STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	R-C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(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 .	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 06/05/19 through 06/20/19, was conducted 08/13/19 through 08/20/19. An extended survey was conducted 08/14/19 through 08/20/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Four complaints were investigated during the survey. Immediate Jeopardy was identified in the area of Freedom from Abuse and Neglect at a Level 4 Pattern, and Quality of Care at a Level 4 Isolated. The census in this 130 certified bed facility was 98 at the time of the revisit survey. The survey sample consisted of 46 resident reviews.	{F 000}		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. 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 ensure it was determined clinically appropriate to self-administer medications (Voltaren) by the interdisciplinary team for one Resident (Resident #113) in a survey sample of 46 Residents. The findings included:	F 554	1. Resident was assessed for self administration of Voltaren Gel on 9/8/19. The Resident was given a log to sign each time she self administered her medication and education regarding use of log and lock box on 9/11/19. 2. Current residents that self administer medication are at risk for the alleged deficient practice. An audit of residents	9/30/19

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

Electronically Signed | 09/12/2019

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F 554	Continued From page 1 Resident #113, was admitted to this facility on 2/2/17. Her diagnoses included but were not limited to: Chronic Obstructive Pulmonary Disease, Pain in unspecified lower leg, generalized anxiety disorder, polyneuropathy, dry eye syndrome of unspecified lacrimal gland, chronic pain syndrome and unspecified dementia without behavioral disturbance. Resident #113's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 7/8/19 was coded as a quarterly assessment. Resident #113 had a BIMS (brief interview for mental status) score of 13 which indicated she was cognitively intact. Resident #113 was coded as being independent in all ADL's (activities of daily living) except for locomotion off the unit which she required extensive assistance of one staff member. On 8/13/19 during facility rounds, Resident #113 was observed in her room and a medication box was on her heating/air conditioning unit that was labeled " Diclofenac Sodium 1% Topical Gel (Voltaren)." Resident #113 stated, "I ordered some more of it today, I order from Professional Pharmacy because they are so slow here getting your meds [medications]". The medication box did have a label from Professional Pharmacy. Eye drops were observed on the Resident's over bed table at the bedside. On 8/19/19 at approximately 9am during an interview with Resident #113 in the presence of Surveyor B and Surveyor C. Resident #113 had Diclofenac Gel on her heating/air unit, eye drops on her over bed table and when asked about her inhaler she stated it is in the bedside table in the	F 554	was performed to identify those who self may administer medications to ensure compliance with policy and procedure for self administration of medications. 3. The DON or designee will educate Licensed Nursing Staff on self medication administration for a resident to include identification, evaluation, storage and documentation needed for self administration. 4. Unit Managers/designee will conduct audits of residents who self administer medications, 3 times a week for 3 months to ensure medication is appropriately stored, given as prescribed, log signed off by resident and documented in the MAR. Findings of the weekly audits will be submitted to the DON / ADON weekly for tracking / trending and further action as needed and a summary will be reported to the monthly QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 554	Continued From page 2	F 554		

drawer. Resident #113 was asked if she keeps a log of when she uses these medications and Resident #113 stated "no". Resident #113 stated during this interview that she applies the Diclofenac Gel on her knees four times daily.

Review of Resident #113's physician orders showed there was an order dated 12/8/18 that read, "Voltaren Gel 1% (Diclofenac Sodium) Apply 4 gram transdermally every 12 hours as needed for Pain apply to wrist/knees." The Resident reported using this medication four times daily which is double the frequency ordered by the physician.

Review of Resident #113's MAR (Medication administration record) for August 2019 revealed that Voltaren Gel had not been administered any for the entire month, despite Resident #113 reporting she applies it four times daily.

Review of Resident #113's careplan revealed no indication that the Resident self-administers any medications. There was a careplan written that read, "The resident has alteration in pain/comfort r/t [related to] dx [diagnosis] of polyneuropathy and GERD [gastro esophageal reflux disease]. She receives scheduled pain medication." The careplan revealed no intervention for Resident #113 to self-administer Diclofenac Gel.

Further review of the clinical record revealed an "Evaluation for Self-Administration of Medications" form with an effective date of 7/3/19 at 11:23 completed by LPN P that indicated Resident #113 had been evaluated to self administer an inhaler and eye drops. There was no indication that Resident #113 had been evaluated to determine if she was safe to

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F 554	Continued From page 3	F 554		

self-administer the topical gel. Additionally the inter-disciplinary team evaluation section III of the form had not been competed and was blank for the inhaler and eye drops evaluation. Therefore, indicating the interdisciplinary team had not reviewed and determined the Resident was safe or this practice was clinically appropriate.

Review of the entire clinical record revealed no indication that the interdisciplinary team had discussed or determined that it was clinically appropriate for Resident #113 to self-administer Diclofenac Sodium Gel.

On 8/19/19 at approximately 8:35am an interview was conducted with LPN B by Surveyor G in the presence of Surveyor C. LPN B was asked about the facility policy/process if a Resident wants to self-administer medications, LPN B stated "I would have to get someone else I am not sure of the policy." When asked if Residents are able to keep medications at their bedside LPN B stated, "no, I know they are not allowed to keep in their room, I know that for a fact!"

On 8/19/19 at 8:45am an interview was conducted with LPN O by Surveyor G in the presence of Surveyor B and Surveyor C. When asked about the process if a Resident wishes to self administer medications, LPN O stated "if they have a self administration form filled out it is ok." When asked if they had to keep the medications anywhere specific LPN O stated, "no." When asked how they know when the Resident administers medications and if they keep any kind of record LPN O stated, "I think they would say something to the nurse and we would document it."

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F 554	Continued From page 4	F 554		

On 8/19/19 at 2:40pm an interview was conducted with RN B who is a unit manager. Surveyor C was present while Surveyor G interviewed RN B. RN B was asked what the process is if a Resident wants to self-administer medication. RN B/Unit Manager stated, "there is a self-administration assessment, the doctor has to determine if they are competent to self-administer, we get an order of whatever the med [medication] is, make sure the assessment is done. I haven't had this but I can read the policy to you."

Review of the facility policy titled "Self-Administration of Medication at Bedside" with a revision date of 8/22/17 read, "The Resident may request to keep medications at bedside for self-administration in accordance with Resident Rights. Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documenting of these actions." The procedure of the policy goes on to state: "the interdisciplinary team will review the evaluation and will document Section III. Approval granted must be checked yes or no. interdisciplinary team member sign the evaluation section. Complete the care plan for approved self-administered drugs. The MAR must identify meds that are self-administered and the medication nurse will need to follow-up with resident as to documentation and storage of medication during each med pass. If kept at bedside, the medication must be kept in a locked drawer."

Review of the facility policy titled "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" with a most revision date

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F 554	Continued From page 5 of 7/23/19, read on page 3 under 14. Bedside Medication Storage: "14.1 Facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order and approval by the Interdisciplinary Care Team and Facility Administration." "14.2 Facility should store bedside medications or biologicals in a locked compartment within the resident's room." "14.3 Facility should ensure that only Facility representatives and the appropriate resident maintains the keys, access cards, electronic codes, or combinations which open the locked compartment."	F 554		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of 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 provide one Resident (Resident #141) with access to her personal belongings, in a survey sample of 46 Residents. The findings included: Resident #141 was admitted to the facility on	F 557	1. Resident #141□s belongings were taken to her new room during survey on 8/19/19. 2. Current residents that require a room change are at risk for the alleged deficient practice. An Audit of room changes in the last 30 days was performed to ensure residents had their personal belongings.	9/30/19

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F 557	Continued From page 6 6/1/14. Her diagnoses included but were not limited to: Type 2 diabetes mellitus and schizophrenia. Resident #141's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 6/2/19 was coded as a quarterly assessment. Resident #141 was coded as having a BIMS (brief interview for mental status) score of 15 which indicated she was cognitively intact. She was coded as being independent in all aspects of her daily care and required no staff oversight or assistance, to include but not limited to bathing, dressing, toileting, personal hygiene, eating, and locomotion. On 8/19/19 during a Resident interview with Resident #141, the Resident stated she had changed rooms a few days ago because the ceiling tiles were falling. She was observed to have a large quantity of her personal belongings in bags on her bed. Resident #141 stated that many of her personal items to include clothes were still in the previous room. On 8/20/19 during an interview with Resident #141 in her room, the Resident stated that she had received some of her personal belongings but still needed her reacher and blue chair that remain in her old room. She stated her brother was coming to visit later in the day and she needed the chair for him to sit in when he visits. It was observed that the Resident's bed was covered with bags of her personal possessions. Review of Resident #141's clinical record revealed that the room change had taken place on 8/15/19.	F 557	3. The Executive Director or Designee will educate the Social Services Department on the procedure for room changes to include personal items are moved to the new room with the resident. 4. Social Services to conduct weekly audits for 3 months of room changes to ensure that personal belongings were relocated with the resident. Findings of the weekly audits will be submitted to the DON / ADON weekly for tracking / trending and further action as needed and a summary will be reported to the monthly QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 557	Continued From page 7 On 8/19/19 at approximately 4:42pm an interview was conducted with Employee J, the Social Worker, in his office in the presence of Surveyor B and Surveyor G. When the Social Worker was asked who is responsible for room changes, he stated he was responsible for room changes. The Social Worker confirmed that Resident #141 had moved rooms and stated "there was something going on with her room, so she needed a room just temporary." When the Social Worker was asked if he knew that her personal belongings were still in the old room, the social worker stated "I didn't know". On 8/20/19 at 11:38am an interview was conducted with Employee J, the Social Worker in the conference room, in the presence of the survey team and he was asked if Resident #141 had received her items from the old room. The social worker stated "they did it last night". No further information was provided.	F 557		
{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, staff interview and clinical record review, the facility staff failed to accommodated one resident of 46 sampled residents (Resident #121's) need of a callbell.	{F 558}	1 The call bell for resident # 121 was relocated within his reach during survey. 2. Current residents are at risk for call bell not being with in reach.	9/30/19

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{F 558}	Continued From page 8 The findings include: Resident #121, an 88 year old male who was admitted to the facility on 06/25/2013 with diagnoses to include but not limited to right-sided paralysis due to stroke, contracture of the right hand, right elbow, right wrist, and right leg and limitation of activities due to disability. Resident #121's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/03/2019 was coded as a quarterly review. Resident #121 was coded with a Brief Interview of Mental Status (BIMS) score of "3" out of possible 15, indicating severely impaired cognition. He was coded as being totally dependent for all of his ADL's (activities of daily living). On 08/13/19 at approximately 5:55 pm, Resident #121 was observed sitting in his wheelchair, in his room next to his bed, yelling "Help, Nurse!". He stated that he wanted to see his nurse because he wanted his medications and to get back into bed. His callbell was not visible and he was unable to locate it when asked. Employee D was observed in the hallway and came into Resident #121's room to provide assistance. Employee D located the callbell which had fallen to the floor between the wall and the bed, on the opposite side of where Resident #121 was sitting in his wheelchair. When asked if she thought Resident #121 could reach his callbell to call for assistance, she stated "No, it should be kept within his reach so he can use it". Employee D clipped the callbell to Resident #121's shirt.	{F 558}	3. The DCS or Designee will educate staff on call bell placement to ensure the call bell is within reach to ensure the resident has a way to communicate needs. 4. Unit Managers or Designee will conduct audits 3 times per week for 3 months of 5 residents to ensure the call bells are in reach of the resident. Findings of the weekly audits will be submitted to the DON / ADON weekly for tracking / trending and further action as needed and a summary will be reported to the monthly QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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{F 558}	Continued From page 9 On 08/15/19 at approximately 5:10 pm, Resident #121 was again observed sitting in his wheelchair, in his room next to his bed, calling out for help. His callbell was clipped to a curtain at the foot of his bed, approximately 4 1/2 feet from the ground. Resident #121 was approximately 5-6 feet away from the callbell and when asked, he was unable to locate it. RN A was asked to come into his room and stated, "the callbell is definitely out of his reach".	{F 558}		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed to timely provide a written notice of a room change for one Resident (Resident #141) in a survey sample of 46 Residents. The findings included:	F 559	1. Resident #141□s room change took place on 8/15/19. The notification of room change was performed on 8/20/19 by the Social Worker. 2. Current residents that require a room change are at risk for the alleged deficient practice. An Audit of room changes in the last 30 days was performed to ensure residents have notification of room	9/30/19

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F 559	Continued From page 10 Resident #141 was admitted to the facility on 6/1/14. Her diagnoses included but were not limited to: Type 2 diabetes mellitus and schizophrenia. Resident #141's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 6/2/19 was coded as a quarterly assessment. Resident #141 was coded as having a BIMS (brief interview for mental status) score of 15 which indicated she was cognitively intact. She was coded as being independent in all aspects of her daily care and required no staff oversight or assistance, to include but not limited to bathing, dressing, toileting, personal hygiene, eating, and locomotion. On 8/19/19 during an interview with Resident #141, the Resident stated she had changed rooms a few days ago because the ceiling tiles were falling. She was observed to have a large quantity of her personal belongings in bags on her bed. Review of Resident #141's clinical record revealed that the room change had taken place on 8/15/19. On 8/19/19 at approximately 4:42pm an interview was conducted with Employee J, the Social Worker, in his office in the presence of Surveyor B and this writer, Surveyor G. When the Social Worker was asked who is responsible for room changes, he stated he was responsible for room changes. The Social Worker confirmed that Resident #141 had moved rooms and stated "there was something going on with her room, so she needed a room just temporary." When the	F 559	change. 3. The Executive Director or Designee will educate the Social Services Department on the procedure for room changes to include the timely written notification of a room change. 4. Social Services to conduct weekly audits for 3 months of room changes to ensure personal belongings were relocated with the resident. Findings of the weekly audits will be submitted to the DON / ADON weekly for tracking / trending and further action as needed and a summary will be reported to the monthly QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 559	Continued From page 11 Social Worker was asked about notification he stated "she is with [name redacted] so I notified her case worker." A copy of this notification was requested. On 8/20/19 at 11:38am an interview was conducted with Employee J, the Social Worker in the conference room, in the presence of the survey team and he was advised that the requested copy of the room change notification had not been received as requested the day prior. The Social Worker then stated, "I didn't do it in a timely fashion, I did it this morning." Review of the facility policy titled "Room Changes" with an effective date of 11/30/2014 read, "Prior to the room change, the team should give the resident/legal representative notice to allow the resident/legal representative time to prepare for the room change. Emergent conditions or safety concerns, as determined by the team, may supersede the notice period." No further information was provided.	F 559		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to	F 563		9/30/19

