STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/05/2019

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MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/3/19 through 12/5/19. A complaint [VA00043944] was investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 128 certified bed facility was 104 at the time of the survey. The survey sample consisted of seven current resident reviews (Residents #2 through #8) and one closed record review (Resident #1).	F 000		
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	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/03/2020

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

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement the comprehensive plan of care for two of eight residents in the survey sample, Residents #2 and #7. For Resident #2, the facility staff failed to provide preventative skin care routinely per the comprehensive plan of care and for Resident #4, the facility staff failed to administer preventative skin care and treatments for a pressure ulcer per the comprehensive care plan. The findings include: 1. Resident #2 was admitted to the facility on 11/20/14, and most recently readmitted on 11/13/19, with diagnoses including, but not limited	F 656		

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F 656	Continued From page 2 to history of a broken hip and diabetes type 2 (1). The resident was discharged from the facility and was admitted to a local hospital from 11/3/19 until 11/13/19 for surgical repair of a broken hip. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/18/19, Resident #2 was coded as being moderately cognitively impaired for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). The resident was coded as being completely dependent on the assistance of two staff members for bed mobility and transferring between surfaces. The resident was coded as being dependent on the assistance of two staff members for toileting and bathing. The resident was coded as always being incontinent of bladder and bowel. Resident #2 was coded as being at risk of developing pressure ulcers (2), and as having no current pressure ulcers. On 12/3/19 at 4:50 p.m., RN (registered nurse) #1, a unit manager, was observed providing wound care to Resident #2. As a part of the wound care observation, CNA (certified nursing assistant) #1 was also observed providing incontinence care to Resident #2. At the completion of the incontinence care and the wound care, neither CNA #1 nor RN #1 applied any preventative, skin care product to Resident #2. A review of Resident #2's clinical record revealed a Braden Scale for Predicting Pressure Sore Risk (3) dated 11/25/19. The resident's score was 15, indicating the resident was at risk for developing a pressure ulcer.	F 656		

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F 656	Continued From page 3 A review of Resident #2's comprehensive care plan dated 3/11/16 and updated 7/28/19 revealed, in part, the following: "At risk for alteration in skin integrity related to impaired mobility...decrease/minimize skin breakdown risks...Administer treatment per physician orders...Encourage to reposition as needed; use assistive devices as needed...Observe skin condition with ADL (activities of daily living) care daily; report abnormalities...Provide preventative skin care routinely and prn (as needed)." A review of Resident #2's physicians' orders, MARs (medication administration records) and TARs (treatment administration record) for November and December 2019 failed to reveal any evidence of orders for skin protectant, barrier cream, or other pressure ulcer preventative treatment. On 12/3/10 at 5:25 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated Resident #2 is always incontinent of bladder and bowel, and "has to be changed pretty often." She stated since the resident returned from the hospital after her broken hip, it has been much more difficult to move and reposition the resident in bed. When asked if she applied any skin protectant or barrier cream to Resident #2 after her incontinence care, CNA #2 stated, "No. I didn't know I was supposed to." On 12/4/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 (the director of nursing at a sister facility), and ASM #5, an MDS coordinator, were informed of these concerns.	F 656		

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F 656	Continued From page 4 On 12/5/19 at 10:38 a.m., RN #1 was interviewed. When asked if Resident #2 had been receiving preventative skin care since she had returned from the hospital following the survey for her broken hip, RN #1 stated, "I have looked. I don't see anything in November once she got back from the hospital. It looks like we have been putting Zinc Oxide cream on her once a shift since December 1." When asked about implementation of interventions to prevent skin break down, RN #1 stated, "Some kind of barrier cream, at least. She is always incontinent." When asked if he was aware that Resident #2's care plan called for routine preventative skin care, he stated that he was not. RN #1 stated the care plan is the guide for everything the staff does for a resident. He stated barrier cream should have been applied after each and every incontinent episode. RN #1 stated he would get an order for the barrier cream immediately. A review of the facility policy "Interdisciplinary Care Planning" revealed, in part, the following: "The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive...Implementation. Once the care plan is developed, the staff must implement the interventions identified in the care plan. These may include, but is not limited to administering treatments and medications." No further information was provided prior to exit. (1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website	F 656		

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F 656	Continued From page 5 https://medlineplus.gov/diabetes.html. (2) "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear." This information is taken from the National Pressure Ulcer Advisory Panel website https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf (3) "The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. A lower Braden Scale Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development." This information is taken from the website https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN/. 2. Resident #4 was admitted to the facility on	F 656		

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F 656	Continued From page 6	F 656		

4/25/11, and was most recently readmitted on 11/15/19, with diagnoses including, but not limited to dementia (1), high blood pressure, and history of a stroke.

