness skin loss with exposed dermis
Location - Sacrum
23. Acquired:
2. Present on Admission

B. Measurements -Area: 0.8 cm2 Length-1.6 cm Width - 0.7 cm

F. Wound Pain
1. Cognitively Impaired

H. Treatment:

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1. Dressing appearance 6. None
2. Cleansing Solution 5. Normal Saline
4. Primary Dressing 17 Other

The Physicians Orders were as follows:

Desitin Max Strength Paste 40% (zinc oxide) Apply to sacral topically every day and evening shift for sacral ulcer. Order Date 6/24/19 at 3:04 PM - D/C [Discontinue] Date: 7/28/19 at 1:03 PM. A printout of Location of Administration Report shows Resident had Desitin Paste applied twice a daily to the sacrum from 7/1/19 until 7/28/19.

Exuderm LP 4 X 4 Pad (Hydroactive Dressing) - Apply to back and sacrum topically every day shift every 3 days for wound. Order 7/11/19 at 3:21 PM (no end date). A printout of Location of Administration shows Nurses signed that they applied this 4 X 4 Pad (dressing) on 7/12/19, 7/15/19, 7/18/19, 7/21/19, 7/24/19, 7/27/19, 7/30/19, 8/2/19 and 8/5/19 (every 3 days as ordered)

Venelex Ointment (Balsam Peru-Castor Oil) Apply to sacral topically every day and evening shift for sacral ulcer. Order Date 6/24/19 at 4:09 PM (No end date). A printout of Location of Administration shows Nurses signed that they applied Venelex Ointment to sacrum twice a day from 6/24/19 to 8/5/19.

On 8/6/19 at approximately 6:00 PM in an interview with the DON and Employee I (Corporate Nurse Consultant) when asked how these treatments were to be administered if one of them was a dressing to be changed every three days and the other two were creams to be applied twice a day. "They must have forgotten to

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discontinue the creams after the dressing was ordered."

The Physician Progress Notes dated 4/20/19, 4/22/19, 4/24/19, 4/26/19, 5/25/19, 6/3/19, 6/7/19, 6/28/19, 7/9/19 and 7/17/19 (all signed by Medical Director) do not address wound or assessment by the physician.

Physician Progress Notes (by the acting Medical Director) read:

"8/6/19 at 10:22 PM -Skin / Wound note- Resident skin to sacrum and buttocks re-assessed, resident remains on comfort care wounds to right and left buttock healed. Sacrum noted to be stage 3 full thickness wound noted about the size of a dime. No wound measurements at this time due to comfort care. Resident is at risk for further skin breakdown due to COPD, Kidney Failure, and DM. Treatment order changed to cover sacrum with Allevyn [wound dressing] Q day. New order for skin prep to bilateral heels for prevention. New order for air mattress and heels up - [Acting Medical Director Name redacted] present with nurse at bedside during assessment. RP [name redacted] Author: [DON name redacted]

"8/7/19 at 8:41 AM - Assessment of right and left buttock and sacrum no wound observed to right or left buttock, stage 3 full thickness wound to sacrum, patient is on comfort measure conservative treatment at this time, current treatment order review and appropriate. Patient is at risk for unavoidable skin breakdown due to end stage copd, heart failure, and diabetes."

On 8/7/19 during the end of day meeting the

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Administrator was made aware and no information was provided.

The facility presented the following plan to remove the Immediate Jeopardy:

F 686
Center staff failed to provide care and services to prevent the development of and / worsening of pressure ulcers

A. Resident #5 is currently out of center. Dr. [name redacted] notified on 8.6.19 of negligence related to assessment, improper treatment, delay in initiating and implementing orders, and deterioration of wound resulting in hospitalization.

B. Resident #19's AtmosAir with SAT mattress implemented on Care Plan 2.25.2016. Upon review of chart MD order was entered for AtmosAir with SAT mattress on 3.30.2016. Order was discontinued at 4.1.2016. Resident #19 is currently on an AtmosAir with SAT mattress. Dr. [name redacted] notified of negligence on 8.6.2019 related to promptly identifying and implementing treatment orders for a deterioration in the wound. Dr. [name redacted] assessed resident #19 on 8.6.2019 and clarified location of wound (sacrum), and reviewed/updated treatment order:
Cleanse Sacrum with Normal Saline, apply Santyl to wound bed, apply moist 4x4 gauze, and cover with Alleyvn [sic] dressing.

C. Resident #155's Bariatric Genesis III mattress implemented 8.6.2019. Dr. [name redacted] notified of negligence on 8.6.2019

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related to assessment, improper treatment, delay in initiating and implementing orders, and deterioration of wound. According to Hospital Discharge Summary (Pg. 14 of 17) under wound care instructions it states "General Wound Care." Furthermore in the Hospital Discharge Summary (Pg. 27 of 29) under wound care assessment it states, "Open to Air." Resident admitted to center on 7.29.2019, Skin and Wound Evaluation completed by "[name redacted]," noted Stage 3 to Coccyx measuring 3 x 0.5 with 30% slough in wound bed. On 7.29.2019 Calmoseptine ointment was initiated. On 8.2.2019, resident seen by Charge Nurse and Corporate Nursing Consultant to re-evaluate wound due to suspected changes, new treatment from Dr. [name redacted] initiated:

Cleanse Sacral ulcer with Normal Saline, Apply scant amount of Santyl with lite dressing, every shift.

On 8.4.2019, [name redacted], DON adjusted treatment order per Dr. [name redacted] to:

Cleanse Coccyx ulcer with Normal Saline, apply Santyl to wound bed, and cover with Alleyvn [sic]

On 8.7.2019, Wound specialty Nurse RN, DON, and Dr. [name redacted] re-evaluated Stage 3 to Coccyx. Treatment updated:

Cleanse Sacrum with Normal Saline, apply Santyl to wound bed, apply moist 4x4 gauze, and cover with Alleyvn [sic] dressing.

D. Dr. [name redacted] notified on 8.6.19 of negligence on related to assessment, improper treatment, delay in initiating and implementing orders, and deterioration of wound on 8.6.2019 of Resident #156. On 7.31.2019 treatment order obtained from Dr. [name redacted]:

Cleanse Sacrum with Normal Saline, Apply

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F 686	Continued From page 144 Santyl to wound bed, and cover with Allevyn Review of documentation on 7.29.2019 entered by [name redacted], ADON showed DTI to Sacrum. On 7.31.2019, DON and ADON reviewed wound, which was noted as Unstageable. Dr. [name redacted] assessed resident #156 on 8.6.2019 and clarified location of wound (sacrum), and reviewed/updated treatment order: Cleanse Sacrum with Normal Saline, apply Santyl to wound bed, apply moist 4x4 gauze, and cover with Alleyvn [sic] dressing. On 7.31.2019, AtmosAir with SAT Mattress added, on 8.4.2019 the care plan was updated and revised to reflect Device. On 8.6.2019 AtmosAir with SAT mattress was added to physician order set. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: A) Registered Nursing staff educated in correct identification, wound staging, and appropriate treatments for initial assessment before there next scheduled shift. All licensed staff will be educated on re-evaluation of wounds, appropriate treatments, and notification to registered nurse and physician or extender if wound deterioration is suspected prior to next scheduled shift. B) Weekly wound rounds will be completed by DON, UM [unit manager] , MD and/ or MD extender and documented in physician progress notes and skin wound evaluation.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		9/21/19

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F 689	Continued From page 145 §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 record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to adequately supervise and assist to prevent injury for one resident (Resident #101) in a sample size of 46 residents. The findings included: 1. For Resident #101, the facility staff served a cup of coffee (no lid) to her without checking the temperature on 07/16/2019 and did not have a hot liquids assessment on file. Resident #101, a 90-year old female, was admitted to the facility on 03/23/2018. Diagnoses included but not limited to dementia. Resident #101's most recent Minimum Data Set with an Assessment Reference Date of 06/29/2019 was coded as an annual assessment. The Brief Interview for Mental Status was coded as a 5 out of possible 15 indicative of severe cognitive impairment. Functional status for eating was coded as requiring supervision from staff and one person physical assist for support. On 07/14/2019 at 4:21 PM, Resident #101 was	F 689	1. Resident # 101 □ No longer resides in the facility. 2. All residents are a risk for injury related to hot liquids 3. SDC or Designee will educate all staff regarding serving hot liquids at an appropriate temperature. 4. DON or Designee will audit coffee temperatures 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process. 5. Date of Compliance is September 21st, 2019.	

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observed in her room wearing a green shirt with a large stain on it.

On 07/14/2019 at 4:53 PM, Resident #101 was observed sitting on her bed fully dressed wearing a green shirt with a large stain on the front of it. The stain color had a pinkish tinge to it. The stain was from the lower chest to the waist region and extended out to beyond bilateral midclavicular lines. When asked about how the stain got there, Resident #101 looked down at her shirt and touched the stain and stated she didn't know. When asked if her shirt was wet, Resident #101 stated "No."