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F 563	Continued From page 12 a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide residents with the right to deny visitors/volunteers into their private rooms for 4 residents (Resident #107 #44 #47 and #133), in a survey sample of 46 Residents. The facility staff did not protect the Residents from unsolicited private visits from strangers. The findings included; Resident #107 was admitted to the facility on 10-26-18. The Resident's diagnoses included homelessness, pain, malnutrition, hypotension, multiple suicide attempts, and major depressive disorder. The Resident was noted to have severe contractures of both hands, and was his own responsible party.	F 563	1. Residents that are identified as wanting to participate in outside volunteer sponsored supportive services will sign a written informed consent. Resident's personal information (i.e. name, room number, date of birth) shared with outside volunteer sponsored supportive services only after written consent giving the facility permission to share their personal information and giving permission for the resident to receive visitation in an unsupervised setting. A copy of the informed consent will be maintained in the resident's medical record. Resident 107 BIM score of 15 was interviewed by Executive Director and stated he wanted to continue with the Church visitors. Residents 44 have BIM score of 5 and husband agreed for her to be seen by	

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F 563	Continued From page 13 Resident #107's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5-3-19 was coded as a quarterly assessment. Resident #107 was coded with a Brief Interview for Mental Status (BIMS) score off "14" indicating no cognitive impairment. The Resident was also coded as needing extensive to total assistance of one staff member to perform bed mobility, toileting, transferring, hygiene, and dressing. Resident #107 was incontinent of bowel and bladder. Resident #107 had severe range of motion limitations and the MDS assessment stated there were no limitations. Resident #107 was coded for no behaviors and the assessment showed that the Resident did not leave his bed during the week of the assessment. The Resident also did not leave his bed during the course of the survey. On 8-14-19, during general observations of the facility, 2 men were observed knocking one time on the door jamb and immediately entering Resident #107's room without him responding to the knock. The 2 men were followed and seen entering each Resident's room on the way down each of the liberty, and freedom units in the same manner of knocking one time while proceeding into each room, with or without a response. A Licensed Practical Nurse (LPN) from a nursing agency was in the hallway and was asked if the men were doctors, and she responded "no, they are from a church and they visit Residents." The Nurse was asked if they came to see specific residents, or if they visited everyone, and she responded "I don't really know, I am here from an agency on a temporary contract, and I am not sure of that."	F 563	Church visitors. Resident number 43 has a BIM score of 7 , his sister refused to answer the request and he will not receive one on one church visitors . Resident 133 will not receive Church visitors until her guardianship is completed. 2. Residents that receive visitors from outside volunteer sponsored supportive services are at risk. Volunteers from Support Services that are deemed “Volunteers” per Consulate Policy and State of VA LTC Regulations will have to follow the guidelines set forth for “Volunteers “per Consulate Policy and State of VA LTC Regulations. Resident Right to deny visitors will be adhered to based on individual resident assessment. 3. Facility staff will be educated on Residents Right to deny visitors and to check when visitors enter a room if they have a Visitors Badge. Staff should follow up and assure that resident wants to have individual visitor in their room. 4. ED/designee will audit weekly Visitor log and 5 residents a week to assure residents have not received unwanted 1 on 1 visitation. Review findings in QAPI monthly for 3 months. 5. Date of compliance 9/30/2019	

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F 563	Continued From page 14	F 563		

The Activities Director, who had been observed following the surveyor, was approached and asked who the men were. She stated "they are volunteers from [name of church], and they come to see Resident's who are [name of denomination]. She continued to say "they come and pray with those who want it." She was asked how the men know who wants it, and she responded "we [activities] give the church the names, room numbers, religious affiliation, date of birth, and dietary restrictions." During this time the surveyor and activities director were joined by the Administrator, who continued down the hall with them while the interview continued.

The activities director was asked who receives and handles the information at the church, and she responded "I don't really know who handles it, we have a point of contact there." She was asked how often they (the church volunteers) come, and if the volunteers were trained in the facility on dementia or behaviors, and if the volunteers were back ground checked for safety. She responded "No, because they are different people each week, that would be too many people to check, and they come one or two times a week." She was then asked, if she knew their names, and she responded "no". She was asked if the people who come each week are different people, how would the staff know who they were, and specifically with so many temporary agency staff, and she did not respond. At this point the Administrator excused herself and went to the nursing station to speak to another resident and staff member.

The activities director continued walking with the surveyor and was asked to arrange an interview with the 2 men. Initially after the interview with the

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F 563	Continued From page 15	F 563		

activities director, the 2 men could no longer be seen in the hallway. The surveyor and activity director began going room to room, quickly, to locate the 2 men. The room where the 2 men were later found had been looked into on the way down the hallway and could not be seen as the curtain separating the semi private room was pulled around the resident bed.

On the way back up the hall the 2 men were found in that room with a female resident (Resident #44) with dementia. She was in bed, in a hospital gown, and one of the men had a hand on her arm. The curtain was partially drawn, but the men could now be seen from the hallway as they were proceeding out of the room. The 2 men were approached, the surveyor introduced herself, and explained her purpose, and asked their names and purpose in the room. The 2 men did not give their names. They stated they were there to pray with people, and carried a type written list with 24 Resident names, room numbers, religious affiliation, and "prayer code". There were also hand written notes on the sheet. Only 10 of those names on the list were of the denomination of the church they were from, and the men were seen visiting all rooms, most of which were not on the list. They wore no identification and offered none.

Two other surveyors stated they witnessed a third volunteer going into rooms on the colonial hall unsupervised.

An interview was attempted with Resident #44 but due to advanced dementia, the interview was unable to be conducted.

On 8-14-19 after the 2 men left the building

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F 563	Continued From page 16	F 563		

Resident #107 was interviewed and stated he had not invited the men into his room, and didn't know them, or why they were there. He stated "that's a problem here, too many strangers running around." The resident was asked what he meant, and he stated that every day a new staff member in a uniform or others not in uniform would just come on in and he felt he didn't really know anyone. The Resident stated he was anxious and depressed about his condition.

A review of the psychosocial evaluation completed in the facility by the activities director and the social worker for Resident #107 documented the following;

Finds strength in religion - "No"
Religious faith - (different affiliation than the 2 men)
Church affiliation - (different affiliation than the 2 men)
Actively participates - "No"
Was church notified of admission - "No"
More support from church desired - "No"

Further review of psychosocial evaluations completed for Residents #47, #44, #133 who were witnessed receiving private visits from the 2 men in their rooms revealed that Resident #47 was not affiliated with any church, and all other answers were identical to #107 as above.

Resident #44 was of the denomination of the volunteers and was on the list they carried, however, she was documented as not an active participant, and did not wish support from the church, and the church was not notified of her admission.

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F 563	Continued From page 17 Resident #133 was of the denomination of the volunteers and was on the list they carried, however, she was documented as an active participant, and did not wish support from the church, and the church was not notified of her admission.	F 563		
{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, 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, Resident interview, staff interview, facility documentation review, and clinical record review the facility staff neglected to provide care and services for two Residents (Resident #139 and #134) in a survey sample of 46 Residents. This resulted in harm for Resident #139. Immediate Jeopardy was identified for Resident #134 on 08/14/2019 at 5:16 pm at which time the facility was notified. After verification, Immediate Jeopardy was abated on 08/20/2019 at 7:40 pm	{F 600}	1. The corrective action for the alleged deficient practice will be accomplished by: Resident #134's Mattress was replaced on 8/14/19 and is working properly. Resident # 139 is no longer in facility. 2. Current residents who have air mattresses have the potential to be affected by this alleged deficient practice. The facility Maintenance Director conducted an audit on 8/14/19 of air mattresses to ensure that they are in	9/30/19

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{F 600}	Continued From page 18 and the scope and severity was lowered to a Level three isolated due to Resident #139. The findings included: 1. For Resident #139, the facility staff neglected to assess and treat an ongoing urinary tract infection as it developed into sepsis and caused hospitalization resulting in harm. Resident #139, a 55 year old male, was admitted to the facility on 7/16/2018 and discharged to a local hospital on 8/6/2019. His diagnoses included quadriplegia, dysreflexia, and neuropathic bladder. Resident #139's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/19/2019 was coded as a quarterly assessment. Resident #139 was coded a BIMS (Brief Interview of Mental Status) score of 15/15 which indicated no cognitive impairment. He was totally dependent on the assistance of 1-2 persons for his activities of daily living. He was always incontinent of bowel and used a suprapubic catheter (a catheter that goes through the abdominal wall into the bladder) for urinary elimination. On 7/17/2019 a physician assessment indicated that Resident #139 was positive for a urinary tract infection. He was prescribed the antibiotic Macrobid to continue for 7 days. The July 2019 MAR (Medication Administration Record) indicated that this medication was administered. There was no urinalysis culture and sensitivity report which would confirm the diagnosis of a urinary tract infection and specify the antibiotic,	{F 600}	proper working order. Issues identified will be reported to the Executive Director and immediately corrected. Current Residents who have a Foley catheter have the potential to be affected by this alleged deficient practice. Unit Managers/designee will complete audit of residents with Foleys to ensure catheter care is provided as needed and urine color and clarity is documented. Follow up based on findings. 3. The facility staff; Nursing, Housekeeping/Laundry, Dietary, Administration, Therapy, Maintenance, Social Services, and Activities will be educated on abuse and neglect, types of abuse, training, prevention, identification, investigating, protection, reporting/response, residents rights, reporting reasonable suspicion of a crime, Elder Justice Act, resident privacy, and the release of resident protected information. Abuse and Neglect education will be provided to facility. This education will specifically address prevention and protection for residents. Education was initiated on 8/16/19 and will be on-going, no staff will return to work until they have completed the mandatory education on abuse and neglect. This education will be provided to new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. The facility staff- Nursing, Housekeeping/Laundry, Dietary, Administration, Therapy, Maintenance,	

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{F 600}	Continued From page 19 Macrobid, would resolve the infection. Thus it was not certain that Macrobid was the proper antibiotic for this infection. There were no further notes indicating any distress for Resident #139 until 8/6/2019 at 2:01 AM. A note at that time indicated that he had experienced a large watery bowel movement, and he was unresponsive to painful stimuli. The physician was notified and he issued an order to transfer Resident #139 to the local hospital emergency department. Hospital records were obtained and reviewed. The records indicated that when Resident #139 arrived at the hospital he was still unresponsive and he was immediately intubated due to low respirations, altered mental status, and declining oxygen saturation. An initial urinalysis at the hospital showed a "severe" urinary tract infection, and bloodwork showed a White Blood Cell count of 24.9 (normal=4-11) indicating that an infection was present. There was dark tea colored urine in the urine bag. Resident #139 diagnoses at the hospital were "severe" septic shock, respiratory failure, urinary tract infection. The Care Plan was reviewed and the presence of Resident #139's suprapubic catheter was noted, and instructed staff "Suprapubic catheter care and change as noted". It also stated that nursing staff should initiate urology consults as ordered. There was no mention in the clinical record that catheter care took place and that staff were sufficiently alarmed at the dark colored urine in	{F 600}	Social Services, and Activities will be educated on air mattresses being in proper working order, and process of reporting malfunctioning equipment to maintenance staff and facility leadership. Nursing staff will be educated on providing care to residents with Foley catheters, including documentation of catheter care and documentation of color and clarity of urine by SDC/Designee. 4. Director of Maintenance/designee will monitor low air loss mattresses weekly for 3 months. Unit Managers/designee will conduct audits of residents with Foleys to ensure catheter care is provided and urine clarity and color are documented, 3 times per week for three months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule may be modified based on findings. Date of Compliance 9/30/2019	

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{F 600}	Continued From page 20 the catheter bag to alert the physician for a urology consult. This is a harm level deficiency 2. For Resident #134 the facility staff neglected to provide an operating air mattress. This Resident had known stage IV pressure ulcers. Resident #134 was admitted to the facility on 9/27/12, with a recent readmission date of 8/5/19. Resident #134's diagnoses included but were not limited to: MRSA (methicillin resistant staphylococcus aureus) infection, sepsis, stage IV pressure wounds and complete lesion at T2-T6 level of the thoracic spinal cord. Resident #134's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 6/29/19 was coded as a quarterly assessment, Resident #134 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated he was cognitively intact. Resident #134 was coded as being totally dependent upon two staff persons for transfers. On 8/14/19 at approximately 9:30am surveyor G entered the room of Resident #134. Upon opening the room door an audible whooshing noise could be heard. Upon further investigation it was noted that the air hoses coming from the pump connecting to the mattress were taped and the air heard, was air escaping from the hoses. Further observations revealed that Resident #134 was sitting in the middle of his bed and appeared to be sitting in a sunken in area with the mattress	{F 600}		

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{F 600}	Continued From page 21	{F 600}		

around him at a significantly higher elevation than where he was sitting.

On 8/14/19 at approximately 9:30am during a Resident interview, Resident #134 stated if he put his hand underneath his buttocks he could feel the bed frame.

On 8/14/19 at approximately 9:45am Surveyor C accompanied Surveyor G to the Room of Resident #134. Surveyor C observed air leaking from the air hoses as well. Surveyor C advised nursing staff at the nursing station that the air mattress for Resident #134 was not working properly.

Review of Resident #134's physician orders revealed an order dated 3/22/19 that read "skin: Pressure reducing mattress" and had an end date of 8/6/19.

