STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495315	A. BUILDING _____ B. WING _____	C 10/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced abbreviated Emergency Preparedness COVID-19 Focused Survey was conducted from 10/29/20 through 10/30/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced abbreviated COVID-19 Focused Survey was conducted from 10/29/20 through 10/30/20. A complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements The census in this 88 certified bed facility was 66 . Of the 66 current residents, 5 residents were positive for the COVID-19 virus. The survey sample consisted of five current resident reviews (Residents #1 through #5) and one closed record review (Resident #6).	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		12/1/20

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

Electronically Signed | 11/20/2020

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F 657	Continued From page 1 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to review and revise the care plan to include a pressure injury on the buttock, for one of six residents in the survey sample, Resident # 6. The findings include: Resident #6 was admitted to the facility on 8/15/2020 with diagnoses that included but were not limited to: knee replacement surgery, sciatica (pain felt in the back and down the back and outer part of the thigh and leg due to compression on sacral spinal nerve roots or the sciatic nerve, often associated with degeneration of an intervertebral disc.) (1), retention of urine, benign prostatic hypertrophy (An enlarged prostate) (2), high blood pressure and pain. The most recent MDS (minimum data set) assessment, an admission/Medicare five day	F 657	1. Resident #6 has been discharged. 2. Residents with wounds have the potential to be affected by the deficient practice. Care plans for residents with wounds will be reviewed by November 25, 2020. Revisions to Plans of Care will be made as needed to ensure residents with wounds have accurate and updated Plans of Care. 3. Licensed nurses responsible for updating resident's Plans of Care will be re-educated regarding accurate and timely revision to resident care plans. Education to be given by Director of Nursing or her designee. Re-Education to be given between 11-13-20 and 11-25-20. 4. Director of Nursing, or designee will review new orders, new or worsening wounds, nurses' notes and Progress Notes during morning meeting to ensure	

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F 657	Continued From page 2 assessment, with an assessment reference date (ARD) of 8/21/2020, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he was independent after set up assistance was provided. The resident was coded as having an indwelling catheter into his bladder. He was not coded on this assessment as having any pressure injury*/blisters. The discharge assessment, with an ARD of 8/30/2020 coded the resident as having a stage 2 pressure injury**. *A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (3) **Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture	F 657	that residents with new or worsening wounds have appropriate, updated Plans of Care weekly times 4 weeks and then monthly for 3 months. Variances will be reported to QAPI with the follow up as indicated 5. Date of Compliance: 12-1-2020	

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F 657	Continued From page 3	F 657		

associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)(3).

The comprehensive care plan dated, 8/28/2020, documented in part, "Focus: (Resident #6) has a pressure injury to his right heel." Further review of the care plan failed to evidence documentation of the pressure ulcer on the buttock.

The nurse practitioner note dated 8/27/2020 at 12:00 p.m. documented in part, "Patient is seen today for wound assessment per nursing requests...Skin inspection and palpation...1. Right buttock stage II ulcer related to shear: 0.8 X 0.6 (width by length in centimeters); wound bed is 100% granulated tissue; surrounding area blanchable. 2. Right heel slightly opened blister related to friction 7x 7.5 (centimeters); wound bed unstageable and filled with fluid; surrounding skin slightly macerated...Assessment and Plan: 1. Traumatic blister of heel - Ordered to apply skin prep and cover with foam dressing BID (twice a day) float heels while on bed. 2. Pressure ulcer of buttock - ordered to clean site with wound cleanser and apply barrier cream q (every) shift and PRN (as needed)."

The physician orders dated, 8/27/2020 documented, "1. Right heel blister - d/c (discontinue) previous order. 2. Right heel blister; cleanse with wound cleanser, apply skin prep & cover with foam dressing BID. 3. Float heel while on bed. 4. Clean right buttock stage II with wound cleanser apply barrier cream q shift and PRN."

An interview was conducted with LPN (licensed

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practical nurse) #2 on 10/30/2020 at 2:35 p.m. When asked who updates the care plans, LPN #2 stated the MDS nurse. When asked if a resident has a pressure sore on the heel and the buttock should the wounds be included in the comprehensive care plan, LPN #2 stated, "Yes, they both should be addressed on the care plan."

An interview was conducted with LPN #3 on 10/30/2020 at 2:38 p.m. When asked if both the resident's heel and buttock wounds be addressed on the care plan, LPN #3 stated she didn't remember him having a wound on his buttock, I remember his heel. When informed of the nurse practitioner note and orders of 8/27/2020, LPN #3 stated, "I must have missed it."

The facility policy, "Plans of Care" documented in part, "Review, update and/or revise the comprehensive care plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment and as needed."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (4).

