STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495371	A. BUILDING _____ B. WING _____	C 11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL-RICH CREEK	120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 11/04/19 through 11/05/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 120 at the time of the survey. The survey sample consisted of 2 current Resident reviews and 1 closed record review.	F 000	**F658** **Corrective Action(s):** Resident #1's attending physician has been notified that facility staff failed to follow manufacturer's guidelines in placement of the sponge during use of NPWT. A facility incident and accident report was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving NPWT may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of all residents receiving NPWT to identify those at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. Licensed nursing staff have been inserviced on the manufacturer's guidelines regarding sponge placement during NPWT. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will complete NPWT dressing change at least every other week when residents with NPWT (dressings changed by facility staff) are residing at the facility. Any/all negative findings will be corrected at time of discovery and disciplinary action taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** December 10, 2019.	
F 658 SS=D	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: Based on Resident interview, staff interview, clinical record review, and facility document review the facility staff failed to follow professional standards of practice for the use of a NPWT (negative pressure wound therapy) device for 1 of 3 residents, Resident #1. The findings included: For Resident #1 the facility staff failed to follow manufacturer's guidelines for the placement of wound vac sponge. Merriam-Webster medical dictionary describes NPWT as a method of drawing out fluid and infection from a wound to help it heal. A special dressing is placed over the wound and a gentle	F 658		

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

Administrator 11-24-19

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

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F 658	Continued From page 1 vacuum pump is attached. Resident #1's face sheet listed an admission date of 06/24/19 and a readmission date of 08/21/19. The diagnosis list included diagnoses of, but not limited to polyneuropathy, type 2 diabetes mellitus, non-pressure chronic ulcer unspecified part of R (right) lower leg, L (left) below the knee amputation. Resident #1's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/10/19 assigned the resident a BIMS (brief interview for mental status) of 15 out of 15 in section C, cognitive status. Resident #1's comprehensive care plan was reviewed and contained a care plan for "pressure ulcers: ....is at risk for skin breakdown related to DM (diabetes mellitus) and poor mobility, he was admitted with a surgical wound to left stump with sutures intact..kerlix and ace bandage daily....". This care plan was initiated on 07/02/19. Interventions for this care plan include "08/08/19 wound vac to left stump. This care plan was updated on 10/10/19 to read "pressure ulcers: is at risk for skin breakdown related to DM and poor mobility, wound vac to left stump". Interventions updated to include "wound vac as ordered". The orders section of the resident's paper clinical record was reviewed on 11/04/19. It contained a "Doctor's Order Sheet" dated 08/08/19, which read in part "Wound was debrided today. SNAP VAC applied today. Please apply NPWT vac on Saturday (08/10/19). Setting should be continuous at 125 mmhg. Change 3 x week. SNAP VAC can be thrown away on Sat. Any questions call ....(phone number omitted) or .... if	F 658		

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F 658	Continued From page 2	F 658		

on weekend. Return in 2 weeks on 08/22/19 @ 10 AM". This order was signed by the wound care physician.

According to WoundSource.com, a SNAP VAC is a mechanically powered, disposable NPWT system.

Surveyor requested notes from the wound care clinic and was provided these notes on 11/05/18. The initial consultation note from the wound care clinic dated 08/08/19 read in part, "Assessment and Plan: Left BKA (below knee amputation) residual limb wound, debridement today then placed Snap vac, then plan to begin KCI (brand of wound vac) vac ASAP (as soon as possible), changed thrice weekly....RTC (return to clinic 2 weeks, sooner if concerns".

The wound clinic note for 10/08/19 read in part, "Assessment and Plan: ... And yet again vac is applied poorly, with granufoam directly to intact skin, about which the facility is contacted again..." The wound clinic note for 10/29/19 read in part, "Wound care orders are as follows per provider: clean wound with soap and water, rinse well, protect peri wound with na, wound is dressed from wound bed layer to outer dressing with: 1 piece black foam to wound bed drape, track pad, good seal obtained at 125 mmhg, dressing change 3 times a week. Comments: .... (name omitted) Ombudsman for the state of Virginia notified of continued failure of facility to place NPWT appropriately. Call was made to facility asking to speak with director of nursing or with administrator, we were told both were in a meeting and unavailable".