On 07/15/2019 at 8:32 AM, Resident #101 was observed fully dressed sitting in a chair in her room. Her lower shirt and a portion of her upper pants by the right hip region appeared wet. There was a small area of brown dried food on her left upper pant leg.

On 07/15/2019 at 5:18 PM, Resident #101 was observed awake in bed lying on top of her covers wearing a hospital gown. The head of the bed was elevated approximately 60 degrees and her dinner was in front of her on the tray table. The meat was not cut up. There was also stewed tomatoes, mashed potatoes, and strawberries on the tray, all uneaten. Resident #101 was babbling incoherently and picked up a full cup of iced tea (approximately 250 ml) and spilled the entire contents of the glass all over the left side of her hospital gown, sheets, and floor. This surveyor alerted staff and an aide entered the room to clean up the spill.

On 07/15/2019 at approximately 5:50 PM, an interview with Certified Nursing Assistant E (CNA

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E) was conducted. CNA E verified she was assigned to care for Resident #101. When asked about feeding assistance for Resident #101, she stated it was limited. CNA E stated that Resident #101 needs help opening things but she doesn't need someone with her all the time. When asked if she tends to spill food on herself, CNA E stated, "Yes."

On 07/16/2019 at approximately 8:30 AM, Resident #101 was observed in her bed with the head of the bed elevated approximately 60 degrees. There was a full cup of coffee (no lid) on the tray in front of her. Licensed Practical Nurse B (LPN B) was standing by the med cart outside the room. When asked about the coffee on Resident #101's tray, LPN B stated that an employee from Medical Records brought it to Resident #101. LPN B stated that she added cold water to the cup because she was afraid Resident #101 would spill hot coffee on herself. When asked if she checked the temperature before serving the coffee, LPN B stated she did not temp the coffee. This surveyor requested the coffee temperature be checked. At 8:35 AM, Employee H, a registered dietician arrived with the thermometer and measured the coffee temperature. It was 108 degrees Fahrenheit.

On 07/16/2019 at approximately 9:10 AM, an interview with the DON was conducted. When asked about expectation of staff for one person physical assist, she stated that means staff provide assistance with set up and opening things and may need to support to initiate eating. A copy of Resident #101's hot liquids assessment was requested as well as a policy addressing hot liquids assessment.

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F 689	Continued From page 148 On 07/16/2019 at approximately 3:25 PM, the DON verified there is no hot liquids assessment for Resident #101 and no facility policy addressing hot liquids assessment. When asked about expectations for serving hot liquids, the DON stated that [Resident #101] needs to be evaluated to see if it's safe for her to handle her own liquids. The DON also stated that coffee temps should be measured before serving and served at safe temperature. On 07/16/2019 at approximately 4:15 PM, an interview with Employee D from medical records was conducted. When asked about serving coffee to Resident #101, Employee D stated that Resident #101 had her call light on and it is facility policy that all staff address call lights. Employee D stated LPN B was with Resident #101 and LPN B requested a cup of coffee for Resident #101. Employee D stated she got the coffee from the dining room and placed it on the tray. Employee D stated LPN B was in the room with Resident #101 at the time. When asked if she would serve a cup of coffee to a resident if they asked for it, Employee D stated she would always ask the nurse first. On 07/16/2019 at approximately 7:45 PM, the administrator and DON stated they had no further information or documentation to offer.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		9/21/19

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F 690	Continued From page 149 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide services and assistance to maintain continence status for one resident (Resident #91) in a sample size of 46 residents. The findings included:	F 690	1 Resident # 91 □ Inappropriate practice of untimely toileting and review of incontinence products was completed 2 All patients are at risk for untimely toileting. 3 SDC or Designee will educate all staff related timely toileting to prevent the use of incontinent products on continent	

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F 690	Continued From page 150 For Resident #91, the facility staff failed to respond to her requests for assistance to the rest room in a timely fashion. Also, Resident #91 was continent and wearing a brief due to delays in prompt assistance. Resident #91, an 86-year old female, was admitted to the facility on 06/25/2019. Diagnoses included but not limited to history of fall with intertrochanteric fracture, cerebral vascular accident, hypertension, diabetes, and generalized muscle weakness. Resident #91's most recent Minimum Data Set with an Assessment Reference Date of 07/02/2019 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 14 out of possible 15 indicative of intact cognition. Functional status for toileting was coded as requiring extensive assistance from staff and a one-person physical assist for support. Urinary continence was coded as occasionally incontinent (occurring less than 7 times in the 7-day look-back period). On 07/14/2019 at 3:40 PM, Resident #91 was observed in her room seated in her chair. When asked if she had any concerns about the care she received at the facility, Resident #91 stated that she had recently experienced urinary urgencies and burning when urinating. Resident #91 stated she call staff to request assistance going to the restroom but "they walk past as though they don't see me." Resident #91 stated she is not able to "hold it" for very long and ends up urinating in brief due to the delay in assistance. When asked if she needed to wear a brief at home, Resident #91 stated "No" and denied any history with	F 690	residents. 4 DON or designee will do random audits to ensure timely assistance to resident request for toileting and appropriate use of incontinent products 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 through QAPI process. 5 Date of Compliance is September 21st, 2019.	

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incontinence except her recent hospitalization she would sometimes have "accidents." When asked how it made her feel to be wearing a brief, she stated it was aggravating but she was glad she was wearing a brief because it's better than "sitting in it" waiting for staff to come help. Resident #91 stated she would prefer it if staff would just come and help her to the restroom.

On 07/14/2019 at approximately 5:15 PM, the clinical record was reviewed. The admission assessment dated 06/25/19 at 12 p.m. under the header "GU/Bladder (Genitourinary/Bladder)", it was documented "Non-distended bladder." Other options available on the list that were not selected were: continent of bladder; incontinent of bladder; pain on urination; nocturia; catheter utilized.

Excerpts of a nurse's note dated 06/30/2019 at 1:19 p.m. documented, "Resident has c/o [complained of] burning and dysuria notified on-call NP [nurse practitioner] [name], n.o. [nurse order] to obtain u/a and c&s [urinalysis and culture and sensitivity]." "Resident also has an n.o. to start Macrobid 100mg p o b i d x 7 days [by mouth twice a day for 7 days] which was started from the stat box, also has n.o. for Pyridium 100 mg p.o. tid prn x 3 days [by mouth three times a day as needed for 3 days] which has been ordered."

On 07/15/2019 at approximately 1:30 PM, Certified Nursing Assistant D (CNA D) was interviewed. When asked about Resident #91's urinary continence status, CNA D stated that Resident #91 is incontinent at night but she is continent during the day. When asked how she knew Resident #91 was incontinent at night, CNA D stated that Resident #91's brief is always wet in

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the morning. When asked how frequently she offers toileting assistance to Resident #91, CNA D stated "we make A.M. [morning] rounds and P.M. [afternoon/evening] rounds." When asked how frequently in an 8-hour shift, CNA D stated, "Twice."

On 07/15/2019 at approximately 2:00 PM, Registered Nurse A (RN A), unit manager, was asked about Resident #91's urinary continence status. RN A stated Resident #91 is able to make her needs known but stated Resident #91 has some incontinent episodes, usually in evenings. RN A went on to say that Resident #91 told her before that "she's had urgencies and can't hold it." When asked how frequently she should be offered toileting assistance, RN A stated "Every hour." When told CNA D stated she is offered toileting assistance twice a shift, RN A stated, "I think she should ask more often than twice a shift."

On 07/16/19 at approximately 9:15 AM, an interview with the DON was conducted. When DON was notified of findings, she stated the standard is to check on residents every 2 hours and offering toileting assistance. The DON went on to say that just because someone may have episodes of incontinence during the night does not mean they are always incontinent and this requires education for nurses and CNA's. When asked about the expectation for answering call lights, the DON stated that when the call bell rings, we expect someone to go in and answer it in 3-5 minutes to let them know someone will be in to provide the care. If it is a non-clinical person, they leave the light engaged so that they know that they (the residents) need care.