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F 657	Continued From page 5 On 10/30/2020 at approximately 2:00 p.m. ASM (administrative staff member) #1, the executive director, was asked which professional standard of practice the facility follows. At 2:15 p.m. ASM #1 stated the facility follows both Perry and Potter and Lippincott. ASM #1, ASM #2, the interim DON (director of nursing) and LPN #2, were made aware of the above concerns on 10/40/2020 at approximately 4:00 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. (2) This information was obtained from the following website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (3) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf . (4) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		12/1/20

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F 658	Continued From page 6 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined the facility staff failed to follow professional standards of practice for one of six residents in the survey sample, Resident #6. 1.a. The facility staff failed to transcribe physician orders for Keflex and Aspirin to the MAR (medication administration record) upon admission. 1.b. The facility staff failed to transcribe the 8/27/20 physician orders for wound care for Resident #6's pressure sores on the right buttock and left heel. 1.c. The facility staff administered a treatment without a physician's order, for Resident #6. The findings include: 1.a. The facility staff failed to transcribe physician orders for Keflex and Aspirin to the MAR (medication administration record) upon admission. Resident #6 was admitted to the facility on 8/15/2020 with diagnoses that included but were not limited to: knee replacement surgery, sciatica (pain felt in the back and down the back and outer part of the thigh and leg due to compression on sacral spinal nerve roots or the sciatic nerve, often associated with degeneration of an intervertebral disc.) (1), retention of urine, benign prostatic hypertrophy (An enlarged prostate) (2),	F 658	1. Resident #6 has been discharged 2. A review will be conducted by November 25, 2020 for the past 7 days to ensure new admission MD orders have been transcribed per physician orders to include Keflex, aspirin and wound care. A review will also be conducted to ensure administration of a treatment has physician orders. 3. Licensed nurses will be re-educated regarding Medication transcription and Medication/Treatment Administration related to ensuring that there is an active Physician order prior to any treatment being administered. Education to be given between 11-13-20 and 11-25-20. 4. Director of Nursing, or designee will review new orders during morning meeting to ensure that physician orders have been transcribed and treatments have physician orders weekly times 4 weeks and then monthly for 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Date of Compliance: 12-1-2020	

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high blood pressure and pain.

The most recent MDS (minimum data set) assessment, an admission/Medicare five day assessment, with an assessment reference date (ARD) of 8/21/2020, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he was independent after set up assistance was provided. The resident was coded as having an indwelling catheter into his bladder. He was not coded on this assessment as having any pressure injury*/blisters. The discharge assessment, with an ARD of 8/30/2020 coded the resident as having a stage 2 pressure injury**.

*A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (3)

**Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar

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are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). (3)

The "Discharge Summary" from the transferring hospital, dated 8/15/2020 documented in part, "Discharge Medications:
Fiber Diet Tabs [tablet] - take 5 tablets by mouth daily.
lisinopril - hydrochlorothiazide 20 - 12.5 mg per tablet; take 1 tablet by mouth daily (The combination of lisinopril and hydrochlorothiazide is used to treat high blood pressure) (4).
mupirocin 2% ointment apply to both nostrils with a Q-TIP twice a day. (Mupirocin, an antibiotic, is used to treat impetigo as well as other skin infections caused by bacteria. It is not effective against fungal or viral infections) (5)
Pramipexole 0.5 mg tablet; take 0.5 mg by mouth daily. In the evening. (Pramipexole is in a class of medications called dopamine agonists. It works by acting in place of dopamine, a natural substance in the brain that is needed to control movement) (6)
The "Discharge Summary" further documented:
Discharge Instructions: You have been prescribed Keflex, an antibiotic, for 7 days last dose on 8/21/2020. Please complete the entire prescription course. Keflex (is in a class of medications called cephalosporin antibiotics. It works by killing bacteria.) (7)
You will take aspirin after discharge to prevent blood clots from forming in your legs. You should

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take aspirin 81 mg twice a day for 6 weeks." These instructions were documented in bold print. Aspirin (Taking aspirin helps prevent blood clots from forming in your arteries and may help lower your risk for a stroke or heart attack.) (8)

The MAR (medication administration record) for August 2020 documented in part,
Fiber Diet Tabs take 5 tabs po (by mouth) daily.
Lisinopril - hydrochlorathiazide 20-12.5 mg po QD (every day)
Mupirocin 2% ointment apply to both nostrils BID (twice a day) for 5 days.
Review of the MAR failed to document the transcription of the orders for Keflex or aspirin upon admission.

An interview was conducted with LPN (licensed practical nurse) # 2 on 10/30/2020 at 12:53 p.m., regarding the process staff follows for an admission as it related to the physician orders. LPN #2 stated the nurse reviews the orders from the hospital. Then they transcribe them onto the POS (physician order summary). The doctor signs off on the order and then they are transcribed onto the MAR, TAR (treatment administration record). When asked if the nurse should go through all of the documents sent with the residents, LPN #2 stated yes the nurse should ultimately review all documents sent from the receiving facility.

The facility policy, "Physician Orders: documented in part, "Admission Orders: Information received from the referring facility or agency to be reviewed and transcribed to the admission physician order form or electronic equivalent. The attending physician reviews and confirms the orders."

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On 10/30/2020 at approximately 2:00 p.m. ASM (administrative staff member) #1, the executive director, was asked which professional standard of practice the facility follows. At 2:15 p.m. ASM #1 stated the facility follows both Perry and Potter and Lippincott.

ASM #1, ASM #2, the interim DON (director of nursing) and LPN #2, were made aware of the above concerns on 10/30 /2020 at 4:00 p.m.

No further information was provided prior to exit.

1.b. The facility staff failed to transcribe thee 8/27/20 physician orders for wound care for Resident #6's pressure sores on the right buttock and left heel.

The nurse practitioner note dated 8/27/2020 at 12:00 p.m. documented in part, "Patient is seen today for wound assessment per nursing requests...Skin inspection and palpation...1. Right buttock stage II ulcer related to shear: 0.8 X 0.6 (width by length in centimeters); wound bed is 100% granulated tissue; surrounding area blanchable. 2. Right heel slightly opened blister related to friction 7x 7.5 (centimeters); wound bed unstageable and filled with fluid; surrounding skin slightly macerated...Assessment and Plan: 1. Traumatic blister of heel - Ordered to apply skin prep and cover with foam dressing BID (twice a day) float heels while on bed. 2. Pressure ulcer of buttock - ordered to clean site with wound cleanser and apply barrier cream q (every) shift and PRN (as needed)."