Review of Resident #134's careplan revealed an entry dated 8/7/19 that read, "Focus: [Resident #134's name redacted] has potential/actual impairment to skin integrity of the r/t [related to] [sic] paraplegia, use of condom catheter, history of pressure ulcer, side effect of medications. Goal: [Resident #134's name redacted] will maintain or develop clean and intact skin and will be free from further skin breakdown by the review date. Interventions: pressure relieving/reducing mattress to protect the skin while IN BED."

Review of hospital records for Resident #134's hospitalization from 7/31/19-8/5/19 revealed a wound consult that occurred on 8/2/19 and read, "Pt [patient] has two Stage 4 pressure injury wounds. One to each ischial tuberosity..."

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{F 600}	Continued From page 22	{F 600}		

Review of the "Admission/Readmission Data Collection" form dated 8/5/19, section M on page 8-9 revealed an entry that stated "right buttock, left buttock" which contained no description, the description box was blank.

Review of a Nurse Practitioner progress note dated 8/15/19 revealed the following "Pt has a history of of [sic] noncompliance with his mediation [sic] and treatments. He has a stage 4 pressure ulcer to his left and right gluteus, the left gluteus measures 11 cm x 8 cm x 4cm and the right gluteus measures 9.5 cm x 5 cm x 0.2 cm. There was scant sanguineous drainage noted..."

On 8/14/19 at 11:29am Surveyor E accompanied Surveyor G to the room of Resident #134. RN A, the unit manager and LPN C, the treatment nurse were also present. Upon entering the room of Resident #134, Surveyor G remained on the opposite side of the privacy curtain while Surveyor E, RN A and LPN C approached the Resident.

On 8/14/2019 at 11:29 a.m., observation of wounds was conducted by Surveyor E for Resident # 134 with the Wound Care Nurse, LPN (Licensed Practical Nurse) C. RN A, the Unit manager stated the wounds were a stage III and LPN C stated they were a stage IV because bone could be observed. Observations revealed the following: Right Ischial Tuberosity-Stage IV, measurements 7.5 cm x 11.2 cm x 1.5 cm depth, Full thickness tissue loss with bone exposed, white maceration around the rolled edges, wound bed noted as beefy red with yellow, adherent slough present, and redness noted around perimeter of the wound. A small amount of serosanguineous drainage was noted on the

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bandage when removed.

Left Ischial Tuberosity- Stage IV-measurements 8.2 cm x 11.0 cm x 3.5 cm depth, full thickness tissue loss with tunneling, bone exposed. Wound bed appeared beefy red with slough present with rolled edges. LPN C stated "there is more bone exposed on this one and you can see facia."

During the wound care observation on 8/14/19 at 11:29am LPN C and RN A were asked about the air mattress, neither acknowledged they had previously been aware of the mattress not working properly.

On 8/14/19 at 2:43pm maintenance was observed changing out the air mattress for Resident #134. When the Maintenance Director was asked what he was doing, he stated "nursing told me it had a hole". When asked what the tape on the hoses was for, the maintenance director stated "I figured nursing taped it up". He stated he had no prior knowledge of the air mattress not operating.

On 8/14/19 at 3:07pm the Maintenance Director was observed in the room of Resident #134 and Resident #134 was reporting that the replacement air mattress was not working properly.

On 8/14/19 at 3:27pm an interview was conducted with RN A, the Unit Manager. RN A was asked if the air mattress for Resident #134 was operating properly now and RN A said "I know he had to get a new pump and is there adjusting it now".

On 8/14/19 at approximately 3:40pm an interview

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was conducted with the Maintenance Director and he stated "the first pump I put on one of the buttons didn't work so I put a new pump on and it's working fine".

On 8/15/19 at 4:15pm an interview was conducted with the Maintenance Director in the presence of Surveyors C and Surveyor G. When asked about the preventative maintenance sticker on the air mattress, that was removed from Resident #134's bed which had the broken air hoses, the maintenance director stated he had called the rental company and "it was marked as lost" in their system. The sticker revealed preventive maintenance had been performed 5/16 (May 2016) and was due 5/17 (May 2017). When asked if anyone checks the beds or does preventative maintenance, the maintenance director stated, "not really, unless they tell me they are broken not really, housekeeping just cleans them".

On 8/15/19 at 4:15pm with the Maintenance Director Surveyors C & G observed the following: the air supply filter was severely soiled to the point light was not permeable through it. When asked if he could see light through the filter, the maintenance director held the filter to the light he indicated "not through that, no". He removed the tape that was wrapped around the tubing where air was escaping. When asked what it was, the maintenance director said "nursing tape and some kind of plastic or something." Further evaluation revealed the plastic appeared to be a kitchen product, like saran wrap and contained a sticker that had writing "** [two letters, redacted as they are Resident's initials] ". Previous observations of Resident #134's room revealed sandwiches on his bedside table which were

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wrapped in a plastic, similar to what was being observed on the plastic tubing, and Resident #134 stated they provide him with peanut butter sandwiches to increase his protein intake.

On 8/15/19 at approximately 4:45pm Surveyor D accompanied Surveyor G to the beauty shop where the air mattress which had been removed off of Resident #134's bed was stored. Surveyor G then obtained the following details: the tubing/air hoses had a circumference of 3 inches. The air tubes were a corrugated accordion type clear plastic tube with white coated pvc rings with the clear plastic between the rings. One of the tubes revealed that 1 inch of the clear plastic tube remained intact, while 2 inches was severed, being the hole. The second hose was also a circumference of 3 inches. It was broken in two places, with only 1/2 inch intact, with the remaining 2 1/2 inches being severed and was severely damaged.

On 8/15/19 at 4:52pm an interview was conducted in the conference room, with all surveyors present, with Employee D, the supply clerk. Employee D was asked to identify the material that maintenance had identified as "nursing tape" that was wrapped around the damaged air hoses. Employee D stated "I know exactly what that is" and returned with a roll of "Medfix EZ dressing retention tape". The product appears to be porous and the package labeling read, "uses: secures primary dressings and medical appliances. Features: low sensitivity adhesive, water resistant, perforations for easy tearing. Change frequency: up to 7 days".

Review of the policy titled "Bio-medical Equipment Management-Rental" with an effective

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date of 11/30/2014 read as follows: "All biomedical equipment that is rented shall be subject to the same requirements for testing and maintenance as facility owned equipment. Procedure: 1. Any company supplying the facility or its residents with bio-medical equipment, will provide the facility with a copy of its procedures for testing and maintaining their equipment. 2. All equipment will be required to have a tag or label showing the last date that it was tested. 3. During the quarterly check of all bio-medical equipment tags by the maintenance department, all rental equipment should be checked to make sure that the date of the last inspection is within the prior six month period. 4. All equipment without the proper tag should be placed out of service until the vendor can assure compliance with the preventative maintenance schedule."

Review of the "RecoverCare Manual for STAT 5000 C Low Air Loss Mattress Replacement System" read on page 6. "Air filter and filter cap. No tools are necessary to remove filter cap. MedaSTAT USA, LLC recommends that the filter should be inspected and cleaned or replaced with a Genuine MedaSTAT USA, LLC replacement part once a month to ensure optimal performance of the power unit." Page 9 stated, "15.0 Routine Maintenance. The STAT family of products are designed to need very little maintenance. MedaSTAT USA, LLC recommends that the air filter should be checked once a month and cleaned of visible soil". Page 10 read, "16.0 Troubleshooting. Problem. 2. Patient is "bottoming out" inspection procedure: 2.2 check for mattress leaks. 2.3 check air filter for dirt/lint. Possible Solutions: 2.2 replace with appropriate spare parts. 2.3 clean or replace air filter." Page 11 read, "17.0 Returns for Service. This device is

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{F 600}	Continued From page 27 NOT user serviceable. SERVICE AND REPAIR MUST ONLY BE PERFORMED BY AN AUTHORIZED MEDASTATE USA, LLC TECHNICIAN OR REPRESENTATIVE. All service issues should be referred to your local MedaSTAT USA LLC dealer". No further information was provided. Immediate Jeopardy was identified on 08/14/2019 at 5:16 pm at which time the facility was notified. The facility presented the following abatement plan: Resident #134 Mattress was replaced on 8/14/19 and is working properly. 1. Residents with the potential to be affected by alleged deficient practice: The facility Maintenance Director will conduct an audit on 8/14/19 of all air mattresses to ensure that they are in proper working order. Any issues identified will be reported to the Executive Director and immediately corrected. 8/19/19- All residents have the potential to be affected by this alleged deficient practice. The facility RN Unit Managers will conducted a facility wide skin sweep and document the findings in the medical record. Any identified previously undocumented skin impairment concerns will be reported to the attending physician and the responsible party in accordance with the facility wound policy. Any treatment orders will be obtained and implemented immediately.	{F 600}		

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2. Systemic Changes:

The facility staff; Nursing, Housekeeping/Laundry, Dietary, Administration, Therapy, Maintenance, Social Services, and Activities will be educated on abuse and neglect, types of abuse, training, prevention, identification, investigating, protection, reporting/response, resident's rights, reporting reasonable suspicion of a crime, Elder Justice Act, resident privacy, and the release of resident protected information. Abuse and Neglect education will be provided to all staff of the facility. This education will specifically address prevention and protection for residents. Education was initiated on 8/16/19 and will be on-going, no staff will return to work until they have completed the mandatory education on abuse and neglect. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. All staff currently working will be educated on abuse and neglect immediately.

The center Divisional Executive Director to conduct an ADHOC Quality Assurance Performance Improvement meeting 8/16/19, including the Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Central Supply Clerk, Dietary Manager, Activity Director and the Environmental Services Director regarding the plan of removal of immediacy.

The survey team verified the following:

- Resident #134 had a new mattress.

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{F 600}	Continued From page 29 - Residents/family/staff (for BIMS 8 or below with no family) interviewed to ensure free from abuse, neglect. - All air mattresses in working order. - All staff education on abuse/neglect. - Skin assessments were done on all residents and if issues, MD/RP notified and treatments ordered/ in place. After verification, Immediate Jeopardy was abated on 08/20/2019 at 7:40 pm and the scope and severity was lowered to a Level three isolated.	{F 600}		
{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	{F 656}		9/30/19

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{F 656}	Continued From page 30 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to develop and/or implement the care for three residents (Residents #121, #145, #104) in a survey sample of 46 residents. The findings include: 1. For Resident #121, the facility staff failed to develop a care plan for skin breakdown. Resident #121, an 88 year old male who was admitted to the facility on 06/25/2013 with diagnoses to include but not limited to right-sided paralysis due to stroke, contracture of the right hand, right elbow, right wrist, and right leg and limitation of activities due to disability. Resident #121's most recent Minimum Data Set	{F 656}	1. Resident #121 care plan was updated during survey 8/16/19. Resident #145 care plan intervention for pressure relieving boots are being followed. Residents #104 care plan was updated on 8/19/19 during survey. 2. A review of care plans completed with MDS assessments completed since the survey end date of 8/20/19 will be completed for accuracy. Revisions will be made as appropriate by Interdisciplinary team. 3. Education will provided to the interdisciplinary team on development and implementation of comprehensive care plans by Regional MDS Coordinator. Care plans will be reviewed at each morning clinical meeting and updated with changes. Care plans are also reviewed	

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{F 656}	Continued From page 31 (MDS) with an Assessment Reference Date (ARD) of 08/03/2019 was coded as a quarterly review. Resident #121 was coded with a Brief Interview of Mental Status (BIMS) score of "3" out of possible 15, indicating severely impaired cognition. He was coded as being totally dependent for all of his ADL's (activities of daily living) and risk of developing pressure ulcers with treatments including pressure reducing device for chair and bed. Resident #121 had actual skin breakdown on due to a pressure injury, Stage II on the right dorsal foot, as documented on the "Pressure Ulcer Wound Rounds" assessment sheet dated 08/09/19. The care plan was reviewed and there was no focus addressing neither potential nor actual skin breakdown. On 08/15/2019 at approximately 4:50 pm, an interview with the Corporate Clinical Director (Employee C) was conducted. She reviewed the care plan and the pressure ulcer assessment dated 08/09/19 for Resident #121 and confirmed that the care plan did not contain any focus or interventions regarding the prevention or treatment of pressure ulcers. She stated that she would expect to see it on the care plan "because that directs the staff on how to provide the Resident's care and meet his needs". 2. For Resident #145, the facility staff failed to implement an intervention on the care plan associated with wearing her soft boots on both feet while in bed on 08/19/2019. Resident #145, a 95-year old female, was	{F 656}	when MDS assessments are completed and updated based on the assessment findings. 4. A weekly review of 5 random care plans will be completed by Regional MDS Coordinator team or designee to ensure care plans are up to date and address the resident□s current needs, person-centered goals and interventions. Findings will be reviewed during the monthly QAPI meeting for review and recommendations.	

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admitted to the facility on 09/10/2008. Diagnoses included but not limited to generalized muscle weakness, bilateral knee contractures, dysphagia, and gastro-esophageal reflux disease.

Resident #145's most recent Minimum Data Set with an Assessment Reference Date of 07/03/19 was coded as a quarterly review. The Brief Interview for Mental Status was coded as "3" out of possible "15" indicative of severe cognitive impairment. Functional status for bed mobility was coded as requiring extensive assistance from staff. Risk for developing pressure ulcers was coded as "yes."

On 08/19/19, the clinical record was reviewed. A physician's order dated 08/08/2019 documented, "Pressure-relieving boots on both feet while in bed."

The care plan was reviewed. A focus initiated on 06/06/2019 and revised on 06/20/2019 documented, "The resident has pressure injury r/t [related to] immobility, incont & fragile skin [incontinence and fragile skin]. Has lower extremity contractures. Has wd [wound] to sacrum." One intervention associated with this Focus dated 08/16/2019 documented, "Pressure-relieving boots while in bed."