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F 690	Continued From page 153 On 07/16/2019 at approximately 3:55 PM, the DON provided a facility copy of a policy entitled, "Shift Responsibilities for CNA." In Section 4, it was documented "Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the license nurse of any pertinent patient findings (reddened skin, etc.)." The policy did not address the frequency of making rounds to offer toileting assistance. On 07/16/2019 at approximately 7:45 PM, the administrator and DON stated they had no further documentation of information to offer.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility failed to provide respiratory care therapy consistent with infection control measures for 4 Residents (Resident # 68, #503, #92, and #58) in a survey sample of 46 Residents. The findings included:	F 695	1. Resident # 68 □ Nebulizer changed per center protocol. Resident # 503 □ No longer resides in the center. Resident # 92 □ Nebulizer changed per center protocol. Resident # 58 □ Nebulizer and oxygen changed per center protocol.	9/21/19

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F 695	Continued From page 154 1. For resident # 68, the facility failed to cover and date the Nebulizer mask and tubing. Resident # 68 was an 91 year old female admitted to the facility on 03/22/2019 with diagnoses of but not limited to Fracture of right femur, hypertension, atrial fibrillation and wheezing. Most recent (Minimum Data Set) MDS was a quarterly assessment with an (Assessment Reference Date) ARD of 6/24/2019 coded Resident as having a (Brief Interview of Mental Status) BIMS score of 9 indicating Severe Cognitive Impairment. On 7/14/2019 during initial tour of facility at 4:45 PM, Resident # 68 was noted to be lying in bed. On the nightstand next to her bed was a Nebulizer mask with tubing attached that was uncovered and not labeled or dated. On 7/15/2019 at 10:14 AM, Nebulizer mask was noted on the night stand, uncovered and not dated. On 7/16/2019 at 11:14 AM, a Nebulizer Mask was noted on the night stand and was covered in a bag and dated 7/15/19. On 7/16/19 at 2 PM, an interview was conducted with the Director of Nursing who stated the facility policy is to change the nebulizers every Monday, Wednesday and Friday. The Director of Nursing stated it was important to keep the nebulizer covered because of the potential spread of infection.	F 695	2. All residents receiving nebulizer and oxygen therapy are at risk for deficient practice. 3. SDC or Designee will educate licensed staff on proper storage and correct placement of nebulizer and oxygen equipment and appropriate oxygen liter flow per MD order. 4. DON or Designee will audit residents with nebulizer for proper storage, portable oxygen tanks will be audited to ensure tanks are not empty and usage 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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During the debriefing with Administrative staff on 7/16/2019 at 5:30 PM, the Administrator, Director of Nursing, and Corporate Nursing Consultant (Employee E) were informed of the findings.

The Corporate Consultant and Director of Nursing stated the expectation was to keep Nebulizers covered in a bag, labeled and dated.

No further information was provided.

2. For Resident # 503, the facility failed to change the Nebulizer mask and tubing after 7/5/19.

Resident # 503 was a 92 yr old female admitted to the facility on 6/28/2019 with diagnoses of but not limited to Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Heart Failure and Chronic Kidney Disease Stage 3.

Resident # 503's most recent (Minimum Data Set) MDS was an Admission Assessment with an (Assessment Reference Date) ARD of 7/12/2019. The MDS coded her has having a (Brief Interview of Mental Status) BIMS Score of 15 out of 15, indicating no cognitive impairment.

On 7/14/2019 during initial tour of facility at 3:45 PM, Resident # 503 was noted to have an oxygen canister with nasal cannula and a nebulizer tubing set up at the bedside. The oxygen tubing and humidifier were dated 7/14/2019.

Resident #503 had a nebulizer mask with tubing connected in a bag sitting on the bedside table. The date on the bag was 7/5/19.

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On 7/15/19, the nebulizer mask was noted on the bedside table and still in a bag dated 7/5/19.

On 7/16/19 at 11:00 AM, observed the nebulizer mask was on the bedside table in a bag and the dated 7/15/19.

Review of clinical record revealed an order dated 7/1/2019 for "Nebulizer tubing set change M-W- F (Monday- Wednesday- Friday) every night shift for Shortness of Breath/Wheezing.

Review of the July 2019 Medication Administration Record revealed that the nebulizer tubing set up was documented as having been changed on 7/8/19, 7/10/19 and 7/12/19. The date on the bag covering the Nebulizer was dated 7/5/2019.

On 7/16/19 at 2 PM, an interview was conducted with the Director of Nursing who stated the facility policy is to change the nebulizers every Monday, Wednesday and Friday. The Director of Nursing stated it was important to change the nebulizers and keep them covered to prevent the potential spread of infection.

During the debriefing with Administrative staff on 7/16/2019 at 5:30 PM, the Administrator, Director of Nursing, and Corporate Nursing Consultant (Employee E) were informed of the findings.

The Corporate Consultant and Director of Nursing stated the expectation was to change the Nebulizers every Monday, Wednesday and Friday and keep them covered in a bag, labeled and dated. The DON stated the date on the bag would indicate the date the nebulizer was changed.

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No further information was provided.

3. For Resident #92 the facility staff failed to ensure the proper storage and labeling of his Nebulizer equipment.

Resident #92 an 84 year old man admitted to the facility on 6/25/19 with diagnoses of but not limited to respiratory failure, congestive heart failure, COPD (chronic obstructive pulmonary disease) and acute kidney failure.

On 7/15/19 at 9:00 AM observed Nebulizer sitting on bedside table tubing was laying on the table with the mouth piece. Neither were dated or tabled in any way.

On 7/15/19 at 9:03 AM in an interview with Employee B who was asked if she knew when the tubing was last changed, she looked at the tubing and said she could not tell. When asked the procedure for changing them she stated. The tubing was changed on either evening or night shift three days a week. She indicated she was not sure which days or shifts for certain however she stated it comes up on the computer to remind you when to do it.

On 7/16/19 at 9:20 AM in an interview with the DON she was asked how the Nebulizer tubing was stored, she stated that they were kept at the bedside in a bag attached to the Nebulizer machine.

When asked how often they were changed and how you would know if they were changed she

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stated they were tabled and dated on the bag. When asked the importance of changing out the tubing and storing it in the bag she stated to prevent infection and keep it clean.

On 7/16/19 during the end of day meeting the Administrator was notified of the findings and no further information was provided.

4. For Resident #58 the facility staff failed to provide respiratory care in accordance with physician orders.

Resident #58 was admitted to the facility on 4/19/19. The Resident's diagnoses included but were not limited to: cerebral infarction due to embolism of right middle cerebral artery and obstructive sleep apnea.

On 7/14/19 at approximately 4:30pm during initial tour, Resident #58 was observed at his bedside, sitting in a wheelchair visiting with his spouse. Resident #58 was connected to a portable oxygen cylinder, which was on the back of his wheel chair and had a nasal cannula in his nose to deliver the oxygen. It was observed that the O2 cylinder was reading in the red zone, which indicated it was empty.

On 7/14/19 at 4:40pm LPN F was approached and asked to come check Resident #58's oxygen (O2) saturation. LPN F accompanied this writer to Resident #58's room and checked his O2 saturation. LPN F stated, "it is 85-97, the highest I got was 97. I'm going to check his orders." LPN F was asked to look at the O2 cylinder and LPN F stated, "he needs a new tank, that's what is going

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F 695	Continued From page 159 on." Review of Resident #58's physician orders revealed an order that read, "Oxygen at (2) liters per minute via nasal cannula every shift." Review of Resident #58's nursing notes on 7/16/19 at approximately 12 noon revealed no entry or documentation of the incident on 4/14/19 of not having oxygen administered as ordered, the O2 saturation of 85-97%, or notification of the physician. On 07/16/19 at 08:49 AM and interview was conducted with the DON, the DON stated, "we check vitals to include O2 saturation on skilled patients every shift." When asked what acceptable parameters are, she said "typically it is based off of individual assessment but we like to keep them between 90-100% except for a COPD person 85-90%". When asked if these parameters are not met what she would expect to happen, the DON said "I would expect them to do a head to toe assessment, if they have a nebulizer treatment administer that, and reach out to the MD for a change in condition." No further information was provided.	F 695		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 726		9/21/19

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F 726	Continued From page 160 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility failed to ensure nursing staff have the appropriate skills and competencies to conduct assessment and treatment of pressure injuries which resulted in deterioration of the injuries and/or hospitalization for one resident (Resident #5) in a survey sample of 46 Residents, resulting in harm for Resident #5. Immediate Jeopardy was identified on 8/6/19 at 6:17pm and the facility was notified. After verification, Immediate Jeopardy was abated on 8/7/19 at 6:55pm and the scope and severity was	F 726	1. Resident # 5 □ No longer resides in the center. 2. All residents with pressure ulcers are at risk for deficient practice. 3. Wound MD or Designee will educate Registered Nursing staff in correct identification, wound staging, and appropriate treatments for initial assessment. All licensed nursing staff will be educated on re-evaluation of wounds, appropriate treatments, and notification to registered nurse and physician or extender if wound deterioration is suspected. 100% of all current resident	