The physician orders dated, 8/27/2020

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documented, "1. Right heel blister - d/c (discontinue) previous order. 2. Right heel blister; cleanse with wound cleanser, apply skin prep (Skin Prep protects fragile skin) (9) & cover with foam dressing BID. 3. Float hell while on bed. 4. Clean right buttock stage II with wound cleanser apply barrier cream q shift and PRN."

Review of the MAR and TAR failed to document the above orders.

An interview was conducted with LPN (licensed practical nurse) # 2 on 10/30/2020 at 12:53 p.m. When asked if the orders written on 8/27/2020 should be transcribed to the MAR or TAR, LPN #2 stated that they should be. The nurse that documented she received the orders was no longer employed by the facility and was unavailable for interview.

The facility policy, "Physician Orders" documented in part, "Routine Orders - A nurse may accept a telephone order from the physician, physician assistant or nurse practitioner...The order is transcribed to all appropriate areas (MAR, TAR, etc) or electronic equivalent. The nurse shall sign off other orders upon completion or verification of transcriptions. The Clinical Nurse will notify pharmacy per pharmacy policy by telephoning, faxing or completing the order electronically."

According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished.

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On 10/30/2020 at approximately 2:00 p.m. ASM (administrative staff member) #1, the executive director, was asked which professional standard of practice the facility follows. At 2:15 p.m. ASM #1 stated the facility follows both Perry and Potter and Lippincott.

ASM #1, ASM #2, the interim DON (director of nursing) and LPN #2, were made aware of the above concerns on 10/30/2020 at 4:00 p.m.

No further information was provided prior to exit.

1.c. The facility staff administered a treatment without a physician's order, for Resident #6.

The physical therapy note dated, 8/27/2020, documented in part, "Pt (patient) reporting buttocks discomfort, buttocks assessed, with skin break down of open areas observed in multiple areas of buttocks, with skin breakdown also observed on R (right) upper thigh near groin region as well as posterior knee region RLE (right lower extremity). Bruise also identified on R lateral thigh. Nurse notified, with nurse assessing pt (patient) and applying Greer's goo. Earlier this date, nurse reported applying heel pad to RLE heel due to blister like skin breakdown, with nurse reporting pt appropriate to perform functional transfers and functional mobility d/t heel pad application...Summary - Today pt didn't have any bandages on his right heel. Therapist asked nurse if he needed a bandage and if he can ambulate. Nursing stated he did need a bandage and he could ambulate as long as he had no pain. Therapist did notice opening areas on his bottom and skin breakdown behind right knee

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and groin. Nursing did apply Greer's Goo (Greer goo consists of nystatin [Mycostatin] powder, 4 million U (units), hydrocortisone powder, 1.2 g (grams), and zinc oxide paste, [in a sufficient quantity]) (10) on his bottom, behind knee and groin regions."

The nurse practitioner note dated 8/27/2020 at 12:00 p.m. documented in part, "Patient is seen today for wound assessment per nursing requests...Skin inspection and palpation...1. Right buttock stage II ulcer related to shear: 0.8 X 0.6 (width by length in centimeters); wound bed is 100% granulated tissue; surrounding area blanchable. 2. Right heel slightly opened blister related to friction 7x 7.5 (centimeters); wound bed unstageable and filled with fluid; surrounding skin slightly macerated...Assessment and Plan: 1. Traumatic blister of heel - Ordered to apply skin prep and cover with foam dressing BID (twice a day) float heels while on bed. 2. Pressure ulcer of buttock - ordered to clean site with wound cleanser and apply barrier cream q (every) shift and PRN (as needed)." The nurse practitioner that wrote this note was no longer employed by the facility and was unavailable for interview.

The physician orders dated, 8/27/2020 documented, "1. Right heel blister - d/c (discontinue) previous order. 2. Right heel blister; cleanse with wound cleanser, apply skin prep & cover with foam dressing BID. 3. Float heel while on bed. 4. Clean right buttock stage II with wound cleanser apply barrier cream q shift and PRN."

The nurse who applied the Greer's Goo could not be identified by the clinical record as there was no documentation related to the resident's buttocks by nursing.

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An interview was conducted with LPN (licensed practical nurse) # 2 on 10/30/2020 at 12:53 p.m. When asked if a nurse can apply a treatment without a physician order, LPN #2 stated, "No." When asked if a physician order is required to apply Greer's Goo on a resident, LPN #2 stated, "Yes." When asked if Greer's Goo is the same as barrier cream, LPN #2 stated, No, Greer's Goo is a medication and barrier cream is a topical ointment we use for incontinence care.

The facility policy, "Administering Medications" documented in part, "Medications are administered in accordance with prescriber orders, including any required time frame."