On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/22/19, she was coded as having both short-term and long-term memory problems, and as being severely cognitively impaired for making daily decisions. The resident was coded as being completely dependent on the assistance of staff for bed mobility, toileting, personal hygiene and bathing. The resident was coded as transferring out of bed only one or two times during the look back period. The resident was coded as having an indwelling urinary catheter, and as being always incontinent of bowel. The resident was coded as being at risk for developing pressure ulcers, and as having one unstageable pressure ulcer.

A review of Resident #4's progress notes revealed a note dated 10/23/19. The note documented, in part, the following: "Apply Hydrogel Gel to buttocks topically every evening shift for wound care. Cleanse affected area of buttocks with normal saline, apply hydrogel and cover with foam dressing daily."

Further review of the progress notes revealed the following note dated 11/5/19 (13 days since the previous wound note): "Open area to right buttocks that measures 1.5 cm (centimeters) X 1.0 cm X 0.2 cm, 100% beefy red wound bed, no drainage, no odor. Periwound (area around wound) is normal. Continue with hydrogel and foam dressing."

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F 656	Continued From page 7 Further review of the clinical record revealed Resident #4 was discharged to the hospital on 11/10/19, and was readmitted to the facility on 11/16/19. Further review of the progress notes revealed a progress note dated 11/16/19. The note, which was part of the readmission assessment, documented, in part: "Resident readmitted under hospice...DSG (dressing) to coccyx is unstageable, dsg [dressing] replaced." Review of the full readmission assessment dated 11/16/19 failed to reveal any additional information regarding Resident #4's pressure ulcer. Further review of the progress notes revealed a note dated 11/28/19 (12 days since the previous note related to Resident #4's pressure ulcer). This note, written by RN (registered nurse) #2, a unit manager, documented, in part, the following: "Late entry for 11/27/19. Wound note: Sacral wound measuring 6.5 X 3.0 X 0.2. Wound bed is 95% yellow slough and black exchar (sic) with purulent (contains pus) mild drainage and foul odor. Hospice nurse in at time of dressing change. Current treatment in place." A review of Resident #4's October 2019 TAR (treatment administration record) revealed blanks on 10/25/19, 10/27/19, 10/31/19 for the following treatment administration: "Hydrogel Gel Apply to buttocks topically every evening shift for wound care. Cleanse affected area of buttocks with normal saline, apply hydrogel and cover with foam dressing daily." A review of Resident #4's October 2019 TAR revealed blanks on the following days and shifts for the treatment administration, "Barrier cream to	F 656		

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F 656	Continued From page 8 peri (perineal) area, buttocks and scar tissue, BID (twice a day) and prn (as needed) after incontinent episodes every day and evening shift:" Day shift on 10/7/19, 10/10/19, 10/15/19, 10/25/19, and 10/29/19; and evening shift on 10/4/19, 10/9/19, 10/10/19, 10/19/19, 10/20/19, 10/25/19, 10/27/19, and 10/31/19. A review of Resident #4's comprehensive care plan dated 4/13/11 and updated 11/7/19 revealed, in part, the following: "Right buttocks area...Administer treatment per physician orders...Pressure reducing surface on bed and wheelchair." On 12/4/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing at a sister facility, and ASM #5, an MDS coordinator, were informed of these concerns. On 12/5/19 at 10:32 a.m., LPN (licensed practical nurse) #3 was interviewed regarding documentation of treatments administered to residents. She stated she was an agency nurse. LPN #3 stated, "We document everything on [name of electronic health record software]." She stated each nurse has his or her own login identification. When asked what it means if a resident's TAR has blanks where there should be a nurse signature, LPN #3 stated, "If it's not documented, it was not given. Everybody knows that. If you do it, you document it." When asked if failing to provide treatments as ordered is implementing/following Resident #4's comprehensive care plan, LPN #3 stated, "I doubt it." When asked why the care plan is important, she stated that the care plan tells everyone exactly what should be done for the resident.	F 656		