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F 726	Continued From page 161 lowered to level three, isolated. The findings included; 1. For Resident #5, staff continually failed to accurately assess a pressure ulcer, resulting in harm. Resident #5 was admitted to the facility on 1-29-19. Diagnoses included; vertigo, chronic kidney disease, dementia, benign prostatic hypertrophy, stroke, hypertension, congestive heart failure. and chronic Foley catheter. Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-26-19. The Resident was coded with mild cognitive impairment, and no aberrant behaviors. Resident #5 required extensive assistance to total dependence on one to two staff members, for activities of daily living care. The Resident was coded as not having any pressure ulcers at the assessment time, nor on admission. The Resident had a long standing Foley catheter (urine drainage) due to an obstruction, and was incontinent of bowel. The Resident was coded as at risk for pressure sores. At area M-0100 through M-1200 under the MDS skin conditions section of the assessment, the Resident was coded to be at risk for pressure ulcers, had no pressure ulcers, and had no other skin problems such as rashes, and or moisture associated skin damage. A wound observation occurred on 7-16-19 at 11:30 a.m., with Licensed practical nurse C (LPN C), and Certified nursing assistant N (CNA N).	F 726	with pressure areas have been evaluated by RN and physician. 4) DON or designee will review all pressure ulcers to ensure accuracy of assessment and appropriate treatment 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process DON or designee will review all initial assessment of pressure ulcers to ensure that the assessment was completed by registered nurse 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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The nurse removed the bandage from the Resident's coccyx. The 4 inch by 4 inch single bandage had a solid center in it which was a tan telfa like non-adherent 2 inch by 2 inch square. The outer circumference of the square bandage was surrounded by a boarder of adherent malleable stretchy tape, reminiscent of Band-Aid fabric. There was no packing or medicated cream in the hollow wound. Immediately after removing the dressing a green purulent discharge was seen. The wound was circular, and deep with full muscle tissue loss and bone protrusion clearly visualized and palpated by the nurse. The wound had undermined and tunneled circumferentially around, only under the circular rolled wound edges. There was also noted yellow tan slough and black necrotic tissue inside the wound, and silvery white fascia could be seen covering the coccygeal bone protrusion. The LPN measured the wound with a long cotton swab and a wound measuring disposable paper tape. She measured the cotton swab after it was laid on the wound, and placed in the wound for an accurate measurement. The wound measured 2 centimeters (cm) long, 1.5 cm wide, and 1.5 cm deep. The exterior wound edges were rolled (epibole). The Resident was pre-medicated with pain medication and stated he felt no pain as the wound was measured.

Nursing progress notes were reviewed from wound identification to the time of survey. No notes describe any pressure ulcer identification, treatments, assessments for pressure ulcers, or changes to the care plan for Resident #5 after the first identification of the wound on 4-29-19. The initial note described the pressure injury as a red bruise with open skin, and the skin evaluation document of 4-29-19 gave further

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measurements.

Review of the weekly skin assessment sheets since admission "PCC Skin & Wound - Total Body Skin Assessment" documents revealed all (including the initial) were completed by LPN's. The findings were as follows;

1-29-19 - no new wounds
2-5-19 - no new wounds
2-12-19 - no new wounds
2-19-19 - no new wounds
2-26-19 - no new wounds
3-5-19 - no new wounds
3-13-19 - no new wounds
3-25-19 -no new wounds
4-1-19 - no new wounds
4-8-19 -no new wounds
4-15-19 -no new wounds
4-22-19 -no new wounds
From 4-22-19 through 5-26-19, no weekly skin checks were completed.
5-27-19 -no new wounds
6-3-19 -no new wounds
6-10-19 -no new wounds
6-17-19 - no new wounds
6-24-19 - 2 new wounds (left and right buttocks)
7-1-19 -no new wounds
7-8-19 -no new wounds
7-15-19 -no new wounds.

On 4-29-19, another type of assessment document was initiated and performed by all LPN staff, "Skin and Wound Evaluation V 5.0". These documents were started for a "new Pressure wound stage 2 on the Resident's sacrum" and was described as being treated with povidone iodine after cleaning with normal saline, and no dressing. The wound measured 3 cm long x 1.3

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cm wide, no depth, and healable. None of these documents were completed after this initial one until 1 month later, on 5-27-19. The Rest of these particular assessment documents follow below in chronological order:

On 5-27-19 the next "Skin and Wound Evaluation V 5.0" document occurred one month after the first one on 4-29-19. The document describes the sacrum wound as stage 2 unchanged, healable, and documents the measurements of the wound as 1.1 cm long x 0.5 cm wide, and no depth. The treatment remains the same. No eschar, no debridement, no dressing.

On 6-3-19 Sacrum stage 2 pressure ulcer 1.7 cm long x 0.5 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-10-19 sacrum stage 2 pressure ulcer 1.9 cm long x 0.5 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-17-19 sacrum stage 2 pressure ulcer 1.2 cm long x 0.6 cm wide, no depth, same treatment. Healable. No eschar, No debridement, no dressing.

On 6-24-19 staff pin pointed and documented the "Coccyx" portion of the sacrum, instead of just stating sacrum, stage 2 pressure ulcer 1.3 cm long x 0.9 cm wide, no depth, Normal saline, and now, cover with foam dressing. Healable. No eschar, No debridement. A Left buttock and a right buttock were found as "New areas" on 6-24-19, however, had nothing to do with the continuing Sacrum/Coccyx wound according to

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nursing staff.

On 7-2-19 coccyx stage 2 pressure ulcer 1.4 cm long x 0.2 cm wide, no depth, same treatment. Healable. No debridement, No eschar.

On 7-8-19 coccyx stage 2 pressure ulcer 1.5 cm long x 0.5 cm wide, no depth, same treatment. Healable, Deteriorating. No debridement, No eschar.

On 7-9-19 (one day later) the last assessment documented coccyx stage 2 pressure ulcer 1.2 cm long x 0.6 cm wide, no depth, Eschar 20%, deteriorating, healable, treatment; normal saline and enzymatic debridement (ordered 6-3-19).

No assessments by staff described a stage 4 pressure ulcer, and no assessments were completed from 7-14-19. through 7-16-19, until the surveyor found the stage 4 pressure ulcer on 7-16-19.

All of the assessments, including the initial assessment, were completed by LPN's.

The DON was requested to supply surveyors with all policies for skin assessments and pressure ulcers. The DON, and Corporate RN supplied 2 facility policies on skin assessments and pressure ulcers. They are as follows;

1. "Pressure ulcers Manual" - "Skin Assessment" Skin assessments will be completed for all patients. A licensed nurse will ensure that the skin risk assessment is done upon admission, and quarterly thereafter. A skin assessment will also be completed upon re-entry to the center (i.e., after ER visit, dialysis, etc.) The weekly skin

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assessment will be completed thereafter. Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs.

2. "Pressure ulcers Manual" - "Pressure Ulcer monitoring &" A licensed nurse will assess patients for the presence of pressure ulcers: if a pressure ulcer is present, the nurse will evaluate for complications. Provide pain management prior to pressure ulcer treatment as indicated. The wound record will be completed weekly by a licensed nurse for any patient with pressure ulcers. There will be a wound record for each site.

Guidance is provided for the staging of pressure ulcers by the National Pressure Ulcer Advisory Panel (NPUAP), and is as follows;

NPUAP announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury FOR IMMEDIATE RELEASE April 13, 2016.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD),

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F 726	Continued From page 167 intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant (fat) adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. Stage 4 Pressure Injury: If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness stage 4 pressure injury. Do not use (deep tissue pressure injury) DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. The Administrator, DON, and the Registered Nurse (RN) Regional Consultant were made aware of the harm level deficiency at the end of day debrief on 7-16-19. No further information was supplied by the facility. The facility presented the following plan to remove the Immediate Jeopardy:	F 726		

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F 726	Continued From page 168 F726 Center failed to ensure Nursing staff have appropriate skills and competencies to conduct assessment and treatment of pressure of pressure injuries resulting in deterioration of injuries /hospitalization Registered Nurse Consultant educated Director of Nursing (DON) on wound identification, Staging, and appropriate treatment on 8.6.2019. Competency validated through wound rounds and visualizing DON completing assessments. DON will assume responsibility of coordinating Weekly Wound Rounds. Registered Nursing staff educated in correct identification, wound staging, and appropriate treatments for initial assessment before there next scheduled shift. .All licensed staff will be educated on re-evaluation of wounds, appropriate treatments, and notification to registered nurse and physician or extender if wound deterioration is suspected prior to next scheduled shift. This is validated through return demonstration utilizing the Skills Validation for "Skin and Pressure ulcer prevention and management." Wound identification charts with appropriate treatments/products, based on staging, are available to staff in the narcotic books on each of the medication carts.	F 726		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 730		9/21/19

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F 730	Continued From page 169 education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review the facility staff failed to ensure that certified nursing assistants (CNA's) receive regular in-service education for four CNA's (CNA O, CNA P, CNA Q, CNA R) of 15 CNA records reviewed. The findings included; 1. For CNA O the facility staff failed to ensure 12 hours of in-service education was provided annually. CNA O was hired 6/13/16. On 7/15/19 2018-2019 training and education records for CNA O was requested. Review of CNA O's education records revealed that the only in-service education CNA O received was on 4/10/19 and consisted of 11 hours. CNA O received no education in 2018 and did not obtain 12 hours from June 2018-June 2019. On 7/15/19 any additional education records for CNA O was requested and the DON (Director of Nursing) stated everything would be in the computer based system. No further information was provided. 2. For CNA P the facility staff failed to ensure 12	F 730	1. CNA O, P and Q □ No longer employed by center 2. All CNA□s are at risk. 3. SDC or Designee will educate CNA□s on ensuring they complete monthly training hours toward 12 hours of training requirement yearly 4. DON or Designee will audit 20% of CNA□s education weekly 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process. 5. Date of Compliance is September 21st 2019.	