ASM #1, ASM #2, the interim DON (director of nursing) and LPN #2, were made aware of the above concerns on 10/30/2020 at 4:00 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.
(2) This information was obtained from the following website:
https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.
(3) This information was obtained from the following website:
https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
.
(4) This information was obtained from the following website:

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F 658	Continued From page 15 https://medlineplus.gov/druginfo/meds/a601070.html (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a688004.html (6) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697029.html (7) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682733.html (8) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000092.htm (9) This information was obtained from the following website: www.allegromedical.com (10) This information was obtained from the following website: https://emedicine.medscape.com/article/1087691-medication#2.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		12/1/20

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F 686	Continued From page 16 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection for one of six residents in the survey sample, Resident #6. The facility staff failed to assess, document and treat Resident #6's two pressure injuries from 8/27/20 through 8/30/20, per the 8/27/20, physician orders. The findings include: Resident #6 was admitted to the facility on 8/15/2020 with diagnoses that included but were not limited to: knee replacement surgery, sciatica (pain felt in the back and down the back and outer part of the thigh and leg due to compression on sacral spinal nerve roots or the sciatic nerve, often associated with degeneration of an intervertebral disc.) (1), retention of urine, benign prostatic hypertrophy (An enlarged prostate) (2), high blood pressure and pain. The resident was transferred to the hospital on 8/30/2020. The most recent MDS (minimum data set) assessment, an admission/Medicare five day assessment, with an assessment reference date (ARD) of 8/21/2020, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident	F 686	1. Resident #6 has been discharged 2. Residents with wounds have the potential to be affected by the deficient practice. A review of orders for residents with wounds will be conducted by November 25, 2020 to ensure that an active treatment order is in place. 3. Wound Physician to round on all pressure wounds weekly and make recommendations as appropriate. Orders will be updated, obtained as needed, based on findings. Licensed nurses will be re-educated to ensure treatment orders for all wounds are obtained prior to treatment being initiated. Education to be given between 11-13-20 and 11-25-20 by Director of Nursing or her designee. 4. Director of Nursing or designee will perform a review of new or worsening wound documentation during morning meeting to ensure that treatment orders have been obtained for wounds as appropriate weekly times 4 weeks and then monthly for 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Date of Compliance: 12-1-2020	

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was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he was independent after set up assistance was provided. The resident was coded as having an indwelling catheter into his bladder. He was not coded on this assessment as having any pressure injury*/blisters. The discharge assessment, with an ARD of 8/30/2020 coded the resident as having a stage 2 pressure injury**.

*A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (3)

**Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)(3).

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The "Skin Evaluation" dated 8/15/2020 documented the resident had a "surgical site on right knee, dry feet, hard toenails." There was no documentation of any pressure injuries. The "Skin Evaluation" form was blank for the rest of the resident's stay at the facility.

Resident #6 scored a "16" on the Braden scale* dated 8/15/2020. A "16" indicates the resident is "At risk" for developing a pressure injury.

* The Braden Scale for Predicting Pressure Sore Risk was developed to foster early identification of patients at risk for forming pressure sores. The scale is composed of six subscales that reflect sensory perception, skin moisture, activity, mobility, friction and shear, and nutritional status. (4)

A physical therapy note dated, 8/27/2020, documented in part, "Pt (patient) reporting buttocks discomfort, buttocks assessed, with skin break down of open areas observed in multiple areas of buttocks, with skin breakdown also observed on R (right) upper thigh near groin region as well as posterior knee region RLE (right lower extremity). Bruise also identified on R lateral thigh. Nurse notified, with nurse assessing pt and applying Greer's goo. Earlier this date, nurse reported applying heel pad to RLE heel due to blister like skin breakdown, with nurse reporting pt appropriate to perform functional transfers and functional mobility d/t heel pad application...Summary - Today pt didn't have any bandages on his right heel. Therapist asked nurse if he needed a bandage and if he can ambulate. Nursing stated he did need a bandage and he could ambulate as long as he had no

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pain. Therapist did notice opening areas on his bottom and skin breakdown behind right knee and groin. Nursing did apply Greer's Goo ((Greer goo consists of nystatin [Mycostatin] powder, 4 million U (units), hydrocortisone powder, 1.2 g (grams), and zinc oxide paste, [in a sufficient quantity]) (5) on his bottom, behind knee and groin regions."

The occupational therapy note dated, 8/27/2020, documented in part, "During therapy therapist noticed drainage on his sheets and pt stated he thought it was coming from his heel. Therapist looked at his heel and his skin was white and rolled and there was drainage. This was reported to nursing."

The nurse practitioner note dated 8/27/2020 at 12:00 p.m. documented in part, "Patient is seen today for wound assessment per nursing requests...Skin inspection and palpation...1. Right buttock stage II ulcer related to shear: 0.8 X 0.6 (width by length in centimeters); wound bed is 100% granulated tissue; surrounding area blanchable. 2. Right heel slightly opened blister related to friction 7x 7.5 (centimeters); wound bed unstageable and filled with fluid; surrounding skin slightly macerated...Assessment and Plan: 1. Traumatic blister of heel - Ordered to apply skin prep and cover with foam dressing BID (twice a day) float heels while on bed. 2. Pressure ulcer of buttock - ordered to clean site with wound cleanser and apply barrier cream q (every) shift and PRN (as needed)." The nurse practitioner that wrote this note was no longer employed by the facility and was unavailable for interview.

The physician orders dated, 8/27/2020 documented, "1. Right heel blister - d/c

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(discontinue) previous order. 2. Right heel blister; cleanse with wound cleanser, apply skin prep & cover with foam dressing BID. 3. Float heel while on bed. 4. Clean right buttock stage II with wound cleanser apply barrier cream q shift and PRN."

Review of the nurse's notes from 8/15/2020 through 8/30/2020, failed to evidence any documentation of a pressure injury to the resident's heel or buttock.