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F 656	Continued From page 9 On 12/5/19 at 10:38 a.m., RN #1 was interviewed regarding the blank spaces on the TARs. He stated nurse's document on the computer when they administer a treatment. When asked what the blank spaces mean, RN #1 stated, "It means that the treatments weren't given." When asked if the facility staff followed the resident's care plan when they failed to administer a treatment, RN #1stated, "No, I don't think so." He stated the care plan is the guide for everything the staff does for a resident. No further information was provided prior to exit. (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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F 657	Continued From page 10 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, and clinical record review, it was determined that the facility staff failed to review and revise the care plan for one of eight residents in the survey sample, Residents #2. For Resident #2, the facility staff failed to revise the care plan when the resident developed a pressure ulcer (1) on 11/25/19. The findings include: Resident #2 was admitted to the facility on 11/20/14, and most recently readmitted on 11/13/19, with diagnoses including, but not limited to history of a broken hip and diabetes type 2 (2). The resident was discharged from the facility and admitted to a local hospital from 11/3/19 until 11/13/19 for surgical repair of a broken hip. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/18/19, Resident #2 was coded as being moderately cognitively impaired for making daily decisions, having	F 657		

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F 657	Continued From page 11 scored eight out of 15 on the BIMS (brief interview for mental status). The resident was coded as being completely dependent on the assistance of two staff members for bed mobility and transferring between surfaces. The resident was coded as being dependent on the assistance of two staff members for toileting and bathing. The resident was coded as always being incontinent of bladder and bowel. Resident #2 was coded as being at risk of developing pressure ulcers, and as having no current pressure ulcers. A review of Resident #2's physician's orders revealed the following order, written 11/25/19: "Santyl (3) Ointment 250 Unit/GM (units per gram) (Collagenase) Apply to sacrum topically every day shift for wound. Clean with normal saline and apply santyl to slough area of wound." A review of Resident #2's TARs (treatment administration records) for November and December 2019 revealed initials in all boxes for this order, indicating the wound care had been completed as ordered. A review of Resident #2's nursing progress notes revealed the following note, written 11/25/19 by LPN (licensed practical nurse) #1: "Open area noted to sacrum. 1.5 X 1.3 depth .25. NP [name of ASM (administrative staff member) #4] in building informed of area order (sic) received for santyl to slough area every day. Resident RP (responsible party) [name of RR] was informed via phone conversation. Order received to clean area with normal saline and apply santyl to slough area. Cover with dry dressing." A review of Resident #2's comprehensive care plan dated 3/11/16 and updated 7/28/19 revealed,	F 657		

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F 657	Continued From page 12 in part, the following: "At risk for alteration in skin integrity related to impaired mobility...decrease/minimize skin breakdown risks...Administer treatment per physician orders...Encourage to reposition as needed; use assistive devices as needed...Observe skin condition with ADL (activities of daily living) care daily; report abnormalities...Provide preventative skin care routinely and prn (as needed)." At the time of surveyor entrance for this survey, the care plan was not updated to address Resident #2's pressure ulcer identified on 11/25/19. On 12/4/19 at 11:10 a.m., LPN (licensed practical nurse) #4 was interviewed. She stated she was the nurse who discovered Resident #2's pressure ulcer on 11/25/19. When asked about the process for updating a resident's care plan when a pressure ulcer is discovered, LPN #4 stated usually the MDS nurses update the care plans. She stated nurses can initiate a care plan update, but the MDS nurses follow up and make sure the plan is updated. When asked when a care plan should be updated for a new pressure ulcer, LPN #4 stated, "Pretty soon." On 12/4/19 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing at a sister facility, and ASM #5, an MDS coordinator, were informed of these concerns. On 12/5/19 at 10:22 a.m., LPN #7, an MDS coordinator, was interviewed. When asked about the process for updating a care plan for an acute change for a resident, LPN #7 stated, "When the nurses or anyone discovers a new issue, the care plan should be updated." When asked who is responsible for updating the care plan, LPN #7	F 657		

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F 657	Continued From page 13 stated it should technically be updated by whomever discovers the acute change. When asked if floor nurses have the ability to update care plans, LPN #7 stated, "Oh absolutely." When asked about the lack of updates to Resident #2's care plan when the pressure ulcer was discovered on 11/25/19, LPN #7 stated, "Yes, it should have been updated then." She provided the surveyor with a copy of an updated care plan for Resident #2; the updated plan included the presence of the pressure ulcer. A review of the facility policy "Interdisciplinary Care Planning" revealed, in part, the following: "As the care plan is implemented, members of the interdisciplinary team need to evaluate whether the interventions are effective or whether the care plan needs to be revised." No further information was provided prior to exit. (1) "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear." This information is taken from the National Pressure Ulcer Advisory Panel website https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (3) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information is taken from the manufacturer's	F 657		