On 8/19/2019 at 6:20 p.m., Resident #145 was observed lying in her bed with the head of the bed elevated 60 degrees. Certified Nurse Aide K (CNA K) was observed assisting Resident #145 to eat for dinner. Resident #145 was covered with a sheet from the waist down. CNA K was asked if Resident #145 was wearing her soft boots and he lifted the sheet to expose both of her feet and she did not have her soft boots on. When asked if

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Resident #145 was supposed to have soft boots on while in bed, CNA K stated he didn't know and added that he was only assisting her with feeding and someone else does all the other care.

On 08/19/2019 at approximately 6:25 PM, an interview with Licensed Practical Nurse G (LPN G) was conducted. When asked if she was Resident #145's nurse, LPN G replied "Yes." When asked if Resident #145 is supposed to be wearing soft boots while in bed, LPN G stated "I don't know, I'm an agency nurse." LPN G then looked at the electronic health record and stated that Resident #145 should have her boots on. LPN G then walked into Resident #145's room to verify that Resident #145 was not wearing her soft boots. CNA K and LPN G looked around the room for Resident #145's boots and could not locate them. After leaving Resident #145's room, LPN G was asked about the importance of wearing soft boots for Resident #145 and she stated, "It's important for her skin integrity."

On 08/20/2019, the Treatment Administration Record for 08/01/2019 through 08/19/2019 was reviewed. For the treatment (initiated on 08/08/19 at 3:00pm) entitled, "Pressure relieving boots on both feet while in bed. Every shift", there were 6 shifts out of 35 shifts left blank and not signed off as administered. On the evening it was observed that Resident #145 did not have her boots on and the facility staff was unable to locate them in her room, they were signed off as administered for all three shifts (08/19/2019).

On 08/20/2019 at approximately 10 a.m., the DON was asked about her expectations and the use of pressure reducing devices. When shared concerns regarding Resident #145, the DON

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stated "I would expect that she would have her boots on as ordered."

The facility provided a copy of their policy entitled "Clinical Guidelines Skin & Wound." The policy did not specifically address ensuring pressure-relieving devices were implemented as ordered by the physician.

On 06/20/2019 at approximately 7:45 PM, the administrator and the DON had no further information or documentation to offer.

3. For Resident #104, the facility staff failed to develop a care plan for activities.

Resident #104, originally admitted on 4-4-17, and discharged to the Hospital on 7-28-19 with an anticipated return. The Resident was re-admitted to the facility on 7-31-19, after a 3 day hospitalization. Diagnoses included; fractures, urinary tract infections, chronic lung disease, hypertension, chronic kidney disease, and recurrent major depression.

Resident #104's most recent Minimum Data Set with an Assessment Reference Date of 8-7-19 was coded as a full comprehensive review. The Brief Interview for Mental Status (BIMS) score was coded as a 3 out of a possible 15 indicative of severe cognitive impairment. Toileting, dressing, and personal hygiene were coded as extensive to total dependence on staff.

On 8-15-19 at approximately 9:40 a.m., Resident #104 was observed sleeping in bed with the head

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of the bed elevated approximately 45 degrees. Resident #104 was wearing a hospital gown and was covered with a blanket from the waist down.

On 8-15-19 at approximately 3:15 p.m., Resident #104 was observed sleeping in bed with the head of the bed elevated approximately 45 degrees. Resident #104 was wearing a hospital gown and was covered with a blanket from the waist down.

On 8-16-19, The Corporate Registered Nurse Consultant was asked for a copy of the Residents current full care plan. Resident #104's care plan was reviewed, and found to have been created on 7-29-19. Multiple revisions and additions had been made to it since the Resident had been readmitted. The document totaled 28 pages. The care plan review revealed no activities care plan. The only intervention mentioning activities in the care plan was as follows:

"FOCUS - The Resident has potential for injury related to falls related to impaired cognition, frequent incontinence, impaired mobility, use of psychotropic medication use (sic) has a habit of walking with walker and items in her hand at the same time. History of fall. INTERVENTIONS - The resident needs activities that minimize the potential for falls while providing diversion and distraction." dated 7-29-19. There was not a specific focus or measurable goals for Activities.

On 8-16-19 the Activities director was asked to provide the Resident's activities plan. None was received. The DON was asked if she would expect to see activities addressed on the care plan, she stated, "Yes, they should be."

There was no evidence an individualized plan for

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{F 656}	Continued From page 36 activities was scheduled or implemented for Resident #104. On 8-20-19 at approximately 4:45 p.m., the DON was notified of findings and offered no further information or documentation.	{F 656}		
{F 684} SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to ensure treatment was received for four residents (Residents #139, 125, 103, 109) in a survey sample of 46 residents. Resulting in harm for resident #139 The findings include: 1. For Resident #139, the facility staff failed to provide needed care and services for a urinary tract infection causing progression to sepsis and hospitalization. This is harm. Resident #139, a 55 year old male, was admitted to the facility on 7/16/2018 and discharged to a local hospital on 8/6/2019. His diagnoses included quadriplegia, dysreflexia, and	{F 684}	1. Resident # 139 is no longer in facility. Resident #125's wound care orders were clarified and implemented on8/9/19. Resident # 103 is currently out of the facility; Resident #109's knee immobilizer was discontinued on 9/8/19; MD was notified on 9/8/19 of delay in treatment upon return from hospital. Residents who have a Foley catheter have the potential to be affected by this alleged deficient practice. 2. Residents who have a wound care orders are at risk for the alleged deficient practice. Current Residents that receive medication are at risk for alleged deficient practice. Unit Managers/ designee will complete audit of residents with Foleys to ensure catheter care is provided as	9/30/19

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{F 684}	Continued From page 37 neuropathic bladder. Resident #139's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/19/2019 was coded as a quarterly assessment. Resident #139 was coded a BIMS (Brief Interview of Mental Status) score of 15/15 which indicated no cognitive impairment. He was totally dependent on the assistance of 1-2 persons for his activities of daily living. He was always incontinent of bowel and used a suprapubic catheter (a catheter that goes through the abdominal wall into the bladder) for urinary elimination. On 7/17/2019 a physician assessment indicated that Resident #139 was positive for a urinary tract infection. He was prescribed the antibiotic Macrobid to continue for 7 days. The July 2019 MAR (Medication Administration Record) indicated that this medication was administered. However, there was no urinalysis culture and sensitivity report which would confirm the diagnosis of a urinary tract infection and specify the antibiotic, Macrobid, would resolve the infection. Thus, it was not certain that Macrobid was the proper antibiotic for this infection. There were no further notes indicating any distress for Resident #139 until 8/6/2019 at 2:01 AM. A note at that time indicated that he had experienced a large watery bowel movement, and he was unresponsive to painful stimuli. The physician was notified and he issued an order to transfer Resident #139 to the local hospital emergency department. Hospital records were obtained and reviewed.	{F 684}	needed and urine color and clarity is document. Unit Managers / designee will complete Medication Administration Record (MAR) to medication cart comparison to ensure medication availability. Unit Manager /designee will conduct and audit of residents receiving wound care to ensure physician orders are being followed as prescribed. Follow up based on findings. 3. Nursing staff will be educated on providing care to residents with Foleys catheters, including documentation of catheter care and documentation of color and clarity of urine by SDC/Designee. Nursing staff will be educated on Medication administration by the SDC or Designee. Nursing staff will be educated on following physician ordered for wound care treatments and importance of timeliness of implementation of wound care orders. 4. Unit Managers/designee will conduct audits of residents with Foleys to ensure catheter care is provided and urine clarity and color are documented, 3 times per week for three months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule may be modified based on findings 5. Date of Compliance 9/30/2019	

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The records indicated that when Resident #139 arrived at the hospital he was still unresponsive and he was immediately intubated due to low respirations, altered mental status, and declining oxygen saturation.

An initial urinalysis at the hospital showed a "severe" urinary tract infection, and bloodwork showed a White Blood Cell count of 24.9 (normal=4-11) indicating that an infection was present. There was dark tea colored urine in the urine bag.

Resident #139 diagnoses at the hospital were "severe" septic shock, respiratory failure, urinary tract infection.

2. For Resident #125, the facility staff failed to initiate a physician's order for wound care.

Resident #125, a 68 year old male, was admitted to the facility on 4/15/2019. His diagnoses included Parkinson's, paranoid schizophrenia and lymphedema. Resident #125's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/21/2019 was coded as a quarterly assessment. Resident #125 was coded a BIMS (Brief Interview of Mental Status) score of 13/15, indicating no cognitive impairment. Resident #125 required extensive assistance of 1-2 persons for his activities of daily living and was coded as being always incontinent of bowel and bladder.

On 7/18/2019 a wound care physician visited Resident #125 to provide care for lymphademic wounds on both feet. He prescribed gauze

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{F 684}	Continued From page 39 sponges to be applied to both feet and wrapped in gauze dressing. On 8/20/2019 at 3:00 PM, Resident #125 was seen on the outside patio in a wheelchair. His legs and feet were covered with "Unna Boots", gauze bandages impregnated with zinc oxide and wrapped tightly around the lower legs and feet. This was not the treatment that the wound care physician had ordered. 3. For Resident #103, the facility staff failed to administer her Celexa on 08/13/2019 as ordered by the physician. Resident #103, a 77-year old female, was admitted to the facility on 01/20/2019. Diagnoses included but not limited to major depressive disorder. Resident #103's most recent Minimum Data Set with an Assessment Reference Date of 08/01/2019 was coded as an annual assessment. "Total Severity Score" for "Mood" was coded as "00" indicative of no depressive symptoms. "Antidepressant Medications Received" was coded as "7" meaning Resident #103 received an antidepressant each day during the 7-day look-back period. On 08/14/2019 at approximately 8:45 AM, Resident #103 was asked if she had any concerns. Resident #103 stated she did not receive her medications last evening. On 08/14/2019, the physician's orders were	{F 684}		

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reviewed. An order with a start date of 01/21/2019 documented, "Celexa [an antidepressant] tablet 10 MG [milligrams] (Citalopram Hydrobromide) Give 1 tablet by mouth in the evening for depression"

On 08/14/2019 at approximately 10:45 AM, Registered Nurse B (RN B), the unit manager, was asked about the medications Resident #103 received on the evening of 08/13/2019. This surveyor and RN B observed the electronic Medication Administration Record (eMAR) for Resident #103 on 08/13/2019. All of Resident #103's evening medications were signed off as administered with the exception of Celexa. For the administration of Celexa (scheduled 08/13/2019 at 5pm), it was coded as "9" meaning "Other/see Nurse Notes" and signed by Licensed Practical Nurse D (LPN D).

An eMAR note dated 08/13/2019 at 6:58 PM by LPN D documented, "Celexa tablet 10 mg Give 1 tablet by mouth in the evening for depression not available."

On 08/14/2019 at approximately 11:00 AM, this surveyor and RN B approached the med cart to observe the medications available for Resident #103. There were 2 tablet cards of Celexa (Citalopram 10 mg) for Resident #103. Each tablet card had a capacity for 30 tablets. There were 6 tablets remaining in one card and 17 tablets remaining in the other card. RN B and this surveyor also observed Celexa tablet in the back-up box.

On 08/14/2019 at 4:30 PM, an interview with LPN D was conducted. When told about the observation of Celexa tablet cards in the med

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cart, LPN D stated that she didn't see them in the cart on 08/13/2019.

The care plan was reviewed. A focus initiated on 12/15/2015 and revised on 10/17/2016 documented, "[Resident #103] use anti-depressant medication for dx [diagnosis] of major depressive disorder." The goal associated with this focus (revised on 08/08/2019) had a target date of 11/14/2019 and documented, "[Resident #103] will have no issues related to anti depressant use thru [sic] next review date." An intervention associated with this focus/goal initiated on 03/01/2016 documented, "Medication as ordered (see MAR)."

According to Lippincott Manual of Nursing Practice, 10th edition, 2014, under the header, "Standards of Practice", it was documented that common departures from the standards of nursing care included "failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately."

The facility staff provided a copy of their policy entitled, "General Dose Preparation and Medication Administration." Procedures associated with medication unavailability were not addressed in the policy.

On 06/20/2019 at approximately 7:45 PM, the administrator and the DON had no further information or documentation to offer.

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4. For Resident #109 the facility staff failed provide timely comprehensive wound care.

Resident #109 was re-admitted to the facility on 6-8-19 for rehab after a fall and fracture of her right knee with surgery to repair it. The Resident wore a knee immobilizer when she returned to the facility. The Resident had a history of diagnoses to include: Heart disease, diabetes, recurrent major depression, seizures, glaucoma, anxiety, and congestive obstructive pulmonary disease.

Resident #109's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 7-17-19. Resident #109 was coded with a Brief Interview of Mental Status score of "13 out of a possible 15 indicating no cognitive impairment. Resident #109 required limited assistance of one staff member for all activities of daily living except locomotion off of the unit which required extensive assistance with a wheel chair. The Resident was coded as having a surgical wound which required wound care.

On 8-14-19 at approximately 3:00 p.m.., the Resident was interviewed in her room and she refused to allow the knee dressing to be removed to view the wound.

Physician orders were reviewed and revealed the following 6 medication and treatment orders for the Resident's treatment of the right knee surgical wound after her readmission on 6-8-18.

1. Ordered 6-15-19 to begin 6-16-19 - "Remove immobilizer to right knee every day to access area for skin breakdown." The Treatment

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Administration Record (TAR) documented this as having been completed by staff.

2. Ordered 7-9-19 - "Consult wound care as needed".

3. Ordered 7-9-19 - Weekly skin checks every Wednesday to begin 7-10-19, and every Saturday to begin 7-13-19. This appeared on the TAR, however, only for Wednesdays, and not for Saturdays, as the physicians orders required. Skin checks were not completed on Wednesday 8-7-19, and were never completed on Saturdays.

4. Ordered 7-26-19 - "TheraHoney sheet (wound dressing) apply to right knee topically every day shift for wound healing cleanse with normal saline and apply dry dressing." Discontinued 8-8-19.