Review of the MAR (medication administration record) and the TAR (treatment administration record) for August 2020, failed to evidence the treatments prescribed by the nurse practitioner on 8/27/2020.

The comprehensive care plan dated 8/26/2020, documented in part, "Focus: (Resident #6) has potential for impairment to skin r/t (related to) occasional stool incontinence and decreased mobility. A ROM (range of motion) brace is in place to his RLE and he has an indwelling catheter. His is at risk for pressure injury and other skin impairments." The "Interventions" documented in part, "Full body skin assessment weekly by the charge nurse. Keep skin clean and dry, apply moisture barrier after incontinent care. Use lotion on dry skin." The care plan further documented, dated 8/28/2020, "Focus: (Resident #6) has a pressure injury to his right heel." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness. Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate."

An interview was conducted with LPN (licensed

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practical nurse) #2, on 10/30/2020 at 12:53 p.m. When asked how often a skin assessment is completed on the residents, LPN #2 stated that it is done upon admission and then weekly. When asked where staff documented the skin assessments, LPN #2 stated on the "Skin Evaluation" sheet or under the "Assessment" tab in the computer. LPN #2 was asked to review Resident #6's clinical record. After reviewing the record, LPN #2 stated there was nothing under the assessment tab in the computer. LPN #2 was asked how staff could tell if a skin assessment was completed if it's not in the assessment tab or in the nurse's notes. LPN #2 stated, "If it's not documented, it's not done. That's nursing 101." When asked what happens if a nurse or staff member finds an area of concern for pressure injury on a resident, LPN #2 stated the nurse must assess the area, document the area, notify the nurse practitioner or the physician, and update the family. When asked where all of this should be documented, LPN #2 stated it should all be in a nurse's note. When asked if a nurse can apply a treatment without a physician order, LPN #2 stated, "No." When asked if a physician order is required to apply Greer's Goo on a resident, LPN #2 stated, "Yes." When asked if Greer's Goo is the same as barrier cream, LPN #2 stated, No, Greer's Goo is a medication and barrier cream is a topical ointment we use for incontinence care.

An interview was conducted with ASM (administrative staff member) #2, the medical director, on 10/30/2020 at 3:48 p.m. The nurse practitioner notes above were read to the medical director. When asked if the buttock was a pressure ulcer, ASM #2 stated it could be. When spoken of the heel and if that is a pressure ulcer,

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ASM #2 stated it could be depending upon the location of the blister. ASM #2 stated he did not evaluate the resident so he cannot speak to if the areas in question were pressure or not.

The facility policy, "Clinical Guideline Skin &Wound" documented in part, "Licensed nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record. Licensed Nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved. Licensed nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record."

The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8 concerning pressure ulcer assessment, "Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue type (s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)...Signs of deterioration should be addressed immediately." This information was obtained from: National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline. Washington, DC: National Pressure Ulcer Advisory Panel, Second edition published 2014.

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F 686	Continued From page 23 ASM #1, the executive director, ASM #2, the interim DON (director of nursing) and LPN #2, were made aware of the above concerns on 10/40/2020 at approximately 4:00 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. (2) This information was obtained from the following website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (3) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf . (4) This information is taken from the website https://www.ncbi.nlm.nih.gov/pubmed/3299278 (5) This information was obtained from the following website: https://emedicine.medscape.com/article/1087691-medication#2.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		12/1/20

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to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 25 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review and in the course of a complaint investigation, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of six residents in the survey sample, Resident #6. The nursing staff failed to document anything related to Resident #6's two pressure injuries in the clinical record. The findings include: Resident #6 was admitted to the facility on 8/15/2020 with diagnoses that included but were not limited to: knee replacement surgery, sciatica (pain felt in the back and down the back and outer part of the thigh and leg due to compression on sacral spinal nerve roots or the sciatic nerve, often associated with degeneration of an intervertebral disc.) (1), retention of urine, benign prostatic hypertrophy (An enlarged prostate) (2),	F 842	1. Resident #6 has been discharged. 2. A review will be conducted by November 25,2020 for the past 7 days to ensure documentation of wounds is included in the clinical record. 3. Re-Education will be provided to Licensed nurses staff regarding documentation of wounds in the clinical record. Education to be given between 11-13-20 and 11-25-20 by the Director of Nursing or her designee. 4. Director of Nursing, or designee will review documentation of the clinical record during morning meeting to ensure that residents with wounds have appropriate documentation in the clinical record weekly times 4 weeks and then	

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high blood pressure and pain. The resident was transferred to the hospital on 8/30/2020.

The most recent MDS (minimum data set) assessment, an admission/Medicare five day assessment, with an assessment reference date (ARD) of 8/21/2020, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he was independent after set up assistance was provided. The resident was coded as having an indwelling catheter into his bladder. He was not coded on this assessment as having any pressure injury*/blisters. The discharge assessment, with an ARD of 8/30/2020 coded the resident as having a stage 2 pressure injury**.

*A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (3)

**Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are

monthly for 3 months. Variances will be reported to QAPI with the follow up as indicated

5. Date of Compliance: 12-1-2020

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not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)(3).

The "Skin Evaluation" dated 8/15/2020 documented the resident had a "surgical site on right knee, dry feet, hard toenails." There was no documentation of any pressure injuries. The "Skin Evaluation" form was blank for the rest of the resident's stay at the facility.

Resident #6 scored a "16" on the Braden scale* dated 8/15/2020. A "16" indicates the resident is "At risk" for developing a pressure injury.