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F 657	Continued From page 14 website https://www.santyl.com/.	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- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services in a manner to meet professional standards for one of eight residents in the survey sample, Resident #7. For Resident #7, the facility staff failed to clarify two simultaneous orders to treat a pressure ulcer; and a staff member signed off on both treatments, despite only administering one of the treatments. The findings include: Resident #7 was admitted to the facility on 9/1/11, and most recently readmitted to the facility on 1/17 19, with diagnoses including, but not limited to history of a stroke and diabetes type 2. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/18/19, Resident #7 was coded as being severely impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). The resident was coded as being completely dependent on the assistance of two	F 658		

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F 658	Continued From page 15 staff members for bed mobility, toileting, and personal hygiene, and as being completely dependent on the assistance of two staff members for transferring between surfaces. The resident was coded as always being incontinent of bladder and bowels. Resident #7 was coded as being at risk for developing pressure ulcers, and as having one unstageable pressure ulcer. A review of Resident #7's progress notes revealed the following note dated 10/23/19: "CNA reported to me that resident had bloody area to buttocks. Resident assessed and open area measuring 2 X 2 X 0.1 cm (centimeters) noted under right gluteal fold, wound base red with bloody drainage. Area cleaned and protective dressing applied." A review of the physician's orders for Resident #7's and October 2019 TAR (treatment administration record) revealed the following order dated 10/23/19: "Clean right gluteal fold with NS (normal saline). Apply wound gel and cover with dry dressing every evening shift for wound." The TAR contained nurses' initials at all opportunities for this order to be followed, indicating the treatments were completed as ordered. Further review of Resident #7's progress notes revealed the following note dated 10/30/19: "Chart check done new order noted. Cleansed affected area of right ischium with normal saline. Apply Hydrogel and cover with foam dressing every other day and PRN (as needed) for soiling." Further review of Resident #7's progress notes revealed a note dated 11/11/19 (11 days since the most recent note, and 19 days since the wound	F 658		

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F 658	Continued From page 16 was last measured. The note documented: "Resident presents with an area under the right sacral fold that's 4 cm long and 4 1/2 cm wide with full thickness tissue loss in which actual depth is completely obscured by slough and eschar in the wound bed. MD (medical doctor) made aware and writer left a voicemail with RP (responsible party). Awaiting call back. Resident has treatment in place. Facility director also made aware. Resident presents with some discomfort to touch. Resident medicated with prn pain medication. Resident in bed and will be turned and repositioned q2hrs (every two hours). Will continue to monitor." Further review of Resident #7's progress note revealed a note dated 11/20/19. The note documented: "Resident has open wound to right Ishim (sic). Area measuring 4.5 X 4.0 X 2. 50% slough, 50% granulation (healthy, healing) tissue. Moderate amount of purulent (containing pus) drainage. Treatment completed, procedure tolerated well. MD/RP notified. New orders to D/C (discontinue) current orders. Cleanse wound with normal saline, apply santyl and guaze (sic) to affected area and cover with foam dressing daily." LPN (licensed practical nurse) #3 wrote this note. A review of Resident #7's NP (nurse practitioner) notes revealed a note dated 10/29/19. The note, written by ASM (administrative staff member) #4, the NP, documented, in part, the following: "4 cm in diameter open area to right ischium, without surrounding erythema...Cleanse affected area with normal saline, apply hydrogel, cover with foam dressing q 48h (every 48 hours)." Further review of the NP notes revealed a note dated 11/19/19. The note documented, in part,	F 658		

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F 658	Continued From page 17	F 658		

the following: "Unstageable wound to right ischium. [Approximately] 6 cm in diameter with mild surrounding erythema. Wound bed with 60% slough...Pressure injury of right buttock, unstageable...Nursing to cleanse affected area of right ischium daily with normal saline, apply Santyl and gauze and cover with foam dressing daily and prn soiling...Nursing to continue to monitor closely and notify MD/NP of any change in condition."