Surveyor spoke with wound care physician on

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11/04/19 at approximately 2:40 PM. Surveyor asked physician if he was currently treating Resident #1 at the wound clinic and he stated that he was treating resident for a BKA with non-healing wound. Physician stated that he had encountered some problems with the facility incorrectly placing the foam used in the wound vac, by placing on healthy skin, as well as the wound. Physician also stated that there had been some issues with the functioning of the wound vac pump. The physician stated that he had offered to have someone come to the facility to teach the staff about the wound vac, but the facility had denied this until 10/30/19. Surveyor asked to the physician if he had contacted the facility regarding these issues and he stated that he had contacted the director of nursing twice.

Surveyor spoke with the wound care physician again on 11/05/19 at approximately 8:25 AM. Surveyor asked the physician how long he had been treating Resident #1 and the physician stated that he had been treating the resident for the current problem since 08/08/19. Physician stated that he specifically wanted the KCI brand wound vac to be used, but the facility had been using a Cardinal Health brand..

Surveyor spoke with Resident #1 on 11/05/19 at approximately 7:55 AM. Resident #1 stated they put a new wound vac on when he went to the wound clinic last time (10/30/19). Resident #1 stated he had experienced several issues with the previous wound vac not working correctly, but when he voiced concern to the facility staff they told him it was working right. Resident #1 stated that he had told the nurses doing his dressing changes that they were cutting the sponge for the wound vac too big, but they told him they knew

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F 658	Continued From page 4	F 658		

what they were doing.

Surveyor spoke with nurse from the wound clinic on 11/05/19 at approximately 9:30 AM. Wound clinic nurse stated Resident #1 was initially seen in the clinic on 08/08/19 for debridement of the wound and placement of the temporary SNAP vac. Surveyor asked the wound clinic nurse if there had been problems with the facility not doing the dressing changes as ordered, and wound clinic nurse stated that she had received a call from Resident #1, where he stated that the facility staff was not doing the dressing correctly. Wound clinic nurse also stated there was an ongoing issue with the wound dressing sponge not being placed correctly in the wound.

Surveyor spoke with the DON (director of nursing) on 11/05/19 at approximately 11:10 am regarding Resident #1. Surveyor asked the DON if she was aware of any issues with Resident #1's wound vac. DON stated that she had been told the wound care clinic had said the sponge for the dressing had been cut too big. Surveyor asked DON if anyone from the wound care clinic had contacted her regarding ongoing problems with Resident #1's wound vac dressings. DON stated she had received a message last week (week of 10/28-11/01/19) to call the wound care physician. DON stated she returned the call, but never spoke with wound care physician. DON stated she called the clinic and spoke with a nurse. Surveyor asked the DON why the facility was using the Cardinal brand of wound vac system vs. the KCI system, and DON stated, "That's just the provider we use".

Surveyor spoke with the facility administrator on 11/05/19 at approximately 12:30. Surveyor asked

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the administrator if he was aware of any issues with Resident #1's wound care. Administrator stated that he was made aware from the local ombudsman that the wound clinic had reached out to her with concerns of the wound vac not being placed correctly. Administrator stated that he called the wound clinic on 10/31/19 and spoke with wound care nurse at the clinic. Administrator stated that wound care nurse said that there had been some issues with previous dressings, but current dressing (from appointment on 10/29/19) showed improvement/effort.

The surveyor requested and was provided with the manufacturer's guidelines for the Cardinal Health wound vac system which read in part, "3.1 Applying the Dressing: 6. Take measurements of the wound dimensions and note wound type. Select the appropriate foam based on wound assessment. Cut the Cardinal Health NPWT foam dressing to a size that is appropriate for the wound. 7. Place the Cardinal Health NPWT foam dressing in the wound site taking care to avoid contact with the peri-wound skin. Note: The Cardinal Health NPWT foam dressing should cover the entire wound base, including tunneling and undermining. However, the Cardinal Health NPWT foam dressing should not be in contact with intact skin."

The concern of the facility staff not following the manufacturer's guidelines for the placement of the wound vac sponge was discussed with the administrative staff (administrator, DON, regional nurse consultant) during a meeting on 111/0519 at approximately 3:45 PM.

No further information was provided prior to exit.