* The Braden Scale for Predicting Pressure Sore Risk was developed to foster early identification of patients at risk for forming pressure sores. The scale is composed of six subscales that reflect sensory perception, skin moisture, activity, mobility, friction and shear, and nutritional status. (4)

The physical therapy note dated, 8/27/2020, documented in part, "Pt (patient) reporting buttocks discomfort, buttocks assessed, with skin break down of open areas observed in multiple areas of buttocks, with skin breakdown also observed on R (right) upper thigh near groin region as well as posterior knee region RLE (right lower extremity). Bruise also identified on R lateral thigh. Nurse notified, with nurse assessing

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pt and applying Greer's goo. Earlier this date, nurse reported applying heel pad to RLE heel due to blister like skin breakdown, with nurse reporting pt appropriate to perform functional transfers and functional mobility d/t heel pad application...Summary - Today pt didn't have any bandages on his right heel. Therapist asked nurse if he needed a bandage and if he can ambulate. Nursing stated he did need a bandage and he could ambulate as long as he had no pain. Therapist did notice opening areas on his bottom and skin breakdown behind right knee and groin. Nursing did apply Greer's Goo (Greer goo consists of nystatin [Mycostatin] powder, 4 million U (units), hydrocortisone powder, 1.2 g (grams), and zinc oxide paste, [in a sufficient quantity]) (5) on his bottom, behind knee and groin regions."

The occupational therapy note dated, 8/27/2020, documented in part, "During therapy therapist noticed drainage on his sheets and pt stated he thought it was coming from his heel. Therapist looked at his heel and his skin was white and rolled and there was drainage. This was reported to nursing."

The nurse practitioner note dated 8/27/2020 at 12:00 p.m. documented in part, "Patient is seen today for wound assessment per nursing requests...Skin inspection and palpation...1. Right buttock stage II ulcer related to shear: 0.8 X 0.6 (width by length in centimeters); wound bed is 100% granulated tissue; surrounding area blanchable. 2. Right heel slightly opened blister related to friction 7x 7.5 (centimeters); wound bed unstageable and filled with fluid; surrounding skin slightly macerated...Assessment and Plan: 1. Traumatic blister of heel - Ordered to apply skin

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prep and cover with foam dressing BID (twice a day) float heels while on bed. 2. Pressure ulcer of buttock - ordered to clean site with wound cleanser and apply barrier cream q (every) shift and PRN (as needed)." The nurse practitioner that wrote this note was no longer employed by the facility and was unavailable for interview.

The physician orders dated, 8/27/2020 documented, "1. Right heel blister - d/c (discontinue) previous order. 2. Right heel blister; cleanse with wound cleanser, apply skin prep & cover with foam dressing BID. 3. Float heel while on bed. 4. Clean right buttock stage II with wound cleanser apply barrier cream q shift and PRN."

Review of the nurse's notes from 8/15/2020 through 8/30/2020, failed to evidence any documentation of a pressure injury to the resident's heel or buttock.

Review of the MAR (medication administration record) and the TAR (treatment administration record) for August 2020, failed to evidence the treatments prescribed by the nurse practitioner on 8/27/2020.

The comprehensive care plan dated 8/26/2020, documented in part, "Focus: (Resident #6) has potential for impairment to skin r/t (related to) occasional stool incontinence and decreased mobility. A ROM (range of motion) brace is in place to his RLE and he has an indwelling catheter. His is at risk for pressure injury and other skin impairments." The "Interventions" documented in part, "Full body skin assessment weekly by the charge nurse. Keep skin clean and dry, apply moisture barrier after incontinent care. Use lotion on dry skin." The care plan further

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documented, dated 8/28/2020, "Focus: (Resident #6) has a pressure injury to his right heel." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness. Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate."

An interview was conducted with LPN (licensed practical nurse) #2, on 10/30/2020 at 12:53 p.m. When asked how often a skin assessment is completed on the residents, LPN #2 stated that it is done upon admission and then weekly. When asked where it is documented, LPN #2 stated on the "Skin Evaluation" sheet or under the "Assessment" tab in the computer. LPN #2 was asked to review Resident #6's clinical record. After reviewing the record, LPN #2 stated there was nothing under the assessment tab in the computer. LPN #2 was asked how staff could tell if a skin assessment was completed if it's not in the assessment tab or in the nurse's notes. LPN #2 stated, "If it's not documented, it's not done. That's nursing 101." When asked what happens if a nurse or staff member finds an area of concern for pressure injury on a resident, LPN #2 stated the nurse must assess the area, document the area, notify the nurse practitioner or the physician, and update the family. When asked where all of this should be documented, LPN #2 stated it should all be in a nurse's note.

The facility policy, "Clinical Guideline Skin &Wound" documented in part, "Licensed nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record. Licensed Nurse to document presence of skin impairment/new skin impairment when

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observed and weekly until resolved. Licensed nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record."

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner."

ASM #1, the executive director, ASM #2, the interim DON (director of nursing) and LPN #2, were made aware of the above concerns on 10/40/2020 at approximately 4:00 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.
(2) This information was obtained from the following website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

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F 842	Continued From page 32 (3) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf . (4) This information is taken from the website https://www.ncbi.nlm.nih.gov/pubmed/3299278 (5) This information was obtained from the following website: https://emedicine.medscape.com/article/1087691-medication#2.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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	F 880		12/1/20

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procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§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

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IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an infection prevention and control program for one of six residents in the survey sample, (Resident #5), and for two of three units, (the warm observation unit and the hot COVID-19 unit).