Further review of the NP notes revealed a note dated 11/20/19. The note documented, in part, the following: "Unstageable wound to right ischium measuring 4.5 cm X 4 cm X 2 cm, wound bed with 50% slough, 50% granulation tissue, mild surrounding erythema (redness)...Nursing to continue local wound care: cleanse affected area of right ischium daily with normal saline, apply Santyl and gauze and cover with foam dressing daily and prn soiling."

A review of Resident #7's November 2019 TAR revealed staff had not discontinued the first order (initiated 10/23/19) for wound dressing changes, daily. The facility staff continued to sign off on the apply wound gel and cover with dry dressing daily, wound dressing change from 11/1/19 through 11/13/19, as well as signing off on the dressing change for apply Hydrogel and cover with foam dressing every other day (initiated 10/30/19), from 11/2/19 until 12/2/19. Additionally, once the 11/20/19 order for Santyl was initiated, both previous orders remained active, and the facility staff signed off on the Santyl order from 11/19/19 through 11/25/19.

A review of Resident #7's comprehensive care plan dated 8/16/12 and updated 10/23/19

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F 658	Continued From page 18 revealed, in part, the following: "Open area under right gluteal fold ...Will heal within the limits of the disease process ...Administer analgesia (pain medications) per physician orders (offer prior to treatment/therapy) ...Administer treatment per physician orders ...Encourage and assist as needed to turn and reposition; use assistive devices as needed." On 12/4/19 at 10:35 a.m., LPN (licensed practical nurse) #4 was interviewed. When asked what needs to be done if a new order is written for a resident's pressure ulcer treatment, she stated the old order should be discontinued and the new order placed on the TAR. When asked if the old order would disappear from the TAR if it were discontinued, LPN #4 stated, "Yes it would." When asked what she would do if she encountered multiple active orders for one pressure ulcer treatment, LPN #4 stated, "I would definitely call the doctor and clarify that order." On 12/4/19 at 5:30 p.m., ASM (Administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing at a sister facility, and ASM #5, an MDS coordinator, were informed of the concerns regarding, the discrepancies for wound treatment, on the TAR for Resident #7's pressure ulcer treatment in November 2019. On 12/5/19 at 10:38, RN (registered nurse) #1, a unit manager, was interviewed regarding the discrepancies on Resident #7's TAR. He reviewed the November 2019 TAR and stated, "It looks like there are multiple treatments for the same wound at the same time." RN #1 stated it was hard to believe all those treatments were administered at the same time. He stated the	F 658		

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F 658	Continued From page 19	F 658		

floor nurse should have clarified the orders on the TAR to determine which one was active, and should have discontinued the rest.

On 12/5/19 at 11:38 a.m., ASM #2 stated she had identified the agency nurse responsible for signing off on multiple treatments for the same wound for Resident #7 in November 2019. She stated she had spoken with the nurse, who confirmed she administered the normal saline/foam treatment until the Santyl was ordered. Once the Santyl was ordered, she only administered the Santyl. ASM #2 stated the nurse should not have signed off on treatments she had not given, and that the nurse should have discontinued the old orders after clarifying with the NP or physician. She stated she would be writing the overlapping TAR sign-offs as med (medication) errors. When asked what the facility uses as a standard of practice, ASM #2 stated, "Our policies." She stated the policies are based on Lippincott's nursing standards, but that the facility uses the content of its policies as its standard.

The agency nurse who signed off on the treatments was not available for interview prior to exit.

On 12/5/19 at 11:43 a.m., LPN #6 was interviewed regarding the November 2019 TARs for Resident #7. She stated she is an agency nurse, and she knows the other agency nurse who signed off on the multiple treatments. LPN #6 stated, "You cannot have more than one order at a time. You cannot sign off on both of the treatments. I don't know why she did that."