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hours of in-service education was provided annually.

CNA P was hired 7/18/16.

On 7/15/19 2018-2019 training and education records for CNA P was requested.

Review of CNA P's education records revealed that the only in-service education CNA P received was on 5/15/19 and consisted of 5.5 hours. CNA P received no education in 2018 and did not obtain 12 hours from July 2018-July 2019.

On 7/15/19 any additional education records for CNA was requested and the DON (Director of Nursing) stated everything would be in the computer based system.

No further information was provided.

3. For CNA Q the facility staff failed to ensure regular in-service training was provided and 12 hours of in-service education was provided annually.

CNA Q was hired 10/31/16.

On 7/15/19 2018-2019 training and education records for CNA Q was requested.

Review of CNA Q's education records revealed that the only in-service education CNA Q received was in November 2016 and consisted of 7.75 hours. CNA Q received no education in 2018 or 2019.

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F 730	Continued From page 171 On 7/15/19 any additional education records for CNA Q was requested and the DON (Director of Nursing) stated everything would be in the computer based system. No further information was provided. 4. For CNA R the facility staff failed to ensure 12 hours of in-service education was provided annually. CNA R was hired 9/04/07. On 7/15/19 2018-2019 training and education records for CNA R was requested. Review of CNA R's education records revealed that the only in-service education CNA R received was on 12/30/18 and 1/21/19 and consisted of a total of 4 hours. CNA R did not obtain 12 hours of education in 2018. On 7/15/19 any additional education records for CNA R was requested and the DON (Director of Nursing) stated everything would be in the computer based system. No further information was provided.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		9/21/19

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F 755	Continued From page 172 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered medications for 1 resident (#63) in a survey sample of 46 residents. The findings included: 1. For Resident # 63, the cholesterol reducing medication Atorvastatin 10 milligrams was unavailable for administration on 7/13/19.	F 755	1. Resident # 63 □ No longer resides in the facility. 2. All residents are at risk of medication availability and all resident receiving simvastatin are at risk of medication availability. 3. SDC or Designee will educate Licensed Nurses on medication availability and subsequent process. 4. DON or Designee will audit residents receiving Simvastatin and will be audited	

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F 755	Continued From page 173 Resident #63, an 83 year old, was admitted to the facility on 5/28/2019. Diagnoses included but were not limited to Hyperlipidemia, occlusion and stenosis of the right middle cerebral artery, Aphasia following cerebral infarction and Dysphagia. The most current Minimum Data Set (MDS) assessment was a 30 day Admission assessment with an assessment reference date (ARD) of 6/23/2019. Resident # 63 was coded with a Brief Interview of Mental Status score of 7 out of 15 indicating severe cognitive impairment. She required extensive to total assistance of one to two staff persons with activities of daily living. The following nursing note was documented in the clinical record: "Orders-Administration Note 7/13/2019 21:42 (9:42 p.m.) Medication not available" On 7/15/19 at 11:30 a.m., during a meeting held with the Administrator and Director of Nursing (DON), it was reviewed that there was documentation in the nursing notes that a medication was unavailable for administration on 7/13/19 at 1700 (5 p.m.) The facility staff were asked to identify the medication that was unavailable. On 7/15/2019 at 12:50 p.m., the DON provided copies of the nursing notes for July 2019 (including 7/13/19 nursing notes) and July Medication Administration record. When asked what medication was unavailable, the DON stated that she needed to check. The Assistant Director of Nursing (ADON) stated review revealed that Atorvastatin was the medication that was unavailable on 7/13/19.	F 755	for availability weekly 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019.	

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F 755	Continued From page 174 Resident # 63 had a physician order dated 5/29/2019 for Atorvastatin 10 milligrams via PEG (Percutaneous Endoscopic Gastrostomy) tube one time a day for Cholesterol. According to the July 2019 MAR, the Atorvastatin 10 milligrams via PEG tube was not administered on 7/13/2019. The Administrator and DON were notified of the issue at the end of day meeting on 7/15/19. The Director of Nursing (DON) stated the expectation was that the Pharmacy would ensure medications would be available for nurses to administer as ordered by the physician. The DON stated the Pharmacy used by the facility makes several deliveries to the facility and the back-up pharmacy is a local pharmacy located in close proximity to the facility. No further information was provided.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		9/21/19

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F 758	Continued From page 175 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview clinical record review and facility documentation the facility staff failed to ensure Residents are free from unnecessary psychotropic medications	F 758	1. Resident # 95 □ No longer resides in the facility. Resident # 79 □ Medication reviewed and updated.	

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F 758	Continued From page 176 for 3 Residents (#253, #79, and # 95) in a survey sample of 46 Residents. The findings include: 1. For Resident # 253 the facility staff obtained a PRN order for Xanax 0.5 mg without a stop date. Resident #253, 65 year old woman admitted to the facility on 7/10/19 with diagnoses of but not limited to major depressive disorder, muscle weakness, and anxiety disorder. Resident #254 is a new admission and therefore does not yet have an MDS (Minimum Data Set). On 7/15/19 during clinical record review it was discovered that Resident #253 had the following orders for Psychotropic medications: Cymbalta Capsule Delayed Release 60 mg. 1 capsule one time a day for depression Amitriptyline HCL 25 mg at bedtime for depression Xanax 0.5 mg every 12 hours PRN (as needed) for anxiety (ordered 7/10/19 with no stop date) 7/16/19 at 4:15 PM the DON was interviewed and asked how long PRN Psychotropic medications were supposed to be prescribed for and she stated that they should only be prescribed for 14 days and then they had to be reevaluated by the Physician. On 7/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.	F 758	Resident # 253 □ Medication reviewed and updated. 2. All residents receiving Psychotropic medications are at risk. 3. SDC or Designee will educate Licensed Nurses on Psychotropic medication directions and appropriate treatment. 4. DON or Designee will audit residents receiving Psychotropic medications for dosage and appropriate diagnosis. Audit 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process. 5. Date of compliance is September 21st,2019	

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2. For Resident #79 the facility staff failed to limit the use of prn (as needed) psychotropic medications to 14 days.

Resident #79, was admitted to the facility on 4/19/19 with a readmission date of 6/24/19. The Resident's diagnoses included but were not limited to: unspecified dementia with behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and anxiety.

Review of Resident #79's physician orders revealed an order obtained on 7/12/19 that read, "Ativan Solution 2 MG/ML (LORazepam) Inject 0.5 ml intramuscularly every 6 hours as needed for anxiety." In the end date the area was blank.

On 7/16/19 at 4:15 PM the DON was interviewed and asked how long PRN psychotropics were supposed to be prescribed for and she stated that they should only be prescribed for 14 days and then they had to be reevaluated by the Physician.

3. For Resident #95 the facility staff failed to ensure the Resident was not given psychotropic medications unless used to treat a specific condition.

Resident #95 was admitted to the facility on 6/19/19. Diagnoses for Resident #95 included but were not limited to: unspecified dementia without behavioral disturbance, post-traumatic stress disorder, and major depressive disorder.

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Review of the hospital discharge records revealed that Resident #95 was not discharged from the hospital on any antipsychotic medications.

Review of Resident #95's physician orders and Medication Administration Record for July 2019 revealed an order with an initiation date of 6/29/19 for "Risperdal tablet, give 0.5 mg by mouth two times a day for behaviors." Resident #95 received 11 doses of this medication.

Review of Resident #95's nursing notes revealed that on 6/29/19 an entry was made which read, "patient wheeled himself up in wheelchair demanding to be put into his bed. Patient then started yelling.... stated he was going to kill [staff] and was shaking his fist. Dr. [name redacted] was called and new order received for risperdal 0.5 mg BID for behaviors. Haloperidol 2mg IM stat for severe agitation."

Resident #95 was not evaluated by a psychiatrist until 7/3/19 where it was noted "Patient currently having bipolar disorder symptoms with increased grandiosity." The recommendation was made at that time by psychiatric services to discontinue to Risperdal.

On 7/14/19 Resident #95's spouse stated "on 6/29/19 he got angry he was sitting in his w/c for over an hour, he sat for an hour and a half and finally come into the hall screaming and cursing. They gave him a shot of Haldol and started Risperdal 0.5 mg and within 5 days he started having hallucinations."

On 7/16/19 at 11:24am an interview was conducted with the DON (Director of Nursing).