1. The facility staff failed to change a gown in between care of two residents on the warm observation COVID unit (Resident #4 and Resident #5).

2. The facility failed to post signage on the designated warm observation unit and the hot (positive) COVID-19 unit for the usage of PPE (personal protective equipment) per Centers for Disease Control (CDC) guidance.

The findings include:

1. Resident #4 was admitted to the facility on 9/16/20. Resident #4's diagnoses included but were not limited to diabetes, heart failure and a history of COVID-19. Resident #4's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 10/14/20, coded the resident as being cognitively intact. Review of Resident #4's active physician's orders as of 10/29/20, revealed a previous physician's order dated 9/16/20 for droplet isolation times 14 days but did not reveal a current order for isolation precautions. Resident #4's comprehensive care plan dated 10/8/20 documented, "Resident has a respiratory

1. Signage on doors have now been placed on the doors to indicate PPE usage, including the warm/hot units.

2. Residents on the warm/hot units have the potential to be affected by the deficient practice.

3. Facility staff have been re-educated regarding Isolation Precautions and proper PPE for each type of isolation. Facility staff have been re-educated regarding the different levels of isolation in the facility at this time, including the Warm/Hot units, what level of PPE and type of Isolation Precautions are required when providing care or services for those residents. Facility staff also re-educated on posting proper signage for warm/hot units. Education to be given between 11-13-20 and 11-25-20 by the Director of Nursing or her designee.

4. Members of the Management team, and other designated staff will perform rounds of facility randomly during the week to ensure proper signage is posted as appropriate and observe staff use of PPE in various units of facility to ensure appropriate use weekly times 4 weeks and monthly times 3 months. Variances will be reported to QAPI with the follow up as indicated.

5. Date of compliance: 12-1-2020

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infection as evidenced by: A Positive COVID 19 test. Place on contact and droplet precautions..."

Resident #5 was admitted to the facility on 9/22/20. Resident #5's diagnoses included but were not limited to chronic kidney disease, liver failure and urinary retention. Resident #5's most recent MDS, an admission assessment with an ARD of 10/2/20, coded the resident's cognition as moderately impaired. Review of Resident #5's active physician's orders as of 10/29/20 failed to reveal any current physician's orders for isolation precautions. Resident #5's comprehensive care plan dated 10/14/20 documented, "Resident is at risk for infection d/t (due to) possible exposure to COVID 19. Maintain Standard, Contact and Droplet Precautions as directed..."

Review of a facility document titled, "Dogwood (warm observation unit) Isolation revealed Resident #4 was on droplet isolation due to a history of being COVID-19 positive. The form documented the resident finished a 10 day quarantine on the hot COVID unit and was moved to the warm unit. The form documented Resident #4 was asymptomatic. The form further documented Resident #5 was on droplet isolation due to potential exposure to COVID-19.

On 10/29/20 at 9:42 a.m., LPN (licensed practical nurse) #1 was observed in the hall preparing medications at the medication cart. LPN #1 was wearing a gown, face mask and eye protection. LPN #1 applied gloves and entered Resident #4's room with medications. LPN #1 exited the room wearing the same gown, entered Resident #5's room and assisted the resident in the bathroom and with applying a jacket.

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On 10/29/20 at 3:01 p.m., a telephone interview was conducted with LPN #1. LPN #1 stated Resident #4 was on the warm observation unit because she came to the facility from another facility that contained COVID-19. LPN #1 stated Resident #5 was on the warm observation unit because she had went out to the hospital. When asked what PPE (personal protective equipment) should be worn when caring for residents on the warm observation unit, LPN #1 stated a N95 mask and a gown should be worn. LPN #1 stated she had been told that she could wear the same gown at all times since everyone on the unit is on droplet isolation. When asked if she wore the same gown between different residents on the unit, LPN #1 stated yes unless the resident was on another type of isolation besides droplet.

On 10/29/20 at 4:58 p.m., a telephone interview was conducted with RN (registered nurse) #1 (the infection control nurse). RN #1 stated the warm observation unit contained residents who went out of the facility and residents who were possibly exposed to COVID-19. RN #1 stated those residents might be contagious so they are put on the observation unit for so many days. When asked if those residents are supposed to be on isolation, RN #1 stated she did not know if it was true isolation but more like a quarantine. When asked the difference between true isolation and quarantine, RN #1 stated there is only a chance the residents on the warm observation unit have been exposed to COVID-19 versus the residents who are COVID positive behind a plastic curtain on the hot unit. When asked what PPE should be worn when caring for residents on the warm observation unit, RN #1 stated gloves and gowns should be worn (in addition to a face mask and eye protection). RN #1 stated the same gown

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CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

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can be reused when caring for the same resident but a different gown should be worn when caring for different residents so residents aren't possibly infected.

On 10/30/20 at 9:16 a.m., a telephone interview was conducted with LPN #2. LPN #2 stated the warm observation unit contained residents who had went out to the hospital, went out to a doctor's appointment or who were exposed to COVID-19 positive residents. LPN #2 stated the residents on the warm observation unit are supposed to be on droplet isolation for 14 days. When asked if a physician's order should be obtained for droplet isolation, LPN #2 stated she was pretty sure there was a standing physician's order for anyone on the unit and the nurses just needed to activate the order in the computer system. When asked what PPE should be worn when caring for residents on the warm observation unit, LPN #2 stated gloves, a face mask, a gown and a face shield or goggles should be worn. When asked what PPE should be removed before exiting the resident rooms, LPN #2 stated gloves should be removed. LPN #2 further stated that there was a little confusion whether the same gown could be worn between different resident rooms since all residents on that unit should be on droplet isolation but she received clarification on the previous day and a different gown should be worn when entering another resident's room. LPN #2 stated staff should not wear the same gown between different resident rooms because of possible cross contamination. LPN #2 stated by wearing the same gown between different residents, staff could potentially expose the residents to infection.