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F 658 F 684 SS=D	Continued From page 6 THIS IS A COMPLAINT DEFICIENCY. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident interview, clinical record review, facility document review and in the course of a complaint survey the facility staff failed to provide care and treatment to meet the needs of the resident for 1 of 3 residents, Resident #1. The findings included: For Resident #1 the facility staff failed to follow physician's orders for the use of NPWT (negative pressure wound therapy). Merriam-Webster medical dictionary describes NPWT as a method of drawing out fluid and infection from a wound to help it heal. A special dressing is placed over the wound and a gentle vacuum pump is attached. Resident #1's face sheet listed an admission date on 06/24/19 and a readmission date of 08/21/19. The diagnosis list included diagnoses of, but not limited to polyneuropathy, type 2 diabetes	F 658 F 684	**F684** **Corrective Action(s):** Resident #1's attending physician has been notified that facility staff failed to provide physician ordered care and treatment. A facility incident and accident report was completed for this incident **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving NPWT may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of all residents receiving NPWT to identify those at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. Licensed nursing staff have been inserviced on following physician orders for residents receiving NPWT. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will review all physician ordered NPWT interventions at least every other week when residents with NPWT (dressings changed by facility staff) are residing at the facility. Any/all negative findings will be corrected at time of discovery and disciplinary action taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** December 10, 2019	

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F 684	Continued From page 7 mellitus, non-pressure chronic ulcer unspecified part of R (right) lower leg, L (left) below the knee amputation. Resident #1's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/10/19 assigned the resident a BIMS (brief interview for mental status) of 15 out of 15 in section C, cognitive status. Resident #1's comprehensive care plan was reviewed and contained a care plan for "pressure ulcers: ...is at risk for skin breakdown related to DM (diabetes mellitus) and poor mobility, he was admitted with a surgical wound to left stump with sutures intact. Kerlix and ace bandage daily...." This care plan was initiated on 07/02/19. Interventions for this care plan include "08/08/19 wound vac to left stump. This care plan was updated on 10/10/19 to read "pressure ulcers: is at risk for skin breakdown related to DM and poor mobility, wound vac to left stump". Interventions updated to include "wound vac as ordered". The orders section of the resident's paper clinical record was reviewed on 11/04/19. It contained a "Doctor's Order Sheet" dated 08/08/19, which read in part "Wound was debrided today. SNAP VAC applied today. Please apply NPWT vac on Saturday (08/10/19). Setting should be continuous at 125 mmhg. Change 3 x week. SNAP VAC can be thrown away on Sat. Any questions call ....(phone number omitted) or .... if on weekend. Return in 2 weeks on 08/22/19 @ 10 AM". This order was signed by the wound care physician. According to WoundSource.com, a SNAP VAC is a mechanically powered, disposable NPWT	F 684		

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F 684	Continued From page 8 system. The orders section of the resident's paper clinical record also contained a handwritten physician's telephone order dated 08/13/19 at 2 pm, which read in part, "1) DC wound vac 125 mmhg 2) Wound vac to Left stump at 120 mmhg continuous. Change Tue-Thur-Sat and prn (as needed) 3) Monitor wound vac to left stump @ 120 mmhg continuous Q (every) shift". The orders section of the paper record also contained a handwritten physician's telephone order dated 08/13/19 at 3 pm, which read in part, "4) Hold wound vac until 8/20/19 then reapply wound vac to left stump. 5) Wet to dry NS (normal saline) dressing to left stump QD (every day) until 8/20/19". LPN (licensed practical nurse) #1 wrote both of these orders. The second of these orders indicated it was a voice order from the wound clinic nurse. The progress notes section of Resident #1's electronic clinical record was reviewed on 11/05/19. It contained a nurse's progress note dated 08/08/19, which read in part, "1:41 PM Resident returned from appointment with wound clinic at 1200 hours alert and verbal. Orders for wound vac at 125 mmhg settings continous (sic) and change 3 times a week...". The electronic clinical record also contained a nurse's progress note dated 08/13/19, which read in part, "2:41 PM 10 AM new order received -1) DC (discontinue) wound vac 125 mmhg, 2) Wound vac to left tum at 120 mmhg continuous. Change Tue-Thurs-Sat and PRN (as needed), 3) Monitor wound vac to left stump at 120 mmhg continuous q (every) shift. New dressing applied to left stump, slough tissue noted in wound bed."	F 684		

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F 684	Continued From page 9	F 684		

Surveyor requested notes from the wound care clinic and was provided these notes on 11/05/18. The initial consultation note from the wound care clinic dated 08/08/19 read in part, "Assessment and Plan: Left BKA (below knee amputation) residual limb wound, debridement today then placed Snap vac, then plan to begin KCI (brand of wound vac) vac ASAP (as soon as possible), changed thrice weekly....RTC (return to clinic 2 weeks, sooner if concerns".