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F 758	Continued From page 179 The DON confirmed that Resident #95 was not admitted to the facility on any antipsychotic medications and they had been implemented in response to his behaviors. The DON also acknowledged that Resident #95 had experienced auditory and visual hallucinations. No further information was provided.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review the facility staff failed to store food in accordance with professional standards for food service safety for 1 of 1 kitchens.	F 812	1. Container containing soup was labeled and dated. The shell eggs were moved to the bottom shelf. Employees with facial hair are wearing beard guards. All expired bread was discarded. Pan in the bottom on the warm box has been	9/21/19

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F 812	Continued From page 180 The findings included: On 7/14/19 during a tour of the kitchen accompanied by Employee F, dining services associate the following was observed in the walk-in cooler: * a container containing an undetermined product, with no label to indicate the contents or date prepared or to be used by, had a clear wrap covering that had fallen into the contents of the container. Employee F stated, "I guess it's soup." * in the shell pasteurized eggs were stored on the second shelf from the bottom with ham, turkey, turkey breast and bacon stored directly below the eggs. When Employee F was asked if this is where eggs are normally stored, Employee F stated, "yeah right here." Employee F was observed with facial hair on his chin, he had no beard guard on throughout the kitchen observation on 7/14/19. On 7/14/19 at 3:45pm Employee G, Dietary manager arrived and completed the remainder of the tour with this writer. On 7/14/19 at 3:45pm it was observed that hot dog buns were in the bread rack with an expiration date of 7/12/19. The dietary manager was asked what the date read, she stated "it says July 12." and she discarded the hot dog buns. On 7/14/19 the warmer that the Dietary manager called the "warm box" was observed with a metal pan in the bottom which had a significant amount of tan colored film on the surface of the water and around the edges. The Dietary manager stated,	F 812	cleaned. Sanitizer bucket corrected. Double door cooler has been taken out of service. 2. All residents are at risk for this deficient practice. 3. SDC or Designee will re-educate Dining Services staff on labeling and dating, proper storage of eggs, proper use of beard guards, cleaning and sanitizing, and proper refrigerator temperatures. 4. Dining Services Manager or Designee will audit three times a week for two weeks, monthly times two and then quarterly twice. Facility will monitor performance through QAPI process. 5. Date of compliance is September 21st,2019	

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"it's like lime build-up." When asked how often this is cleaned, the dietary manager said, "at the end of the shift they run it through the dish machine."

On 7/14/19 at approximately 3:50pm a red sanitizer bucket was siting in the 2 compartment sink located near the dry storage room, the dietary manager tested the contents for sanitation content and it tested as zero parts per million (ppm) of chemical sanitation. The dietary manager confirmed there was no sanitizer liquid in the bucket and stated, "she is changing them out now." The dietary manager indicated that the solution in the red buckets are used to wipe down table surfaces and food service equipment in the kitchen.

On 7/14/19 at approximately 4pm the double door cooler located beside the coffee urn, had 2 thermometers inside. It was observed that the temperature was 60 degrees Fahrenheit (F) on both thermometers. When the dietary manager was asked to read the temperature she said "it says 42." She was advised she was reading the Celsius side of the thermometer and she looked again and said "it's 59, but she has been in and out of here a lot." The dietary manager then put a new thermometer inside. (Refrigerated storage must be maintained at or below 41 degrees F).

During a follow-up tour of the kitchen on 7/15/19 at 10:33am the dietary manager accompanied this writer. The walk-in cooler was observed with eggs still stored on the second from the bottom shelf with turkey and bacon stored below the eggs. The dietary manager stated, "because they are pasteurized eggs they do no harm to meats." The container, Employee F identified on 7/14/19

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as being soup was observed to be covered with a clear wrap and included a label indicating it was soup with a use by date.

On 7/15/19 the pan in the warmer box still had some tan colored build-up around the edges and the Dietary manager stated, "they got most of it off but couldn't get that off."

On 7/15/19 at approximately 10:37am the 2 door cooler, located beside the table with the coffee urn, the temperature was observed to be at 50 degrees F. The dietary manager confirmed this and that she had put this new thermometer in place on 7/14/19.

On 7/15/19 at 3:38pm the 2 door cooler, located beside the table with the coffee urn, the temperature was observed to be at 45 degrees F and a sign had been placed on the door which read, "do not use- we have put a work order in for repair."

On 7/15/19 at 3:40pm the dietary manager stated, "I moved the eggs to the bottom shelf and put the dented cans to the dented can area to not be used."

Review of the Refrigerator temperature log for the 2 door cooler revealed temperature recordings for 7/14/19 of 35 degrees F, 37 F and 38 F. On 7/15/19 the following temperatures were recorded: "34 degrees F, 36 degrees F, 46 degrees F" which included a entry that read, "out service [sic] work order for repair."

Review of the facility policy titled "Refrigerated and Frozen Food" with an effective date of 9/14/18 read, "All refrigerated food shall be stored

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in sealed/closed containers, labeled, indicating the name of the product and use-by-date." The policy also read, "place foods in the following order on shelves in the refrigerator: Raw poultry: bottom shelf".

Review of the facility policy titled "Refrigerator and Freezer Temperatures" with an effective date of 9/14/18 read that the refrigerator temperatures are to be 41 degrees F or less.

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, page 72 read "Preventing Food and Ingredient Contamination: Food shall be protected from cross contamination by: separating raw animal foods during storage." "Except when combined as ingredients, separating types of raw animal foods from each other such as beef and poultry during storage by: b. arranging each type of food in equipment so that cross contamination of one type with another is prevented."

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.12, pages 73-74 stated: "Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food service establishment, shall be identified with the common name of the food."

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-304.14, page 77 stated: "cloths in-use for wiping counters

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F 812	Continued From page 184 and other equipment surfaces shall be: held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114" No further information was provided.	F 812		
F 841 SS=J	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility has failed to ensure the Medical Director has coordinated medical care in the facility and implemented resident care policies for one resident (Resident #5) in a survey sample of 46 Residents, resulting in harm for Resident #5. Immediate Jeopardy was identified on 8/6/19 at 6:17pm and the facility was notified. After verification, Immediate Jeopardy was abated on 8/7/19 at 6:55pm and the scope and severity was lowered to level three, isolated. The findings included; 1. For Resident #5, the facility staff failed to ensure the Medical Director has coordinated	F 841	1. Resident # 5 □ No longer resides in the facility. 2. All resident with pressure ulcers are at risk 3. Administrator or designee will educate medical director on coordination of care specific to pressure ulcer. 4. Administrator or designee will review residents seen by wound care physician weekly to ensure medical director has coordinated appropriate medical care. 5. Date of compliance is September 21st,2019	9/21/19

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medical care, resulting in harm.

Resident #5 was admitted to the facility on 1-29-19. Diagnoses included; vertigo, chronic kidney disease, dementia, benign prostatic hypertrophy, stroke, hypertension, congestive heart failure. and chronic Foley catheter.

Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4-26-19. The Resident was coded with mild cognitive impairment, and no aberrant behaviors. Resident #5 required extensive assistance to total dependence on one to two staff members, for activities of daily living care. The Resident was coded as not having any pressure ulcers at the assessment time, nor on admission. The Resident had a long standing Foley catheter (urine drainage) due to an obstruction, and was incontinent of bowel. The Resident was coded as at risk for pressure sores.

At area M-0100 through M-1200 under the MDS skin conditions section of the assessment, the Resident was coded to be at risk for pressure ulcers, had no pressure ulcers, and had no other skin problems such as rashes, and or moisture associated skin damage.

A wound observation occurred on 7-16-19 at 11:30 a.m., with Licensed practical nurse C (LPN C), and Certified nursing assistant N (CNA N). The nurse removed the bandage from the Resident's coccyx. The 4 inch by 4 inch single bandage had a solid center in it which was a tan telfa like non-adherent 2 inch by 2 inch square. The outer circumference of the square bandage was surrounded by a boarder of adherent

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malleable stretchy tape, reminiscent of Band-Aid fabric. There was no packing or medicated cream in the hollow wound. Immediately after removing the dressing a green purulent discharge was seen. The wound was circular, and deep with full muscle tissue loss and bone protrusion clearly visualized and palpated by the nurse. The wound had undermined and tunneled circumferentially around, only under the circular rolled wound edges. There was also noted yellow tan slough and black necrotic tissue inside the wound, and silvery white fascia could be seen covering the coccygeal bone protrusion. The LPN measured the wound with a long cotton swab and a wound measuring disposable paper tape. She measured the cotton swab after it was laid on the wound, and placed in the wound for an accurate measurement. The wound measured 2 centimeters (cm) long, 1.5 cm wide, and 1.5 cm deep. The exterior wound edges were rolled (epibole). The Resident was pre-medicated with pain medication and stated he felt no pain as the wound was measured.

Nursing progress notes were reviewed from wound identification to the time of survey. No notes describe any pressure ulcer identification, treatments, assessments for pressure ulcers, or changes to the care plan for Resident #5 after the first identification of the wound on 4-29-19. The initial note described the pressure injury as a red bruise with open skin, and the skin evaluation document of 4-29-19 gave further measurements.

Physician's orders and Medication and Treatment Administration Records (MAR's/TAR's) were reviewed and revealed no physicians order for prevention of pressure sores from bowel

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incontinent episodes such as an incontinence barrier cream. Only the following 4 orders appeared after the pressure sore developed for the sacral coccyx acquired pressure ulcer treatment;

1. Ordered 4-29-19 start 4-29-19 discontinued 7-8-19 Clean open area to sacrum with normal saline and apply betadine twice per day at morning and bedtime. No dressing. No change to this order occurred after 2.5 months without healing.