On 10/30/20 at 11:54 a.m., a telephone interview

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was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the facility staff had enough PPE supplies to care for the residents.

On 10/30/20 at 3:22 p.m., a telephone interview was conducted with ASM #2 (a consultant director of nursing). ASM 2 stated anyone on isolation should have a physician's order for isolation.

On 10/30/20 at 3:25 p.m., ASM #1 was made aware of the above concerns.

The facility policy titled, "COVID-19 - Pandemic Plan" documented, "17. The center will designate an area and cohort new admissions/re-admissions whose COVID 19 status is known (negative) or who has been removed from transmission based precautions prior to admission/re-admission for 14 days. (The resident will remain in their room during this time). The patient will then be moved to a different room/area of the center. The Center will designate an area (PUI [persons under investigation] unit) for residents who: Upon admission the COVID-19 status is unknown or is awaiting test results. Resident with possible exposure and awaiting test results. Resident with possible signs and symptoms awaiting test results. Place resident in a private room or cohort with another resident whose status is unknown, initiate transmission based precautions (standard, contact, and droplet."

The Centers for Disease Control website documented, "If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for

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different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., Clostridioides difficile)." This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

No further information was presented prior to exit.

2. The facility failed to post signage on the designated warm observation unit and the hot (positive) COVID-19 unit for the usage of PPE (personal protective equipment) per Centers for Disease Control (CDC) guidance.

Review of facility documentation revealed residents in the warm observation unit (rooms 218, 219, 220, 221, 223, 224 and 225) were on contact or droplet isolation. Further review of facility documentation and clinical record documentation revealed residents in the hot (positive) COVID 19 unit (rooms 206, 207, 208, 210 and 212) were on droplet isolation.

On 10/29/20 at 9:35 a.m., observation of the warm observation unit was conducted. No signage regarding designation of the warm observation unit or regarding the use of specific PPE (personal protective equipment) was observed on the unit doors, resident room doors or outside of the resident rooms. On 10/29/20 at 9:55 a.m., observation of the hot (positive) COVID 19 unit was conducted. No signage regarding designation of the COVID 19 positive unit or the use of specific PPE was observed on the plastic barricade unit entrance, resident room

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doors or outside of the resident rooms.

On 10/30/20 at 9:16 a.m., a telephone interview was conducted with LPN (licensed practical nurse) #2 (the unit manager). LPN #2 stated signs had not been placed outside of each resident's room door because all residents on the warm observation and hot COVID units were on droplet precautions. LPN #2 further stated paper signs had previously been placed at the entrances of the warm observation unit and the hot COVID unit but the facility staff felt paper signs were not appropriate for infection control reasons so the signs had been removed and the facility staff was waiting for laminated signs.

On 10/30/20 at 11:54 a.m., ASM (administrative staff member) #1 (the executive director) was made aware of the above concern. ASM #1 confirmed the information provided by LPN #2 and stated hopefully the facility would have laminated signs by the beginning of the following week.

The facility policy titled, "Isolation-Initiating Transmission-Based Precautions" documented, "3. When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee): d. Determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions: (1) The signage informs the staff of the type of CDC (Centers for Disease Control) precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room..."

The Centers for Disease Control website

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F 880	Continued From page 41 documented, "Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms." This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html No further information was presented prior to exit.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP,	F 882		12/1/20

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F 882	Continued From page 42 must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure the designated infection preventionist had completed specialized training in infection prevention and control. The findings include: On 10/29/20 at 4:41 p.m., a telephone interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the current designated infection control nurse was RN (registered nurse) #1, the interim assistant director of nursing who had begun employment on Monday (10/26/20). ASM #1 was asked to provide documentation of RN #1's infection control training. On 10/29/20 at 4:58 p.m., a telephone interview was conducted with RN #1 regarding infection control training. RN #1 stated she had been in the skilled nursing field for 21 years, had been the designated infection control nurse at other facilities and had been a director of nursing since 2012 but had not completed any formal specialized trainings or courses for infection prevention and control. On 10/30/20 at 11:54 a.m., ASM #1 was made aware of the above concern. The facility policy titled, "Infection Preventionist" failed to document specific information regarding specialized training and the facility did not have a	F 882	1. Residents have the potential to be affected by this deficient practice. 2. Residents have the potential to be affected by this deficient practice. 3. Unit Manager completed Infection Control Preventionist Training on 11/18/2020 and will be designated as the Infection Preventionist. Other members of Licensed Nurses, including MDS nurse to complete Infection Preventionist Training as a backup. 4. Executive Director or designee to review Infection Preventionist training of Unit Manager/Licensed Nursing staff to ensure training completed by designated Infection Preventionist and to ensure facility has an Infection Preventionist who has completed specialized training in infection prevention and control weekly times 4 weeks and monthly times 3 months. Variances will be reported to QAPI with the follow up as indicated. 5. Date of Compliance: 12-1-2020	

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F 882	Continued From page 43 job description for the Infection Preventionist. No further information was presented prior to exit.	F 882		