The wound clinic note for 09/10/19 read in part, "Wound care orders are as follow per above provider: clean wound with soap and water, rinse well. Protect peri wound with na, Wound is dressed from wound bed layer to outer dressing with: Dakins wet to dry applied today as facility did not supply wound VAC supplies. Wound VAC to be restarted upon return to facility at 125 mmhg, dressing change frequency: 3 times a week...".The wound clinic note for 09/24/19 read as previous note.

The wound clinic note for 10/08/19 read in part, "Assessment and Plan: ... And yet again vac is applied poorly, with granufoam directly to intact skin, about which the facility is contacted again..." The wound clinic note for 10/29/19 read in part, "Wound care orders are as follows per provider: clean wound with soap and water, rinse well, protect peri wound with na, wound is dressed from wound bed layer to outer dressing with: 1 piece black foam to wound bed drape, track pad, good seal obtained at 125 mmhg, dressing change 3 times a week. Comments: .... (name omitted) Ombudsman for the state of Virginia notified of continued failure of facility to place NPWT appropriately. Call was made to facility asking to speak with director of nursing or with

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administrator, we were told both were in a meeting and unavailable".

Surveyor spoke with wound care physician on 11/04/19 at approximately 2:40 PM. Surveyor asked physician if he was currently treating Resident #1 at the wound clinic and he stated that he was treating resident for a BKA with non-healing wound. Physician stated that he had encountered some problems with the facility incorrectly placing the foam used in the wound vac, by placing on healthy skin, as well as the wound. Physician also stated that there had been some issues with the functioning of the wound vac pump. The physician stated that he had offered to have someone come to the facility to teach the staff about the wound vac, but the facility had denied this until 10/30/19. Surveyor asked to the physician if he had contacted the facility regarding these issues and he stated that he had contacted the director of nursing twice.

Surveyor spoke with the wound care physician again on 11/05/19 at approximately 8:25 AM. Surveyor asked the physician how long he had been treating Resident #1 and the physician stated that he had been treating the resident for the current problem since 08/08/19. Surveyor asked the physician what the setting on the wound vac were to be set on, and the physician stated that the setting is to be 125 mmhg, surveyor asked the physician if he had ever given the facility an order to decrease the wound vac setting to 120 mmhg, and he stated that he had not, and that he wanted the setting to be 125 mmhg for the duration of the treatment. Physician stated that he specifically wanted the KCI brand wound vac to be used, but the facility had been using a different brand. Surveyor asked the

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wound care physician if he was aware that the settings on the wound vac had been decreased to 120 mmhg, and he stated that he was not.

Surveyor spoke with Resident #1 on 11/05/19 at approximately 7:55 AM. Resident #1 stated they put a new wound vac on when he went to the wound clinic last time (10/30/19). Resident #1 stated he had experienced several issues with the previous wound vac not working correctly, but when he voiced concern to the facility staff they told him it was working right. Resident #1 stated that he had told the nurses doing his dressing changes that they were cutting the sponge for the wound vac too big, but they told him they knew what they were doing.

Surveyor spoke with nurse from the wound clinic on 11/05/19 at approximately 9:30 AM. Wound clinic nurse stated Resident #1 was initially seen in the clinic on 08/08/19 for debridement of the wound and placement of the temporary SNAP vac. Wound clinic nurse stated the facility was to replace the temporary vac on 08/11/19 with one supplied by the facility, but the facility had a problem obtaining a wound vac, so the SNAP vac was not replaced until 08/13/19. Surveyor asked wound clinic nurse if she gave the facility a telephone order to decrease the setting on the wound vac, and wound clinic nurse stated, "Absolutely not, our standing orders are 125 mmhg". Surveyor then asked wound clinic nurse if she gave the facility an order to discontinue the wound vac and use wet to dry dressings, and wound clinic nurse stated since the facility was having an issue obtaining a wound vac, she obtained an order for them to hold the wound vac and use wet to dry dressings until the resident's next appointment at the wound clinic. Surveyor

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asked the wound clinic nurse if there had been problems with the facility not doing the dressing changes as ordered, and wound clinic nurse stated that she had received a call from Resident #1, where he stated that the facility staff was not doing the dressing correctly. Wound clinic nurse also stated there was an ongoing issue with the wound dressing sponge not being placed correctly in the wound.