2. Ordered 6-3-19 start 6-4-19 discontinued 7-9-19 Clean wound with normal saline & apply Vasolex ointment to coccyx wound topically once per day & as needed with allevyn dressing.

3. Ordered 7-10-19 start 7-10-19 discontinued 7-16-19 Cleanse sacrum/coccyx with normal saline apply intrasite gel (hydrogel water gel to keep wound bed moist) and cover with coversite once every day.

4. Ordered 7-16-19 start 7-17-19 Cleanse sacral wound with saline, apply iodoform (iodine impregnated gauze for packing into a hole) and cover area with coversite one time per day, after the examination by surveyors and an LPN, and was not ordered to be administered until the following day (7-17-19) further delaying care.

Review of the MAR/TAR's revealed that the pressure sore treatments that were ordered as above, were not administered on 5/18, 5/24, 6/4, 6/10, 6/20, 6/26, 7/8, and 7/9/19. No nursing notes reveal the reason for the omissions.

It is of note to mention that the "Vasolex" ointment

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ordered on 6-3-19 was a debridement agent. Debridement is the removal of dead and damaged tissue from a wound. This can be completed by surgical/cutting out removal, or chemical enzyme/liquefying of dead tissue to remove it. Resident #5's "skin wound evaluation" documents on that date show no necrotic/dead tissue in need of debridement.

An interview was conducted via telephone with the Resident's physician (who was also the facility medical director) and all surveyors present on 7-16-19 at 6:45 p.m. The doctor stated he had seen the Resident on 7-15-19 between the hours of 7:00 a.m., to 8:00 a.m. He stated that he was aware the Resident had a wound, and had reviewed the recent nursing notes which stated the Resident had a stage 2 pressure sore, and so in his progress note dated 7-15-19, he wrote a stage 2 sacral decubitus. The nursing notes were reviewed from the doctor's previous visit of 6-22-19, none stated the Resident had a stage 2 decubitus ulcer. The doctor was informed that an RN surveyor had assessed the wound this morning (7-16-19), and he was asked if he had been made aware of the findings. He stated "No." The doctor was asked if he evaluated the wound, and he stated "it looked like a stage 2 when I saw him, but I was interested in the shingles, my focus was not the wound." The surveyors asked if he could describe the wound, and he stated "it was on his coccyx area."

The doctor was asked if a debridement agent would be used for a stage 2 decubitus ulcer which had no eschar, and he stated "No.", The doctor went on to say, "but he has been in failing health for several months with heart disease which is an obvious factor for skin integrity, and

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we don't need to aggressively treat as the prognosis is poor."

The doctor stated that the Resident was also losing weight and nutrition was an issue, with mineral loss. The doctor was asked why minerals and supplements had not been ordered as a replacement to mitigate this, and if that would be of value. The doctor stated yes it would be of value, but due to his age and failing health the Resident was supportive care at this stage and his overall prognosis was poor.

The physician was asked why a Resident, regardless of age, who was ambulatory and recovering from a hospitalization and receiving aggressive occupational and physical therapy within the past few months would not be treated for a pressure wound. The doctor repeated "I didn't go into the detail of the wound, and chose to look at the nursing notes. The doctor was asked why none of his progress notes discuss evaluation of the wound until this last note yesterday, and he responded that the Resident's "prognosis was poor, and I thought he had shingles, but probably just heat rash, I was not there to see the decubitus."

The DON was requested to supply surveyors with all policies for skin assessments and pressure ulcers. The DON, and Corporate RN supplied 2 facility policies on skin assessments and pressure ulcers. They are as follows;

1. "Pressure ulcers Manual" - "Skin Assessment"
Skin assessments will be completed for all patients. A licensed nurse will ensure that the skin risk assessment is done upon admission, and quarterly thereafter. A skin assessment will

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also be completed upon re-entry to the center (i.e., after ER visit, dialysis, etc.) The weekly skin assessment will be completed thereafter. Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs.

2. "Pressure ulcers Manual" - "Pressure Ulcer monitoring &" A licensed nurse will assess patients for the presence of pressure ulcers: if a pressure ulcer is present, the nurse will evaluate for complications. Provide pain management prior to pressure ulcer treatment as indicated. The wound record will be completed weekly by a licensed nurse for any patient with pressure ulcers. There will be a wound record for each site.

The Administrator, DON, and the Registered Nurse (RN) Regional Consultant were made aware of the harm level deficiency at the end of day debrief on 7-16-19. No further information was supplied by the facility.

The facility presented the following plan to remove the Immediate Jeopardy:

F841
Identification of those residents were the Medical Director failed to coordinate medical care in the center and ensure timely and appropriate treatment for wound management

Resident #5's Medical Director failed to coordinate medical care in the center and ensure timely and appropriate treatment for wound management. Current Acting Medical Director,

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F 841	Continued From page 191 Dr. [redacted] , notified on 8/6/19 of negligence from lack of oversight. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice Acting Medical Director, Dr. [redacted] has been notified on 8/6/19 of Medical Director Responsibilities: those responsibilities are as follows 1. Directing and Coordinating care in the center 2. Coordinating Physical Exams, which also includes skin assessment, documenting all assessments in patient clinical record with current treatment plan. 3. Participates in Policy, Procedures and Guidelines to oversee comprehensive care of patients 4. Participates in Resident Care Management 5. Improves Performance of Medical Services within the center 6. Participates in QAPI process	F 841		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/21/19

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F 880	Continued From page 192 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 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 193 §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, resident interview, staff interview, facility documentation review and clinical record review the facility staff failed to transport linens so as to prevent the spread of infection and failed to store medical respiratory equipment in a manner to prevent the development and transmission of communicable diseases and infections concerning linens and 7 Residents (Resident #58, Resident #79, Resident #95, Resident #92, Resident #3, Resident #68, Resident #503 in a survey sample of 46 Residents. The findings included: 1. The facility staff failed to transport linens so as to prevent the spread of infections. On 07/15/19 at 11:20 AM observed soiled linen cart outside of room 320 overflowing with soiled linen to the extent that lid would not close. On 07/15/19 at 11:24 AM CNA H was observed to pushed soiled linen cart, which contained	F 880	1. Linen storage has been corrected Resident # 58 □ Oxygen tank changed. Resident # 79 □ Nebulizer changed. Resident # 95 □ No longer resides in the facility. Resident # 92 □ Nebulizer changed. Resident # 3 □ No longer resides in the facility. Resident # 68 □ Nebulizer changed. Resident # 503 □ No longer resides in the facility. 2. 2a) All residents are at risk of infection control through linen transport and storage. 2b) Residents who receive respiratory therapy ie: Nebulizer and oxygen therapy are at risk. 3. The Nurse Educator or Designee will educate all staff on appropriate storage of respiratory equipment and transporting	

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F 880	Continued From page 194 soiled linen which was overflowing from the top and the lid was not closed, the entire length of the 300 hall. During this transport CNA H passed 21 rooms, many of which were dually occupied. On 7/15/19 an interview was conducted with the Director of Nursing (DON). When the DON was asked how soiled linen should be transported she indicated with the lid closed on the soiled linen cart. Review of the facility policy titled "Standard Precautions" with an effective date of 12/26/17 read, "Linen. Handle, transport and process used linen that avoids transfer of microorganisms to other patients and environment, i.e., placed in appropriate designated plastic bag and closed prior to removing from room and/or sending done chute." No further information was provided. 2. For Resident #58 the facility staff failed to store respiratory equipment in a manner to prevent the development and transmission of communicable diseases and infections while not in use. Resident #58 was admitted to the facility on 6/13/19. The Resident's diagnoses included but were not limited to: cerebral infarction due to embolism of right middle cerebral artery and obstructive sleep apnea. On 7/14/19 at approximately 4:33pm it was observed that Resident #58's nebulizer and c-pap machine masks were laying open to air (not in a bag).	F 880	linen. 4. A. The DON or Designee will audit 10% of residents who receive respiratory therapy to ensure proper storage. 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process. B. The DON or Designee will audit rounds to ensure proper storage and transport of linen 3x a week for 2 weeks, then weekly for 2 weeks than monthly x 2 through QAPI process 5. Date of Compliance is September 21st, 2019	

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F 880	Continued From page 195	F 880		

On 07/15/19 at 11:21 AM Resident #58's c-pap mask was noted at the bedside, mask was on table (not in a bag) with dried food on the outside of mask.

On 07/15/19 at 05:23 PM Resident #58's c-pap was noted on the bedside table, open to air, not in a bag.

On 7/15/19 an interview was conducted with the DON. When asked her expectation for the storage of any respiratory equipment such as c-pap masks, nebulizer masks, etc. when not in use, the DON stated, "they are to be stored in a bag."

Review of the facility policy titled "Respiratory/Oxygen Equipment" with an effective date of 8/4/15, under the heading CPAP/BIPAP Set-up Adult, it read, "mask and tubing are to be placed in a bag when not in use." In this same policy under the heading Medicated Nebulizer Treatment the policy stated, "rinse out nebulizer reservoir with tap water, dry and place in a plastic bag when not in use."