5. Ordered 8-8-19 Cephalexin capsule (antibiotic) 500 mg every six hours (to be given at 12mn, 6 a.m., 12 noon, and 6 p.m.) by mouth for surgical site infection for 7 days. To start on 8-9-19. The MAR (Medication Administration Record) revealed that on all four administration times for 8-9-19, 8-10-19, 8-11-19, and on 8-12-19 at midnight only, nurses documented the code "U" (which means "unknown" in the MAR code), and "-SA" which has no code attached to describe the meaning in the record, and appears no where else in the document. The medication was not administered for 3 days after ordered, and was omitted for a total of 13 doses. The facility stat box contents were reviewed and Cephalexin (Keflex) was available in the facility stat medication box for immediate need of administration.

6. Ordered 8-9-19 - "Santyl Ointment (enzymatic

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removal agent for dead necrotic tissue) 250 unit/GM (grams) apply to right knee topically every day shift for wound healing cleanse with normal saline apply Santyl and cover with dry dressing." To start 8-9-19, and was not completed on 8-12-19.

Review of the nursing notes documented by LPN C (wound nurse) indicated that on 8-3-19 the interdisciplinary team met and discussed the findings by Licensed practical Nurse (LPN) C. He had assessed the knee and had documented the following:

On 8-3-19 at 4:46 p.m., the nurse wrote "slight slough and drainage from the incision (surgical site) noted to right knee, also redness around wound bed noted. Continue with current treatment orders, will continue to monitor daily."

No other nursing notes describe the wound until 3 days later 8-6-19 at 2:29 p.m., when LPN C documents again "Wound to right knee 30% slough and drainage from incision (surgical wound still closed) noted to right knee, also redness around wound bed noted, no odor noted, will continue to monitor." The Resident continues to complain of knee pain in the notes daily.

On 8-8-19 a social work note describes that the social worker has set up transportation to an orthopedic appointment scheduled for 8-16-19, at 10:30 a.m.

On 8-9-19 the Resident continues to complain of knee pain. A nursing note describes the Resident as "continue oral antibiotic related to right knee wound". Which is documented as not given on the MAR, and "small amount purulent (infected

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pus) blood tinged drainage, and resident tolerates well (wound care)."

On 8-12-19 the nursing note documents at 1:56 a.m., "patient continues on antibiotic from right knee infection." However, this was documented as not given on the MAR.

From 8-13-19 through the time of survey the Resident continued to complain of pain and was administered pain medication with effective results.

Physician progress notes were reviewed and revealed only one note for the months of July and August 2019, that note was written on 7-5-19, and the doctor did not see the Resident again. The note revealed a diagnosis and assessment which documented "local infection of the skin and subcutaneous tissue of the right knee with swelling, redness, warmth, and pain complaints.

All August 2019 "Weekly skin integrity review"(WSIR) 2 page assessment documents , and "Non-pressure Skin Condition" (NPSC) 3 page assessment documents, were reviewed and revealed that LPN C assessed the wound and documented the following;

WSIR On 8-1-19, No description, only: "Right knee open area treatment in place."
NPSC On 8-1-19, "left leg, drainage small to medium amount, yellow, purulent, with no odor, wound edges intact."
NPSC On 8-6-19, left knee (front), drainage small to medium amount, pink/red, purulent, with no odor, peri wound area intact."
WSIR On 8-8-19, "Right knee (front) surgical incision-recent knee surgery/broken patella (knee

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cap), skin intact."

The surgical incision was in the right knee, and all 4 of these assessments were conducted by LPN C. LPN C was interviewed by surveyors and stated he may have made some errors, and it was the right knee.

The care plan was reviewed and revealed the following:

FOCUS - initiation Dated 7-31-19 - "The Resident is at risk for metabolic complications related to diagnosis of diabetes type 2". INTERVENTIONS - "If infection present consult doctor regarding any changes in diabetic medications. Monitor/document/report as needed any signs symptoms of infection to any open areas: Redness, pain, heat, swelling, or pus formation."

FOCUS - initiation all Dated 8-9-19, unless another date is listed - "(name) the Resident has right knee unhealed surgical wound." INTERVENTION - "Administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing. Monitor dressing to ensure it is intact and adhering. Report loose dressing to nurse. Monitor/document/report as needed any changes in skin status. Observe for pain during wound care. Remove immobilizer to right knee daily and as needed to assess for skin integrity (7-31-19). Administer antibiotic per doctor's order (7-9-19).

The facility Administrator and her team were advised of the failure of staff to provide timely comprehensive wound care for Resident #109 on 8-20-19 at the end of day meeting. They presented no further information.

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{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. 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 provide care and treatment to prevent and treat pressure ulcers for three Residents (Resident #133, #134, and #145) in a survey sample of 46 Residents. This resulted in harm for Resident #133. Immediate Jeopardy was identified on 08/14/2019 at 5:16pm at which time the facility was notified. After verification, Immediate Jeopardy was abated on 08/20/2019 at 3:54pm and the scope and severity was lowered to a Level three isolated. The findings included: 1. For Resident # 133, the facility staff failed to identify a pressure wound until it was identified as a stage 3 pressure wound ulcer on the Achilles	{F 686}	1. Resident #134 Mattress was replaced on 8/14/19 and is working properly. Resident #134 was assessed by the attending physician and hospital discharge summary orders for wound care were addressed on 8/15/19. Resident 133 pressure ulcer is heeled. Residents # 145 pressure relieving boots were applied during survey. 2. Residents with pressure ulcers who have the potential to be affected by this alleged deficient practice. Residents with pressure ulcers will be assessed to ensure that they have ordered interventions in place and they are in working order. Residents who were readmitted from the hospital in the past 30 days with wounds will be audited for discharge orders to ensure orders were addressed. The facility Maintenance Director conducted an audit on 8/14/19 of	9/30/19

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{F 686}	Continued From page 48 heel on 8/8/2019 and described as a stage 3. This is harm. Resident #133, a 90 year old female, was originally admitted to the facility on 8/30/2010, discharged on 7/24/2019 and readmitted on 7/30/2019. Her diagnoses included but were not limited to: Partial Traumatic Amputation of the right lesser toe, Toe Osteomyelitis, right, closed fracture of second toe of right foot, Contracture of the right knee and Dementia, The most recent Minimum Data Set assessment was a 14 day Medicate Assessment with an assessment reference date (ARD) of 8/11/2019. Resident # 133 was coded as having severe cognitive impairment. Resident #133 was coded as requiring extensive to total assistance of one to two staff persons for Activities of Daily Living to include she required extensive assistance of two staff persons for bed mobility and transfer.. Review of the clinical record was conducted on 8/14/2019 and 8/19/2019. Resident #133 had a history of impaired skin integrity with worsening ulcers the toes on her right foot resulting in amputation of the second toe during a hospital stay 7/24/2019-7/30/2019. Resident developed a stage 3 pressure ulcer on her right heel that was identified on 8/8/19 (4 days after the AOC date). This was the same foot on which Resident # 133 was ordered to receive daily treatments to the toes on the right foot since returning to the facility on 7/30/2019 after amputation of her right lesser toe. The staff failed to administer treatments to the right heel as ordered by the physician on 8/11/19 and 8/14/19.	{F 686}	air mattresses to ensure that they are in proper working order. Issues identified will be reported to the Executive Director and immediately corrected. 3. The facility staff- Nursing, Housekeeping/Laundry, Dietary, Administration, Therapy, Maintenance, Social Services, and Activities will be educated on pressure ulcers and include interventions such as air mattresses being in proper working order, and process of reporting malfunctioning equipment to maintenance staff and facility leadership. The nursing staff will be educated on skin assessment completion and documentation and notification of MD if new area identified to include implementation of new orders by SDC or designee. 4. The Unit Managers / Wound Care Nurse will audit 6 weekly skin observations x 3 months to monitor for compliance; variances will be addressed, and findings reported weekly to DON/ADON. The Unit Manager / designee will conduct 3 resident observations weekly x 3 months to validate that pressure ulcer care interventions are appropriate and are being implemented. Variances found, will be immediately corrected, and responsible staff re-educated. Findings from the weekly observations will be submitted to the DON / ADON for tracking / trending and further action as needed.	

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{F 686}	Continued From page 49 Review of the Hospital Discharge Summary dated 7/30/2019 revealed no documentation of a heel wound on discharge from the hospital on 7/30/2019. Review of the nurses notes revealed the following documentation: 8/7/2019 at 1400 (2 p.m.) Nursing Progress Note: Focus: The resident has surgical wound of amputated 2nd toe on right foot. Non pressure wound to 3rd toe on right foot." 8/8/2019 17:45 (5:45 p.m.) Nursing Progress Note: Late Entry: Clarification order for clean tongue with sponge every shift... (there was no mention of any wound assessment or wound care) 8/11/2019 at 06:09 (6:09 a.m.) Nursing Progress Note: Writer change dressing. No pain or distress at the time of dressing change. Writer apply therahoney sheet to lower right Achilles heel topically every day shift for wound healing cleanse area with normal saline apply honey sheet and cover with dry dressing" (sic) There were two Physicians Orders written on 8/3/2019 for treatments to the toes on the right foot. One was written for the 3rd toe on the right foot and the other was for the 2nd toe on the right foot. Review of Physicians Orders revealed there was no documentation of a heel wound until 8/8/2019 when an order was written for: TheraHoney Sheet apply to lower right Achilles Heel topically every day shift for wound healing.	{F 686}	The DON/designee will conduct review of 3 completed wound assessments per weeks x 3 months to ensure accurate evaluation and full documentation of the wounds; this review will also include a visualization of the pressure ulcer and interventions in place for pressure reduction. Variances found will be reviewed with the appropriate staff person for education and/or correction. The Facility Maintenance Director/ designee will conduct a weekly x 3 months of air mattresses to Ensure proper function. Findings from the above weekly observations and record review will be reported to the DON for tracking/trending. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule may be modified based on findings.	

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cleanse area with normal saline apply honey sheet and cover with dry dressing.

Review of the Weekly Skin Integrity Review Forms revealed a form dated 8/7/2019 under "weekly skin evaluation that read "site: right toe(s), description: 3rd toe.; "Skin intact: yes; Notes: toe was bandaged and wrap by wound nurse today" (sic). There was no mention of a heel wound.

There were four Non-Pressure Skin Condition Forms, two on 8/9/19 and two on 8/15/19. There were no mention of a heel wound.

"Pressure Ulcer Wound Rounds" dated 8/9/19 at 9:04 a.m. Initial Identification: the box was not checked for "present on admission"
Site: Right Heel , Type: Pressure , Length: 1.7 cm, Width: 0.5 cm, Stage III Wound Bed: Slough, Color: Pink, Wound Edges: Redness, Drainage: Small, Type: Purulent, Odor: None, Color: Pink/Red, Peri Wound Area: intact Signed by Wound Care Nurse, LPN (Licensed Practical Nurse) C.

8/15/19 at 14:05 (2:05 p.m.)
Site: Right Heel , Type: Pressure , Length: 1.4 cm, Width: 0.5 cm, Stage III Wound Bed: Slough, Color: Yellow, Wound Edges: Firm/ No Redness, Drainage: Moderate, Type: Purulent, Odor: None, Color: Pink/Red, Peri Wound Area: intact Signed by Wound Care Nurse, LPN (Licensed Practical Nurse) C.

Review of the August 2019 Treatment Administration Record revealed no documentation that treatments were administered to Resident # 133's Achilles heel on 8/14/2019.

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There were blanks for 8/14/19. There was a number 9 written for the treatments scheduled on 8/11/2019 (number 9 was the code for Other/ See Nurse Notes). Review of the nurses notes for 8/11/2019 revealed documentation "Medication Administration Note: done previous shift." There was no documentation on the Treatment Administration Record of who or if anyone administered the treatment on 8/11/2019.

Observation of the right heel wound was conducted on 8/19/19 with Licensed Practical Nurse C. The wound on the right heel was a Stage 3 with Full thickness tissue loss and yellow slough, measurement 1.4 cm x .5 cm.

Review of the 8/6/2019 5 Day Medicare MDS Assessment revealed documentation in the MDS section M0100 (Skin conditions), Resident # 133 was coded as at risk for pressure ulcer formation. The Resident currently had no pressure ulcers during the assessment at section (M0900). In review of section M1200, skin and ulcer treatments (preventive measures), only "pressure reducing device for bed" was coded. The section was also coded for surgical wound care. That mattress was classified by the manufacturer as a "pressure reducing mattress" according to the Corporate Registered nurse.

Review of the 8/11/2019 14 Day Medicare MDS Assessment revealed documentation in the MDS section M0100 (Skin conditions), Resident # 133 was coded as at risk for pressure ulcer formation. The Resident currently was coded for an unhealed pressure ulcer noted during the assessment at section (M0900). The pressure ulcer was coded as a Stage 3. In review of

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section M1200, skin and ulcer treatments (preventive measures), only "pressure reducing device for chair, and pressure reducing device for bed" were coded.

Review of the August 2019 physician's orders, and Medication and Treatment Administration Records (MARs/TARs), revealed that no preventive orders were documented as active orders prior to the development of the stage 3 pressure ulcer development on Resident #133's right heel on 8/8/2019.

On 8/19/19, LPN C, the wound care nurse, was asked about the purpose of the TAR. The reply was "that tells us what the doctor ordered, so the nurses can complete the treatments, and shows they are completed when we sign them off." LPN C stated the nurses should administer treatments as written by the physician.

On 8/20/19 at approximately 2:45 p.m., Corporate Nurse (Employee I) was asked to provide information about Resident # 133's wounds. Employee I stated the wounds to Resident # 133's toes were caused by Osteomyelitis and presented information from the Hospital Discharge Summary. No information was provided about the heel wound.

No further information was provided by the facility.

1a. For Resident #134 the facility staff failed to provide a functioning air mattress, this Resident had known Stage IV pressure ulcers.

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Resident #134 was admitted to the facility on 9/27/12, with a recent readmission date of 8/5/19. Resident #134's diagnoses included but were not limited to: MRSA (methicillin resistant staphylococcus aureus) infection, sepsis, stage IV pressure wounds and complete lesion at T2-T6 level of the thoracic spinal cord.