Surveyor spoke with LPN #1 on 11/105/19 at approximately 1:20 PM regarding Resident #1. Surveyor asked LPN #1 if she had written the order to change the settings on the wound vac from 125 mmhg to 120 mmhg, and she stated that she had because the settings on the wound vac being used by the facility did not have a setting for 125 mmhg. Surveyor then asked LPN #1 who gave her the order, and she stated that the order came from the wound care clinic. Surveyor then informed LPN #1 that she had spoken with the nurse from the wound care clinic and that wound clinic nurse had stated that she had not given the order to change the settings on the wound vac. LPN #1 stated to surveyor, "Then why would I have numbered the orders 1, 2,3,4,5 if they didn't all come from the same place?".

LPN #1 returned to speak with surveyor on 11/05/19 at approximately 2:10 PM. LPN #1 stated to surveyor that she was mistaken about who gave her the order to change the settings on the wound vac. LPN #1 stated to surveyor that the facility's medical director had given the order to change the setting on the wound vac, due to the wound vac system the facility was using did not have a 125 mmhg setting. LPN #1 stated to surveyor, "I guess I shouldn't have numbered them that way".

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Surveyor spoke with the DON (director of nursing) on 11/05/19 at approximately 11:10 am regarding Resident #1. Surveyor asked the DON if she was aware of any issues with Resident #1's wound vac. DON stated that she had been told the wound care clinic had said the sponge for the dressing had been cut too big. Surveyor asked DON if anyone from the wound care clinic had contacted her regarding ongoing problems with Resident #1's wound vac dressings. DON stated she had received a message last week (week of 10/28-11/01/19) to call the wound care physician. DON stated she returned the call, but never spoke with wound care physician. DON stated she called the clinic and spoke with a nurse. Surveyor asked the DON why the facility was using the Cardinal brand of wound vac system vs. the KCI system, and DON stated, "That's just the provider we use". Surveyor asked the DON if she was aware that the wound care physician had indicated he preferred the KCI system be used, and DON stated, "No one from ... (name omitted) office indicated to use the KCI vac".

Surveyor spoke with the facility administrator on 11/05/19 at approximately 12:30. Surveyor asked the administrator if he was aware of any issues with Resident #1's wound care. Administrator stated that he was made aware from the local ombudsman that the wound clinic had reached out to her with concerns of the wound vac not being placed correctly. Administrator stated that he called the wound clinic on 10/31/19 and spoke with wound care nurse at the clinic. Administrator stated that wound care nurse said that there had been some issues with previous dressings, but current dressing (from appointment on 10/29/19) showed improvement/effort. Administrator stated

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F 684	Continued From page 14 that he spoke with a representative from the KCI company and that they are coming to do inservice with staff on the correct placement of the wound vac. Surveyor requested and was provided with a facility policy entitled "Negative Pressure Wound Therapy" which read in part "General Guidelines: 3. Change dressings per physician orders and manufacturers guidelines. Steps in Procedure: 1. Identify and size the wound to be treated. 6. Cut sponge dressing size: a. Using clean scissors or scalpel, trim the sponge dressing material to a size that is slightly smaller than the wound, and a shape that approximates the wound." The concern of the facility staff not following the physician's orders for the use of NPWT was discussed with the administrative staff (administrator, DON, regional nurse consultant) during a meeting on 11/105/19 at approximately 3:45 PM No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

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F 842	Continued From page 15 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842	F842 **Corrective Action(s):** Resident #1's attending physician has clarified the order which omitted the physician's name. Resident #1's comprehensive plan of care has been updated to reflect their current condition and treatments. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all residents medical records will be conducted by the DON, ADON and/or Unit Managers to identify physician orders in the past 90 days which do not have the prescribing physician's name on them. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on the clinical documentation standards regarding receiving, writing, and transcribing physician orders per facility policy and procedure.. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** December 10, 2019	