No further information was provided.

3. For Resident #79 the facility staff failed to store respiratory equipment in a manner to prevent the development and transmission of communicable diseases and infections while not in use.

Resident #79 was admitted to the facility on 4/19/19. The Resident's diagnoses included but were not limited to: acute and chronic respiratory failure with hypoxia.

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F 880	Continued From page 196 On 7/14/19 at 6:27pm it was observed that Resident #79's nebulizer and bi-pap machine masks were laying open to air (not in a bag). On 7/15/19 an interview was conducted with the DON. When asked her expectation for the storage of any respiratory equipment such as c-pap masks, nebulizer masks, etc. when not in use, the DON stated, "they are to be stored in a bag." Review of the facility policy titled "Respiratory/Oxygen Equipment" with an effective date of 8/4/15, under the heading CPAP/BIPAP Set-up Adult, it read, "mask and tubing are to be placed in a bag when not in use." In this same policy under the heading Medicated Nebulizer Treatment the policy stated, "rinse out nebulizer reservoir with tap water, dry and place in a plastic bag when not in use." No further information was provided. 4a. For Resident #95 the facility staff failed to store respiratory equipment in a manner to prevent the development and transmission of communicable diseases and infections while not in use. Resident #95 was admitted to the facility on 6/19/19. The Resident's diagnoses included but were not limited to: obstructive sleep apnea. On 7/14/19 at approximately 4:35pm it was observed that Resident #95's c-pap machine mask was laying open to air (not in a bag).	F 880		

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On 7/15/19 an interview was conducted with the DON. When asked her expectation for the storage of any respiratory equipment such as c-pap masks, nebulizer masks, etc. when not in use, the DON stated, "they are to be stored in a bag."

Review of the facility policy titled "Respiratory/Oxygen Equipment" with an effective date of 8/4/15, under the heading CPAP/BIPAP Set-up Adult, it read, "mask and tubing are to be placed in a bag when not in use."

No further information was provided.

4b. For Resident #95 the facility staff failed to ensure foley catheter tubing and urine collection bag are maintained in a manner to prevent the development and transmission of communicable diseases and infections.

Resident #95 was admitted to the facility on 6/19/19.

On 7/15/19 Resident #95 was observed in the therapy gym, sitting in a wheel chair with his foley catheter tubing and urine collection bag touching the floor.

On 7/15/19 an interview was conducted with the DON and when asked about a foley catheter she indicated that they should not touch the floor.

No further information was provided.

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5. For Resident #92 the facility staff failed to maintain infection control by not storing and labeling nebulizer equipment properly.

Resident #92 an 84 year old man admitted to the facility on 6/25/19 with diagnoses of but not limited to respiratory failure, congestive heart failure, COPD (chronic obstructive pulmonary disease) and acute kidney failure.

On 7/15/19 at 9:00 AM observed Nebulizer sitting on bedside table tubing was laying on the table with the mouth piece neither was dated or tabled in any way.

On 7/15/19 at 9:03 AM in an interview with Employee B who was asked if she knew when the tubing was last changed, she looked at the tubing and said she could not tell. When asked the procedure for changing them she stated. The tubing was changed on either evening or night shift three days a week. She indicated she was not sure which days or shifts for certain however she stated it comes up on the computer to remind you when to do it.

On 7/16/19 at 9:20 AM in an interview with the DON she was asked how the Nebulizer tubing was stored, she stated that they were kept at the bedside in a bag attached to the Nebulizer machine.

When asked how often they were changed and how you would know if they were changed she stated they were tabled and dated on the bag. When asked the importance of changing out the tubing and storing it in the bag she stated to prevent infection and keep it clean.

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On 7/16/19 during the end of day meeting the Administrator was notified of the findings and no further information was provided.

6. For Resident # 3 the facility staff failed to maintain infection control by not changing out tube feeding bag and tubing and syringe every 24 hours.

Resident #3 a 78 year old woman was admitted to the facility on 7/4/14 with diagnoses of but not limited to Hemiplegia, aphasia, dementia without behaviors, CVA (Stroke), Dysphagia and Gastroesophageal Reflux. Resident #3's most recent MDS (Minimum Data Set), dated 4/26/19 and coded as an OBRA Quarterly Review, codes the Resident as having a BIMS (Brief Interview of Mental Status) score of 99 indicating she is unable to be assessed. Due to Dysphagia Resident is dependent on G-Tube feedings for nutrition.

On 7/14/19 at approximately 5:45 PM Resident # 3 was observed lying in bed. Beside the bed was an IV pole and the tube feeding bag and syringe were hanging up dated for 7/12/19.

On 7/15/19 during the clinical record review it was noted that the physicians order for the tube feeding for Resident #3 read:
Jevity 1.2 - Give 237 ML 4 times a day via gravity feed.

According to the facility policy for tube feeding

#8 - Syringes are to be changed daily with proper labeling identification to include the patient's,

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F 880	Continued From page 200 name, date, and time. On 7/16/19 at 9:25 AM in an interview with the DON she was asked how the tube feeding equipment was stored, she stated that the syringe was kept in a bag with the name and date written on it usually hanging on the IV pole and the syringe was changed every night. The tubing was changed every 24 hours as well usually on night shift. When asked the importance of changing out the tubing and syringe every 24 hours she stated to prevent infection and keep it clean. On 7/16/19 during the end of day meeting the Administrator was notified of the findings and no further information was provided. 7. For Resident # 68, the facility failed to cover and date the Nebulizer mask and tubing. Resident # 68 was an 91 year old female admitted to the facility on 03/22/2019 with diagnoses of but not limited to Fracture of right femur, hypertension, atrial fibrillation and wheezing. Most recent (Minimum Data Set) MDS was a quarterly assessment with an (Assessment Reference Date) ARD of 6/24/2019 coded Resident as having a (Brief Interview of Mental Status) BIMS score of 9 indicating Severe Cognitive Impairment. On 7/14/2019 during initial tour of facility at 4:45	F 880		

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PM, Resident # 68 was noted to be lying in bed. On the nightstand next to her bed was a Nebulizer mask with tubing attached that was uncovered and not labeled or dated.

On 7/15/2019 at 10:14 AM, Nebulizer mask was noted on the night stand, uncovered and not dated.

On 7/16/2019 at 11:14 AM, a Nebulizer Mask was noted on the night stand and was covered in a bag and dated 7/15/19.

On 7/16/19 at 2 PM, an interview was conducted with the Director of Nursing who stated the facility policy is to change the nebulizers every Monday, Wednesday and Friday. The Director of Nursing stated it was important to keep the nebulizer covered because of the potential spread of infection.

During the debriefing with Administrative staff on 7/16/2019 at 5:30 PM, the Administrator, Director of Nursing, and Corporate Nursing Consultant (Employee E) were informed of the findings.

The Corporate Consultant and Director of Nursing stated the expectation was to keep Nebulizers covered in a bag, labeled and dated.

No further information was provided.

8. For Resident # 503, the facility failed to change the Nebulizer mask and tubing after 7/5/19.

Resident # 503 was a 92 yr old female admitted to the facility on 6/28/2019 with diagnoses of but

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not limited to Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Heart Failure and Chronic Kidney Disease Stage 3.

Resident # 503's most recent (Minimum Data Set) MDS was an Admission Assessment with an (Assessment Reference Date) ARD of 7/12/2019. The MDS coded her has having a (Brief Interview of Mental Status) BIMS Score of 15 out of 15, indicating no cognitive impairment.

On 7/14/2019 during initial tour of facility at 3:45 PM, Resident # 503 was noted to have an oxygen canister with nasal cannula and a nebulizer tubing set up at the bedside. The oxygen tubing and humidifier were dated 7/14/2019.

Resident #503 had a nebulizer mask with tubing connected in a bag sitting on the bedside table. The date on the bag was 7/5/19.

On 7/15/19, the nebulizer mask was noted on the bedside table in a bag dated 7/5/19.

On 7/16/19 at 11:00 AM, observed the nebulizer mask was on the bedside table in a bag and the dated 7/15/19.

Review of clinical record revealed an order dated 7/1/2019 for "Nebulizer tubing set change M-W- F (Monday- Wednesday- Friday) every night shift for Shortness of Breath/Wheezing.

On 7/16/19 at 2 PM, an interview was conducted with the Director of Nursing who stated the facility policy is to change the nebulizers every Monday, Wednesday and Friday. The Director of Nursing stated it was important to change the nebulizers and keep them covered to prevent the potential

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F 880	Continued From page 203 spread of infection. During the debriefing with Administrative staff on 7/16/2019 at 5:30 PM, the Administrator, Director of Nursing, and Corporate Nursing Consultant (Employee E) were informed of the findings. The Corporate Consultant and Director of Nursing stated the expectation was to change the Nebulizers every Monday, Wednesday and Friday and keep them covered in a bag, labeled and dated. The DON stated the date on the bag would indicate the date the nebulizer was changed. No further information was provided.	F 880		