Resident #134's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 6/29/19 was coded as a quarterly assessment, Resident #134 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated he was cognitively intact. Resident #134 was coded as being totally dependent upon two staff persons for transfers.

On 8/14/19 at approximately 9:30am, Surveyor G entered the room of Resident #134. Upon opening the room door an audible whooshing noise could be heard. Upon further investigation it was noted that the air hoses coming from the pump connecting to the mattress were taped and the air heard, was air escaping from the hoses. Further observations revealed that Resident #134 was sitting in the middle of his bed and appeared to be sitting in a sunken in area with the mattress around him at a significantly higher elevation than where he was sitting.

On 8/14/19 during a Resident interview, Resident #134 stated if he put his hand underneath his buttocks he could feel the bed frame.

On 8/14/19 at approximately 9:45am Surveyor C accompanied Surveyor G to the Room of Resident #134. Surveyor C observed the mattress to be broken and air leaking from the air

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hoses as well. Surveyor C advised nursing staff at the nursing station that the air mattress for Resident #134 was not working properly.

Review of Resident #134's physician orders revealed an order dated 3/22/19 that read "skin: Pressure reducing mattress" and had an end date of 8/6/19.

Review of Resident #134's careplan revealed an entry dated 8/7/19 that read, "Focus: [Resident #134's name redacted] has potential/actual impairment to skin integrity of the r/t [related to] [sic] paraplegia, use of condom catheter, history of pressure ulcer, side effect of medications. Goal: [Resident #134's name redacted] will maintain or develop clean and intact skin and will be free from further skin breakdown by the review date. Interventions: pressure relieving/reducing mattress to protect the skin while IN BED."

During a wound care observation on 8/14/19 at 11:29am LPN C and RN A were asked about the air mattress, neither acknowledged they had previously been aware of the mattress not working properly.

On 8/14/19 at 2:43pm maintenance was observed changing out the air mattress for Resident #134. When the Maintenance Director was asked what he was doing, he stated "nursing told me it had a hole". When asked what the tape on the hoses was for, the maintenance director stated "I figured nursing taped it up". He stated he had no prior knowledge of the mattress not operating.

On 8/14/19 at 3:07pm the Maintenance Director was observed in the room of Resident #134 and

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Resident #134 was reporting that the replacement air mattress was not working properly.

On 8/14/19 at 3:27pm an interview was conducted with RN A, the Unit Manager. RN A was asked if the air mattress for Resident #134 was operating properly now and RN A said "I know he had to get a new pump and is there adjusting it now".

On 8/14/19 at approximately 3:40pm an interview was conducted with the Maintenance Director and he stated "the first pump I put on one of the buttons didn't work so I put a new pump on and it's working fine".

On 8/15/19 at 4:15pm an interview was conducted with the Maintenance Director in the presence of Surveyors C and Surveyor G. When asked about the preventative maintenance sticker on the air mattress, that was removed from Resident #134's bed which had the broken air hoses, the maintenance director stated he had called the rental company and "it was marked as lost" in their system. The sticker revealed preventive maintenance had been performed 5/16 (May 2016) and was due 5/17 (May 2017). When asked if anyone checks the beds or does preventative maintenance, the maintenance director stated, "not really, unless they tell me they are broken not really, housekeeping just cleans them".

On 8/15/19 at 4:15pm with the Maintenance Director Surveyors C & G observed the following: the air supply filter was severely soiled to the point light was not permeable through it. When asked if he could see light through the filter, the

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maintenance director held the filter to the light he indicated "not through that, no". He removed the tape that was wrapped around the tubing where air was escaping. When asked what it was, the maintenance director said "nursing tape and some kind of plastic or something." Further evaluation revealed the plastic appeared to be a kitchen product, like saran wrap and contained a sticker that had writing "** [two letters, redacted as they are Resident's initials]".

On 8/15/19 at approximately 4:45pm Surveyor D accompanied Surveyor G to the beauty shop where the air mattress which had been removed off of Resident #134's bed was stored. Surveyor G then obtained the following details: the tubing/air hoses had a circumference of 3 inches. The air tubes were a corrugated accordion type clear plastic tube with white coated pvc rings with the clear plastic between the rings. One of the tubes revealed that 1 inch of the clear plastic tube remained intact, while 2 inches was severed, being the hole. The second hose was also a circumference of 3 inches. It was broken in two places, with only 1/2 inch intact, with the remaining 2 1/2 inches being severed and was severely damaged.

On 8/15/19 at 4:52pm an interview was conducted in the conference room, with all surveyors present, with Employee D, the supply clerk. Employee D was asked to identify the material that maintenance had identified as "nursing tape" that was wrapped around the damaged air hoses. Employee D stated "I know exactly what that is" and returned with a roll of "Medfix EZ dressing retention tape". The product appears to be porous and the package labeling read, "uses: secures primary dressings and

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medical appliances. Features: low sensitivity adhesive, water resistant, perforations for easy tearing. Change frequency: up to 7 days".

Review of the policy titled "Bio-medical Equipment Management-Rental" with an effective date of 11/30/2014 read as follows: "All biomedical equipment that is rented shall be subject to the same requirements for testing and maintenance as facility owned equipment. Procedure: 1. Any company supplying the facility or its residents with bio-medical equipment, will provide the facility with a copy of its procedures for testing and maintaining their equipment. 2. All equipment will be required to have a tag or label showing the last date that it was tested. 3. During the quarterly check of all bio-medical equipment tags by the maintenance department, all rental equipment should be checked to make sure that the date of the last inspection is within the prior six month period. 4. All equipment without the proper tag should be placed out of service until the vendor can assure compliance with the preventative maintenance schedule."

Review of the "RecoverCare Manual for STAT 5000 C Low Air Loss Mattress Replacement System" read on page 6. "Air filter and filter cap. No tools are necessary to remove filter cap. MedaSTAT USA, LLC recommends that the filter should be inspected and cleaned or replaced with a Genuine MedaSTAT USA, LLC replacement part once a month to ensure optimal performance of the power unit." Page 9 stated, "15.0 Routine Maintenance. The STAT family of products are designed to need very little maintenance. MedaSTAT USA, LLC recommends that the air filter should be checked once a month and cleaned of visible soil". Page 10 read, "16.0

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Troubleshooting. Problem. 2. Patient is "bottoming out" inspection procedure: 2.2 check for mattress leaks. 2.3 check air filter for dirt/lint. Possible Solutions: 2.2 replace with appropriate spare parts. 2.3 clean or replace air filter." Page 11 read, "17.0 Returns for Service. This device is NOT user serviceable. SERVICE AND REPAIR MUST ONLY BE PERFORMED BY AN AUTHORIZED MEDASTATE USA, LLC TECHNICIAN OR REPRESENTATIVE. All service issues should be referred to your local MedaSTAT USA LLC dealer".

1b. For Resident #134 the facility staff failed to provide treatment to wounds as ordered.

Review of current physician orders for Resident #134 revealed an order dated 8/6/19 that read "Calcium Alginate Miscellaneous apply to left buttock topically every day shift for wound healing cleanse wound with normal saline, pat dry and apply calcium alginate and packed in wound bed, and cover with abdominal pad and secure with tape." There was another order dated 8/6/19 that read, "Calcium Alginate Miscellaneous Apply to right buttock topically every day shift for wound healing cleanse wound with normal saline, pat dry, and apply calcium alginate, cover with abdominal pad, and secure with tape."

Review of the TAR (treatment administration record) revealed that Resident #134 received no treatment to his left or right buttock wound from his return from the hospital on 8/5/19 until 8/9/19, when the calcium alginate was applied.

Review of the entire clinical record, to include but not limited to nursing notes, assessments,

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physician progress notes, etc. reveal no evidence of wound treatment until 8/9/19 (4 days following readmission). .

1c. For Resident #134 the facility staff failed to clarify an order and notify the physician of orders from the hospital.

Prior to Resident #134's hospitalization (from 7/31/19 to 8/5/19) his wounds were assessed at the facility on 7/25/19 and identified on the "Pressure Ulcer Wound Rounds" form as "left buttock, 9.7 cm x 9 cm, x 1 cm stage III; right buttock, pressure wound 10 cm x 5.5 cm, stage III."

Review of hospital records for Resident #134's hospitalization from 7/31/19-8/5/19 revealed a wound consult that occurred on 8/2/19 and read, "Pt [patient] has two Stage 4 pressure injury wounds. One to each ischial tuberosity. R [right] wound is 4.5 x 11 x 1cm with ruddy red base. Tissue smooth without signs of granulation. Undermining at the base at 3oclock with 20% yellow slough. L [left] wound is 7.5 x 10.5 x 1.5cm with undermining from 8 to 4oclock. Depths of undermining at 4oclock is 2cm; 9oclock is 2.5cm and 11oclock is 4cm. Drainage is a tan yellow coloration. Wound base is ruddy red with palpable bone and yellow fibrinous slough. Pt is reported to do limited turning which q [every] 2 hour turning would actually be beneficial for wound healing or at least assisting with keeping the wound stable. Recommend to clean wound with Vashe then place AquacelAg and fill void with kerlex, cover with dry dressing held with medipore tape. This dressing can be changed

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daily."

Review of the hospital discharge summary dated 8/5/19 read, "START taking these medications: vashe wound therapy solution start taking on 8/6/19 apply topically daily. STOP taking these medications: Calcium Alginate powder."

Review of a Nurse Practitioner progress note dated 8/15/19 revealed the following "Pt has a history of of [sic] noncompliance with his mediation [sic] and treatments. He has a stage 4 pressure ulcer to his left and right gluteus, the left gluteus measures 11 cm x 8 cm x 4cm and the right gluteus measures 9.5 cm x 5 cm x 0.2 cm. There was scant sanguineous drainage noted. His discharge paperwork showed to his wound treatment to be vashe cleanser apply topically. The order however is an incomplete order and didn't indicate the location to apply, what treatment to use for the actual wound and what dressing to apply. Due to the order not being complete it was not used."

3. For Resident #145, the facility staff failed to provide pressure relieving boots on both feet as ordered while she was in bed on 08/19/2019.

Resident #145, a 95-year old female, was admitted to the facility on 09/10/2008. Diagnoses included but not limited to generalized muscle weakness, bilateral knee contractures, dysphagia, and gastro-esophageal reflux disease.

Resident #145's most recent Minimum Data Set with an Assessment Reference Date of 07/03/19 was coded as a quarterly review. The Brief

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Interview for Mental Status was coded as "3" out of possible "15" indicative of severe cognitive impairment. Functional status for bed mobility was coded as requiring extensive assistance from staff. Risk for developing pressure ulcers was coded as "yes."

On 08/19/19, the clinical record was reviewed. A physician's order dated 08/08/2019 documented, "Pressure-relieving boots on both feet while in bed."

The care plan was reviewed. A focus initiated on 06/06/2019 and revised on 06/20/2019 documented, "The resident has pressure injury r/t [related to] immobility, incont & fragile skin [incontinence and fragile skin]. Has lower extremity contractures. Has wd [wound] to sacrum." One intervention associated with this Focus dated 08/16/2019 documented, "Pressure-relieving boots while in bed."

On 8/19/2019 at 6:20 p.m., Resident #145 was observed lying in her bed with the head of the bed elevated 60 degrees. Certified Nurse Aide K (CNA K) was observed assisting Resident #145 to eat for dinner. Resident #145 was covered with a sheet from the waist down. CNA K was asked if Resident #145 was wearing her soft boots and he lifted the sheet to expose both of her feet and she did not have her soft boots on. When asked if Resident #145 was supposed to have soft boots on while in bed, CNA K stated he didn't know and added that he was only assisting her with feeding and someone else does all the other care.

On 08/20/2019, the Treatment Administration Record for 08/01/2019 through 08/19/2019 was reviewed. For the treatment (initiated on 08/08/19

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at 1500) entitled, "Pressure relieving boots on both feet while in bed. Every shift", there were 6 shifts out of 35 shifts left blank and not signed off as administered. On the evening it was observed that Resident #145 did not have her boots on and the facility staff was unable to locate them in her room, they were signed off as administered for all three shifts (08/19/2019).

On 08/20/2019 at approximately 10 a.m., the DON was asked about her expectations and the use of pressure reducing devices. When shared concerns regarding Resident #145, the DON stated "I would expect that she would have her boots on as ordered."

The facility provided a copy of their policy entitled "Clinical Guidelines Skin & Wound." The policy did not specifically address ensuring pressure-relieving devices were implemented as ordered by the physician.

On 06/20/2019 at approximately 7:45 PM, the administrator and the DON had no further information or documentation to offer.

Immediate Jeopardy was identified on 08/14/2019 at 5:16pm at which time the facility was notified.

The facility presented the following abatement plan:

Resident #134 Mattress was replaced on 8/14/19 and is working properly. Resident #134 to be assessed by the attending physician and hospital discharge summary orders for wound care will be addressed on 8/15/19.

1. Residents with the potential to be affected by

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alleged deficient practice:

All residents with pressure ulcers who have the potential to be affected by this alleged deficient practice. Residents with pressure ulcers will be assessed to ensure that they have all ordered interventions in place and they are in working order. Residents who were readmitted from the hospital in the past 30 days with wounds will be audited for discharge orders to ensure orders were addressed. The facility Maintenance Director conducted an audit on 8/14/19 of all air mattresses to ensure that they are in proper working order. Any issues identified will be reported to the Executive Director and immediately corrected.

2. Systemic Changes:

I. The facility staff- Nursing, Housekeeping/Laundry, Dietary, Administration, Therapy, Maintenance, Social Services, and Activities will be educated on pressure ulcers and include interventions such as air mattresses being in proper working order, and process of reporting any malfunctioning equipment to maintenance staff and facility leadership. Education initiated on 8/14/19 and be on-going, no staff will return to work until they have completed the mandatory education on pressure ulcers. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. All staff currently working will be provided the mandatory education.