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F 842	Continued From page 16 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint survey the facility staff failed to ensure a complete and accurate clinical record for 1 of 3 residents, Resident #1. The findings included: For Resident #1 the facility staff failed to include the name of the prescribing physician on a handwritten telephone order. Resident #1's face sheet listed an admission date on 06/24/19 and a readmission date of 08/21/19. The diagnosis list included diagnoses of, but not limited to polyneuropathy, type 2 diabetes mellitus, non-pressure chronic ulcer unspecified part of R (right) lower leg, L (left) below the knee amputation. Resident #1's most recent quarterly MDS (minimum data set) with an ARD (assessment	F 842		

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reference date) of 10/10/19 assigned the resident a BIMS (brief interview for mental status) of 15 out of 15 in section C, cognitive status.

Resident #1's comprehensive care plan was reviewed and contained a care plan for "pressure ulcers: ...is at risk for skin breakdown related to DM (diabetes mellitus) and poor mobility, he was admitted with a surgical wound to left stump with sutures intact. Kerlix and ace bandage daily...." This care plan was initiated on 07/02/19. Interventions for this care plan include "08/08/19 wound vac to left stump. This care plan was updated on 10/10/19 to read "pressure ulcers: is at risk for skin breakdown related to DM and poor mobility, wound vac to left stump". Interventions updated to include "wound vac as ordered".

The orders section of the resident's paper clinical record contained a handwritten physician's telephone order dated 08/13/19 at 2 pm, which read in part, "1) DC wound vac 125 mmhg 2) Wound vac to Left stump at 120 mmhg continuous. Change Tue-Thur-Sat and prn (as needed) 3) Monitor wound vac to left stump @ 120 mmhg continuous Q (every) shift". The orders section of the paper record also contained a handwritten physician's telephone order dated 08/13/19 at 3 pm, which read in part, "4) Hold wound vac until 8/20/19 then reapply wound vac to left stump. 5) Wet to dry NS (normal saline) dressing to left stump QD (every day) until 8/20/19". LPN (licensed practical nurse) #1 wrote both of these orders. The second of these orders indicated it was a voice order from the wound clinic nurse.

Surveyor spoke with nurse from the wound clinic on 11/05/19 at approximately 9:30 AM. Wound

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clinic nurse stated Resident #1 was initially seen in the clinic on 08/08/19 for debridement of the wound and placement of the temporary SNAP vac. Wound clinic nurse stated the facility was to replace the temporary vac on 08/11/19 with one supplied by them. Surveyor asked wound clinic nurse if she gave the facility a telephone order to decrease the setting on the wound vac, and wound clinic nurse stated, "Absolutely not, our standing orders are 125 mmhg". Surveyor then asked wound clinic nurse if she gave the facility an order to discontinue the wound vac and use wet to dry dressings, and wound clinic nurse stated the facility was having an issue obtaining a wound vac, therefore she obtained an order for them to hold the wound vac and use wet to dry dressings until the resident's next appointment at the wound clinic.

Surveyor spoke with LPN #1 on 11/105/19 at approximately 1:20 PM regarding Resident #1. Surveyor asked LPN #1 if she had written the order to change the settings on the wound vac from 125 mmhg to 120 mmhg, and she stated that she had because the settings on the wound vac being used by the facility did not have a setting for 125 mmhg. Surveyor then asked LPN #1 who gave her the order, and she stated that the order came from the wound care clinic. Surveyor then informed LPN #1 that she had spoken with the nurse from the wound care clinic and that wound clinic nurse had stated that she had not given the order to change the settings on the wound vac. LPN #1 stated to surveyor, "Then why would I have numbered the orders 1, 2,3,4,5 if they didn't all come from the same place?".

LPN #1 returned to speak with surveyor on 11/05/19 at approximately 2:10 PM. LPN #1

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F 842	Continued From page 19 stated to surveyor that she was mistaken about who gave her the order to change the settings on the wound vac. LPN #1 stated to surveyor that the facility's medical director had given the order to change the setting on the wound vac, due to the wound vac system the facility was using did not have a 125 mmhg setting. LPN #1 stated to surveyor, "I guess I shouldn't have numbered them that way". The concern of the facility staff failing to include the name of the prescribing physician on a handwritten telephone order was discussed with the administrative staff (administrator, director of nursing, regional nurse consultant) on 11/105/19 at approximately 3:45 PM. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY.	F 842		

11/24/19