II. The center Divisional Executive Director to conduct an ADHOC Quality Assurance

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{F 686}	Continued From page 64 Performance Improvement meeting 08/15/19, including the Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Central Supply Clerk, Dietary Manager, Activity Director and the Environmental Services Director regarding the plan of removal of immediacy. The Regional Director of Clinical Services will make the Medical Director aware of the immediate jeopardy abatement plan via telephone on 8/15/19. The survey team verified the following: - New mattress for Resident #134 - All residents with pressure ulcers will be assessed and ensure all ordered interventions are in place and in working order - All residents readmitted in last 30 days with wounds audit DC orders were addressed - All air mattresses in working order - All staff educated on pressure ulcers and the process for reporting malfunctioning equipment by staff interviews After verification, Immediate Jeopardy was abated on 08/20/2019 at 3:54pm and the scope and severity was lowered to a Level three isolated.	{F 686}		
{F 689} SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	{F 689}		9/30/19

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{F 689}	Continued From page 65 §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, facility documentation review and clinical record review the facility administration failed to mitigate accident hazards for one Resident (Resident #134) in a survey sample of 46 Residents. Immediate Jeopardy was identified on 08/14/2019 at 5:16pm at which time the facility was notified. After verification, Immediate Jeopardy was abated on 08/19/2019 at 3:30 pm and the scope and severity was lowered to a Level two isolated. The findings included: For Resident #134, during a mechanical lift, the base of the lift was not fully extended. In addition, Resident #134 was left alone in a lift. Resident #134 was admitted to the facility on 9/27/12, with a recent readmission date of 8/5/19. Resident #134's diagnoses included but were not limited to: MRSA (methicillin resistant staphylococcus aureus) infection, sepsis, stage IV pressure wounds and complete lesion at T2-T6 level of the thoracic spinal cord. Resident #134's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 6/29/19 was coded as a quarterly assessment, Resident #134 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated he was cognitively intact. Resident #134 was coded as being totally dependent upon two staff persons	{F 689}	1.Residents #134 was attempted to be assessed by the License Nurse on 8/14/19, resident refused to allow assessment and stated that he had no injuries. Staff who failed properly supervise and use the mechanical lift while transferring Resident #134 at the time of the alleged deficient practice received one on one education regarding the Policy and procedure for use of the mechanical lift in accordance with manufacture instructions and expectations to utilize 2 staff members when using the mechanical lift and that residents are to never be left unattended when in the sling. This education was provided by the Director of Nursing on 8/15/19. 2. Residents who require the use of a mechanical lift have the potential to be affected by the alleged deficient practice. On 8/14/19 the Nursing Administration team identified residents that require use of a mechanical lift for transfer. Each resident identified to require a mechanical lift for transfer was assessed to ensure no signs of injury present. Identified adverse findings will be immediately reported and addressed in accordance with facility policy. 3.Direct care staff, which includes License Nurses, Certified Nursing Assistants & Therapy Staff, will receive education on Mechanical Lift Policy and Procedure in	

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{F 689}	Continued From page 66 for transfers. On 8/14/19 at 2:46pm, CNA F was observed in the room with Resident #134 without PPE (personal protective equipment) on, the Resident was on contact precautions. On 8/14/19 at approximately 2:50pm when CNA F exited the room, she was interviewed. CNA F stated, "I had to hurry up and get him off the lift and didn't see any gowns. He was left just hanging." When asked who had gotten Resident #134 into the mechanical lift CNA F indicated she didn't know she had just come on her shift. On 8/14/19 at approximately 2:47pm, this surveyor went to the nursing station and it was revealed that CNA G and CNA H had assisted Resident #134 into the lift. Upon interview CNA G stated, "I gowned up, took the lift into the room and wasn't comfortable with how he wanted me to put the sling under him so I came out and got him [referring to CNA H]." CNA G then stated, "we [referring to CNA H and herself] returned to the room, we hooked it up and asked if he wanted to sit in the chair or other bed and he said he would prefer to sit in the sling. I let maintenance know the bed was ready and while we were waiting we unbuckled the mattress, we saw a lot of bio-hazard so we got that together, took the gown off and came out of the room." CNA H stated, "he was just hanging over the A bed". CNA G and CNA H confirmed they had left Resident #134 suspended in the air in the mechanical lift sling and left the room. They stated that "maintenance was in the room". On 8/14/19 in the afternoon, an interview was conducted with Employee E, the Maintenance	{F 689}	accordance with manufacture instructions by the Staff Development Coordinator/Designee. Education was initiated on 8/14/19 to staff currently working on site at the facility. Education will remain on-going and no direct care staff member will be allowed to begin work until the mandatory education has been completed regarding the Mechanical Lift Policy, manufacture instructions, and a mechanical lift competency is completed. This Education will be provided to new direct care employees as part of their new hire orientation, also to include contract and agency staff prior to them starting work. 4.The DON or Designee will conduct weekly audits for 3 months of newly hires to ensure training new personnel have competencies for use of mechanical lift. Unit Manager or designee will conduct weekly observations of 3 residents for 3 months for proper use of the mechanical lift. Findings of the weekly audits will be submitted to the DON / ADON weekly for tracking / trending and further action as needed and a summary will be reported to the monthly QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on outcomes.	

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Director and he indicated he was working on changing out the mattress and was not supervising Resident #134 and was not aware nursing staff had even exited the room.

On 8/14/19 at 3:50pm, CNA I and CNA J went into Resident #134's room with a mechanical lift. They used the mechanical lift and at no point moved the legs of the lift out to extend the base of support and raised Resident #134 into the air. They were not able to obtain a weight because they had not zeroed out the scale prior to lifting. Surveyor G asked CNA I and CNA J if they had used this lift previously and CNA J stated "I have not". They again lifted Resident #134 into the air, again without extending the legs of the scale to extend the base of support.

On 8/19/19, during review of the facility plan of correction, conducted by Surveyor A and Surveyor F there was evidence of a skills fair held. This skills fair included a competency on use of the mechanical lift. The "Mechanical Lift Competency Skills Checklist" stated under number 2. "Two staff members are used during transfer." under number 7. "adjust the base of the mechanical lift so that the legs of the lift will be as wide as possible." CNA H and CNA I attended this training on 7/31/19 and CNA J attended this training on 7/16/19. There was no evidence CNA G attended this training.

No further information was provided.

Immediate Jeopardy was identified on 08/14/2019 at 5:16pm at which time the facility was notified.

The facility presented the following abatement

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{F 689}	Continued From page 68	{F 689}		

plan:

1. The corrective action for the alleged deficient practice will be accomplished by:

Residents #134 was attempted to be assessed by the License Nurse on 8/14/19, resident refused to allow assessment and stated that he had no injuries.

Staff who failed properly supervise and use the mechanical lift while transferring Resident #134 at the time of the alleged deficient practice received one on one education regarding the Policy and procedure for use of the mechanical lift in accordance with manufacture instructions and expectations to utilize 2 staff members at all times when using the mechanical lift and that residents are to never be left unattended when in the sling. This education was provided by the Director of Nursing on 8/15/19.

2. Residents with the potential to be affected by alleged deficient practice:

All residents who require the use of a mechanical lift had the potential to be affected by the alleged deficient practice. On 8/14/19 the Nursing Administration team identified residents that require use of a mechanical lift for transfer. Each resident identified to require a mechanical lift for transfer will be assessed to ensure no signs of injury present. Any identified adverse findings will be immediately reported and addressed in accordance with facility policy.

3. Systemic Changes:

I. Direct care staff, which includes License

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Nurses, Certified Nursing Assistants & Therapy Staff, will receive education on Mechanical Lift Policy and Procedure in accordance with manufacture instructions by the Staff Development Coordinator/Designee. Education was initiated on 8/14/19 to all staff currently working on site at the facility. Education will remain on-going and no direct care staff member will be allowed to begin work until the mandatory education has been completed regarding the Mechanical Lift Policy, manufacture instructions, and a mechanical lift competency is completed. This Education will be provided to all new direct care employees as part of their new hire orientation, also to include contract and agency staff prior to them starting work.

II. The center Divisional Executive Director to conduct an ADHOC Quality Assurance Performance Improvement meeting on 8/15/19, including the Medical Director, Director of Nursing, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Dietary Manager, Activity Director and the Environmental Services Director regarding the plan of removal of immediacy.

The Regional Director of Clinical Services made the Medical Director aware of the immediate jeopardy abatement plan via telephone on 8/15/19.

The survey team verified the following:
- Staff education on mechanical lift competency/supervision by interviewing staff

After verification, Immediate Jeopardy was abated on 08/19/2019 at 3:30 pm and the scope

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{F 689}	Continued From page 70 and severity was lowered to a Level two isolated.	{F 689}		
{F 726} SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review	{F 726}	1.CNA G received education on 8/14/19; CNA H received education on 8/14/19,	9/30/19

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{F 726}	Continued From page 71 the facility administration failed to ensure four staff (CNA G, CNA H, CNA I, CNA J) had the competencies and skill sets to provide nursing services to assure resident safety during use of a mechanical lift for one resident (Resident #134) in a survey sample of 46 residents. The findings included: Resident #134 was admitted to the facility on 9/27/12, with a recent readmission date of 8/5/19. Resident #134's diagnoses included but were not limited to: MRSA (methicillin resistant staphylococcus aureus) infection, sepsis, stage IV pressure wounds and complete lesion at T2-T6 level of the thoracic spinal cord. Resident #134's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 6/29/19 was coded as a quarterly assessment, Resident #134 was coded as having a BIMS (brief interview for mental status) score of 15, which indicated he was cognitively intact. Resident #134 was coded as being totally dependent upon two staff persons for transfers. On 8/14/19 at 2:46pm, CNA F was observed in the room with Resident #134 without PPE (personal protective equipment) on, the Resident was on contact precautions. On 8/14/19 at approximately 2:50pm when CNA F exited the room, she was interviewed. CNA F stated, "I had to hurry up and get him off the lift and didn't see any gowns. He was left just hanging." When asked who had gotten Resident #134 into the mechanical lift CNA F indicated she didn't know she had just come on her shift.	{F 726}	CNA I received education on 8/14/19, CNA J received education on 8/14/19. The above CNA□s received education regarding the Policy and procedure for use of the mechanical lift in accordance with manufacture instructions and expectations to utilize 2 staff members when using the mechanical lift and residents are to never be left unattended when in the sling. 2.Residents who require the use of a mechanical lift had the potential to be affected by the alleged deficient practice. 3.Direct care staff, which includes License Nurses, Certified Nursing Assistants & Therapy Staff, will receive education on Mechanical Lift Policy and Procedure in accordance with manufacture instructions by the Staff Development Coordinator/Designee. Education was initiated on 8/14/19 to staff currently working on site at the facility. Education will remain on-going and no direct care staff member will be allowed to begin work until the mandatory education has been completed regarding the Mechanical Lift Policy, manufacture instructions, and a mechanical lift competency is completed. This Education will be provided to new direct care employees as part of their new hire orientation, also to include contract and agency staff prior to them starting work. 4.The DON or Designee will conduct weekly audits for 3 months of newly hires to ensure training new personnel have competencies for use of mechanical lift. Unit Manager or designee will conduct weekly observations of 3 residents for 3	

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{F 726}	Continued From page 72 On 8/14/19 at approximately 2:47pm, this surveyor went to the nursing station and it was revealed that CNA G and CNA H had assisted Resident #134 into the lift. Upon interview CNA G stated, "I gowned up, took the lift into the room and wasn't comfortable with how he wanted me to put the sling under him so I came out and got him [referring to CNA H]." CNA G then stated, "we [referring to CNA H and herself] returned to the room, we hooked it up and asked if he wanted to sit in the chair or other bed and he said he would prefer to sit in the sling. I let maintenance know the bed was ready and while we were waiting we unbuckled the mattress, we saw a lot of bio-hazard so we got that together, took the gown off and came out of the room." CNA H stated, "he was just hanging over the A bed". CNA G and CNA H confirmed they had left Resident #134 suspended in the air in the mechanical lift sling and left the room. They stated that "maintenance was in the room". On 8/14/19 in the afternoon, an interview was conducted with Employee E, the Maintenance Director and he indicated he was working on changing out the mattress and was not supervising Resident #134 and was not aware nursing staff had even exited the room. On 8/14/19 at 3:50pm, CNA I and CNA J went into Resident #134's room with a mechanical lift. They used the mechanical lift and at no point moved the legs of the lift out to extend the base of support and raised Resident #134 into the air. They were not able to obtain a weight because they had not zeroed out the scale prior to lifting. Surveyor G asked CNA I and CNA J if they had used this lift previously and CNA J stated "I have	{F 726}	months for proper use of the mechanical lift. Findings of the weekly audits will be submitted to the DON / ADON weekly for tracking / trending and further action as needed and a summary will be reported to the monthly QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on outcomes	

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{F 726}	Continued From page 73	{F 726}		

not". They again lifted Resident #134 into the air, again without extending the legs of the scale to extend the base of support.

On 8/19/19, during review of the facility plan of correction, conducted by Surveyor A and Surveyor F there was evidence of a skills fair held. This skills fair included a competency on use of the mechanical lift. The "Mechanical Lift Competency Skills Checklist" stated under number 2. "Two staff members are used during transfer." under number 7. "adjust the base of the mechanical lift so that the legs of the lift will be as wide as possible." CNA H and CNA I attended this training on 7/31/19 and CNA J attended this training on 7/16/19. There was no evidence CNA G attended this training.

Review of the facility policy titled "Lifting and Moving Residents" read on page 4. "Note: two staff members must be present when transferring a resident with a mechanical (i.e. Hoyer) lift." On the same page the policy stated, "adjust the base of the mechanical lift so that it will be as wide as possible."

Review of the user manual for the Invacare Reliant mechanical lift on page 19 had a safety warning that read, "the legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety." On page 25 of this manual under "Lifting the Patient" the same safety warning is written, which stated, ""the legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety." Under 1. it stated, "with the legs of the base open and locked...." Page 5 of this manual defines safety warnings as "warning indicates a

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{F 726}	Continued From page 74 potentially hazardous situation which, if not avoided, could result in death or serious injury." No further information was provided.	{F 726}		
{F 755} SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	{F 755}		9/30/19

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{F 755}	Continued From page 75 This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility documentation review and clinical record review the facility staff failed to provide ordered medications to four Residents (Resident #112, Resident #140, Resident #141, Resident #107) in a survey sample of 46 Residents. The findings included: 1. For Resident #112 the facility staff failed to provide medications as ordered by a physician. Resident #112 was admitted to the facility on 1/11/16. His diagnoses included but were not limited to: unspecified systolic heart failure and COPD (chronic obstructive pulmonary disease). On 8/13/19 at 5:51pm during a Resident interview, Resident #112 stated that he has to keep up with his medications because the nurses will not order them from the pharmacy and he runs out. Review of physician orders for Resident #112 revealed the following orders [not an exclusive list]: * "Carvedilol tablet 12.5mg give 1 stable by mouth two times a daily related to unspecified systolic (congestive) heart failure". The date of this order was 1/8/18, with no end date. * "Budesonide Suspension 0.5 mg/2ml 1 ml inhale orally two times a day for COPD, rinse mouth after use." The date of this order was 1/8/18, and contained no end date. Review of Resident #112's MAR (medication administration record) for August 2019 revealed	{F 755}	1. For Residents #112, #140, #141 and #107 physician was notified of missed medication administration and of pain medication not available for medication on 9/8/19 no new orders given. For resident #107, pain medication was obtained on 8/11/19. 2. Residents that receive medication and pain medication are at risk for alleged deficient practice. Unit Managers / designee will complete audits of current facility residents with Physician orders for pain medication to ensure they are available and receive medications as ordered. Unit Managers / designee will complete Medication Administration Record (MAR) to medication cart comparison to ensure medication availability. 3. DON/Designee re-educated nursing staff related to medication availability and medication administration and documentation. Licensed nurse will be re-educated on what to do when medications are not available including notifying the provider and the pharmacy. Medications that were not available to be administered will be reported on the 24-hour report and reviewed during the morning meeting. Unit Manager / designee will investigate reason for unavailable meds and coordinate correction with pharmacy and ensure that the provider has been notified 4. Licensed nurse will conduct medication administration observations for 3	

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{F 755}	Continued From page 76 that on 8/5/19 he did not receive Budesonide Suspension 0.5mg/2ml and indicated to "see nursing note". Further review of Resident #112's MAR for Aug. 2019 revealed that Resident #112 did not receive Carvedilol tablet 12.5mg on 8/12/19 or either of the two doses on 8/13/19. Review of the nursing notes for Resident #112 revealed an entry on 8/5/19 that read, "medication not available scheduled to be delivered tonight by pharmacy". Review of the nursing notes revealed an entry on 8/13/19 at 10:01am that read, "waiting on pharmacy". 2. For Resident #140 the facility staff failed to administer medications as prescribed by the physician. Resident #140 was admitted to the facility on 6/4/19. Her diagnoses included but were not limited to: dementia with behavioral disturbance and mood disorder due to known physiological condition with depressive features. Review of Resident #140's physician orders revealed a current order, with an origination date of 8/2/19 that read, "Rivastigmine Tartrate Capsule 1.5 mg give 1.5 mg by mouth two times a day for dementia." Review of Resident #140's MAR revealed that on 8/9/19 the Resident did not receive Rivastigmine Tartrate Capsule as ordered.	{F 755}	residents per week for 3 months to ensure medications are available and administered per physician order. Variances will be addressed, and corrective action and/or education will be provided. Provider will be notified when medications were not administered due to availability. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 9/30/2019	

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{F 755}	Continued From page 77	{F 755}		

Review of Resident #140's nursing notes revealed an entry on 8/9/19 at 12:21pm that read, "medication not in cart, notified MD, reordered today for the next Pharmacy delivery. No side effects noted."

3. For Resident #141 the facility staff failed to administer medications as prescribed by the physician.

Resident #141 was admitted to the facility on 6/1/14. Her diagnoses included but were not limited to: Type 2 diabetes mellitus and schizophrenia.

Review of Resident #141's physician orders revealed a current order, with an origination date of 6/15/19 that read, "Capsaicin Cream 0.1% Apply to knees topically every day and evening shift related to Primary Generalized (osteo) arthritis".

Review of Resident #141's MAR revealed that on 8/6/19, two scheduled does on 8/9/19, 8/10/19 and 8/12/19 the Resident did not receive Capsaicin Cream as ordered.

Review of Resident #141's nursing notes revealed an entry on 8/9/19 at 19:54pm that read, "reordered cream from pharmacy, not in stock currently, resident denies pain to knees at this time".

On 8/20/19 at 9:48am. an interview was conducted with Employee B, the DON (director of nursing). When Employee B was asked what is

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the importance of administering meds in a timely manner, the DON stated, "that they are supposed to follow MD orders and they get what they need when they are supposed to have it.

Review of the facility policy titled "6.0 General Dose Preparation and Medication Administration" page 2 revealed the following: "Facility staff should 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 provided.

4. For Resident #107 the facility staff failed to ensure pain medications were available for administration.

Resident #107 was admitted to the facility on 10-26-18. The Resident's diagnoses included homelessness, pain, malnutrition, hypertension, multiple suicide attempts, and major depressive disorder. The Resident was noted to have severe contractures of both hands.

Resident #107's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5-3-19 was coded as a quarterly assessment. Resident #107 was coded with a Brief Interview for Mental Status (BIMS) score off "14" indicating no cognitive impairment.

On 8-14-19 the Resident was interviewed and stated that he was anxious and depressed about his condition and had pain in his extremities, which were noted to be severely contracted. The

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Resident stated that he could not always get his pain medication on time, because the nurses told him it was not available.

On 8-15-19 the Resident's nursing progress notes, physicians orders, and Medication Administration Record (MAR)were reviewed and revealed the following for Norco tablet 7.5-325 mg;

Nursing progress notes - 8-7-19 at 9:20 p.m.- "medication unavailable.", 8-8-19 at 6:45 a.m.- "medication unavailable.", 8-9-19 at 7:35 a.m.- "medication unavailable.", 8-11-19 at 1:32 p.m.- "medication unavailable.", 8-11-19 at 9:56 p.m.- "medication unavailable."

MAR - 8-7-19 "not given see nursing note", 8-8-19 "not given see nursing note", 8-9-19, "not given see nursing note", 8-11-19 2:00 p.m. "refused" however nursing notes indicate it was unavailable, 8-11-19 9:00 p.m. "not given see nursing note".

The current physician's order was found - Norco tablet 7.5-325 mg (milligrams) give one tablet by mouth every 8 hours related to low back pain non-pressure chronic ulcer of skin. Ordered on 11-20-18 soon after admission.

On 6-11-19 at approximately 3:45 p.m., the DON was asked about the expectation of nurses when administering medications and she stated that the nurse should administer the medications on time, and call the back up pharmacy for refill as needed on an emergency basis.

On 6-11-19 at approximately 4:00 p.m., the Administrator and DON were notified of findings

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{F 755}	Continued From page 80 and they offered no further documentation or information.	{F 755}		
{F 761} SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to label insulin as to when it was opened and/or when it was to be discarded as per manufacturer recommendations of after 28 days, for 2 vials of insulin located in the Colonial #3 medication cart	{F 761}	1. Insulin pens and vials removed and discarded during survey. Medication / treatment carts and medication storage areas for over-the-counter [OTC] medications will be inspected to ensure that medications have not expired, are	9/30/19

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{F 761}	Continued From page 81 and the facility staff failed to store medications in a locked compartment to ensure Residents and unauthorized staff do not have access for one of three medication carts on the Colonial unit. The findings include: On 8/13/19 at approximately 4:30 pm during review of the Colonial #3 medication cart, the following was observed: *A 3 milliliter Novolog FlexPen was noted open but with no open date. *A 10 milliliter multi-dose vial of Humalog U-100 was noted with an open date of 7/2/19 and an expired date of 7/30/19. An interview was conducted with LPN H who was present during the review of the Colonial medication cart #3. In reference to the Novolog FlexPen, LPN H stated, "This should have been marked with an open date, it has been used, I cannot tell when it was opened" and in reference to the multi-dose vial of Humalog, LPN H stated, "This insulin has expired and should not be on the cart, it should have been discarded on 7/30". Review of the facility policy located in the "LTC Facility's Pharmacy Services and Procedures Manual" and entitled, "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles", revised 07/23/19, subheading "Procedure", item 4 read: "Facility should ensure that medications and biologicals that (1) have an expired date on the label; (2) have been retained no longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier".	{F 761}	appropriately labeled/dated, and stored. 2. Current Residents receiving medication have the potential to be affected. Medication / treatment carts and medication storage areas will be inspected by DON/designee to ensure that medications have not expired, and are appropriately labeled/dated, and stored. 3. Licensed nursing staff will be re-educated on proper medication storage, including discarding of expired medications by DON/designee and external nurse consultant. Medication / treatment carts will be inspected weekly by licensed nurses to ensure that opened medications have been dated and that expired medications have been discarded per facility policy. 4. The DON and or designee will audit medication and treatment carts 2 times weekly for 3 months to ensure expired medications are discarded and proper medication storage is achieved. Variances will be corrected, and responsible staff will be re-educated. The results will be reported to the Quality Assurance Performance Committee by the DCS for 3 months for further compliance and or revisions	

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Item 5 read: "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened". Item 5.3 read: "If a multi-dose vial has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial".

Review of the manufacturer's drug information sheets and recommendations, for both the Humalog and the Novolog FlexPen, indicate to discard any unused medication 28 days after opening.

2. The facility staff failed to store medications in a locked compartment to ensure Residents and unauthorized staff do not have access for one of three medication carts on the Colonial unit.

On 8/14/19 at 9:47am, Surveyors C and G were walking up the hall and observed a medication cart parked outside of room 174. A cup of medications that contained 12 pills that consisted of white, pink, and a green pill.

LPN F came from the nursing station and approached her cart. When asked about the medications on top of the medication cart, LPN F stated "I'm so sorry I probably should have put it in the cart". When LPN F was asked to identify

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{F 761}	Continued From page 83 the pills in the container she named the following: "Spironolactone, senna, oxybutynin Chloride, Iron, lasix, and eliquis". LPN F stated the medications were for the Resident in room 174. LPN F confirmed there were 12 pills in the cup. Surveyor C identified one of the pills as being a narcotic. On the afternoon of 8/14/19, LPN F was asked to provide a list of the medications that had been left unattended on her medication cart and the handwritten list provided read, "Buspirone 5mg, Spironolactone 25mg, senna plus 8.6-50mg, oxybutynin chloride ER tablet 5mg, Ferrous sulfate 325mg, furosemide 20mg, eliquis tablet 5mg, Toprol XL tablet extended release." Review of the facility policy titled "5.3 Storage and Expiration Dating of Medications, biological's, syringes and needles" read, "3.3 Facility should ensure that all medications and biological's, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." No further information was provided.	{F 761}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	{F 880}		9/30/19

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{F 880}	Continued From page 84	{F 880}		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	R-C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(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 880}	Continued From page 85 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review the facility failed to wear personal protective equipment and follow transmission based precautions to prevent the spread of infections for one Resident (Resident #134) in a survey sample of 46 Residents. The findings included: Resident #134 was admitted to the facility on 9/27/12, with a recent readmission date of 8/5/19. Resident #134's diagnoses included but were not limited to: MRSA (methicillin resistant staphylococcus aureus) infection, sepsis, and stage IV pressure wounds. On 8/14/19 at 2:46pm, CNA F was observed in room 197, manipulating the bed linen with only gloves on. Room 197 was observed to have isolation supplies to include gowns, gloves,	{F 880}	1.CNA F was provided educated on Isolation Precautions including donning and doffing of Personal Protective Equipment 9/8/19. 2.All residents have the potential to be affected by deficient practice. DON/Designee will conduct an audit of current residents on isolation to ensure appropriate PPE is worn upon entering resident□s room. 3.Staff will be educated by the Staff Development Coordinator or Designee on Isolation precautions and the proper procedure for donning and doffing of Personal Protective equipment. 4.DON or designee with conduct an audit 3 times per week for 3 months to ensure employees are donning and doffing PPE	

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{F 880}	Continued From page 86 masks, etc. hanging on the door. Review of the Physician Orders for Resident #134, who resided in room 197 revealed he was on "contact isolation status" and had a diagnosis of MRSA (methicillin resistant staphylococcus aureus) infection. On 8/14/19 at 2:46pm, RN A, the Unit Manager was present outside of room 197 and when asked why CNA F was in the room without any PPE (personal protective equipment) on, the Unit Manager replied, "I just walked up with when you did, I will talk to her". On 8/14/19 at approximately 2:50pm when CNA F exited the room, she was asked what the isolation supplies on the door were for. CNA F stated "he is on isolation". When CNA F was asked why she wasn't wearing any of the PPE, CNA F stated, "I had to hurry up and get him off the lift and didn't see any gowns". When asked if she should have had a gown and mask on, CNA F stated "yes". Review of the facility policy titled "Isolation-Categories of Transmission-Based Precautions" read under the policy statement, "Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others." Under the contact precautions heading of the policy, it read: 1. "In addition to standard precautions, implement contact precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contract with the resident or indirect contact with environmental surfaces or resident-care items in the resident's	{F 880}	per policy and procedure. 5. Date of Compliance 9/30/2019	

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{F 880}	Continued From page 87 environment." 5. "Gown: a. wear a disposable gown upon entering the contact precautions room." The Center for Disease Control and Prevention (CDC) stated "based on the current evidence, CDC continues to recommend the use of Contact Precautions for MRSA-colonized or infected patients." Information found at the CDC website address: https://www.cdc.gov/mrsa/healthcare/inpatient.html accessed 8/23/19. No further information was provided.	{F 880}		