On 12/5/19 at 11:45 a.m., RN #2, a unit manager,

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F 658	Continued From page 20 was interviewed. She was shown the November 2019 TARs. RN #2 then stated, "I would have called the doctor to clarify and discontinue whichever ones are not correct." She stated a nurse should only sign off on one order at a time for pressure ulcer. A review of the facility policy "Requirements and Guidelines for Clinical Record Content" revealed, in part, the following: "If a medication or treatment is discontinued by the physician, the licensed nurse discontinues the item from the MAR or TAR per center practice. The nurse removes the discontinued medication or treatment supplies from the cart(s) and returns the items to the pharmacy for credit or follows the pharmacy procedure for disposition." A review of the facility policy "Medication Administration: Medication Pass" revealed, in part, the following: "Administer medication according to specific procedure...Document initials on MAR for each medication administered." No further information was provided prior to exit. According to Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, page 181 reads "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation ..."	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		

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F 686	Continued From page 21 §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, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to assess, stage, and provide services in a manner to prevent new pressure ulcers from forming, and to prevent current pressure ulcers from worsening, for two of eight residents in the survey sample, Residents #2 and #4. The facility staff failed to prevent, identify, and treat Resident #2's pressure injuries to the sacrum/right buttock prior to being found at an advanced stage (*unstageable), resulting in harm. For Resident #2, the staff failed to measure and include descriptions of Resident #4's, right buttock, pressure ulcer when it was initially discovered on 10/23/19 and failed to provide treatments to treat the wound and protect the resident's skin from breakdown on multiple dates in October and November 2019. The findings include: 1. Resident #2 was admitted to the facility on 11/20/14, and most recently readmitted on	F 686		

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F 686	Continued From page 22 11/13/19, with diagnoses including, but not limited to history of a broken hip and diabetes type 2 (3). On 11/3/19, the resident was discharged from the facility and was admitted to a local hospital for surgical repair of a broken hip. The resident was readmitted to the facility on 11/13/19. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/18/19, Resident #2 was coded as being moderately cognitively impaired for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). The resident was coded as being completely dependent on the assistance of two staff members for bed mobility and transferring between surfaces. The resident was coded as being dependent on the assistance of two staff members for toileting and bathing. The resident was coded as always being incontinent of bladder and bowel. Resident #2 was coded as being at risk of developing pressure ulcers, and as having no current pressure ulcers. A review of Resident #2's clinical record revealed a Braden Scale for Predicting Pressure Sore Risk (6) dated 11/25/19. The resident's score was 15, indicating the resident was at risk for developing a pressure ulcer. A review of Resident #2's nursing progress notes revealed the following note, written 11/25/19 by LPN (licensed practical nurse) #1: "Open area noted to sacrum. 1.5 X 1.3 depth .25. NP [name of ASM (administrative staff member) #4, nurse practitioner] in building informed of area order (sic) received for santyl to slough area every day.	F 686		

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F 686	Continued From page 23 Resident RP (responsible party) [name of RP] was informed via phone conversation. Order received to clean area with normal saline and apply santyl to slough area. Cover with dry dressing." Review of the physician orders for Resident #2, revealed the following order, written 11/25/19: "Santyl Ointment 250 Unit/GM (units per gram) (Collagenase) Apply to sacrum topically every day shift for wound. Clean with normal saline and apply santyl to slough area of wound." Review of Resident #2's TARs (treatment administration records) for November and December 2019 revealed initials in all boxes for this order, indicating the wound care was completed as ordered and that on 12/2/19, LPN [licensed practical nurse] #1 had changed the resident's pressure ulcer dressing. Further review of Resident #2's clinical record revealed no additional documentation regarding Resident #2's pressure ulcer identified on 11/25/19. Resident #2's comprehensive care plan dated 3/11/16, and updated on 7/28/19 documented, in part, the following: "At risk for alteration in skin integrity related to impaired mobility...decrease/minimize skin breakdown risks... Administer treatment per physician orders...Encourage to reposition as needed; use assistive devices as needed...Observe skin condition with ADL (activities of daily living) care daily; report abnormalities...Provide preventative skin care routinely and prn (as needed)." The care plan was not updated with specific	F 686		

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F 686	Continued From page 24 information about Resident #2's pressure ulcer identified on 11/25/19. A physician's order dated 11/1/19 and discontinued on 11/13/19, documented in part: "Body audits every night shift every Mon (Monday), Thu (Thursday) for skin assessment." Resident #2 was in the hospital from 11/3/19 through 11//13/19, and there were no additional orders for body audits documented upon Resident #2's readmission to the facility on 11/13/19, through the beginning of the survey. Further review of Resident #2's physicians' orders, MARs (medication administration records) and TARs for November and December 2019 failed to reveal any evidence of orders for skin protectant, barrier cream, or other pressure ulcer preventative treatment. On 12/3/19 at 4:50 p.m., RN (registered nurse) #1, a unit manager, was observed providing wound care to Resident #2. RN #1 removed the old dressing from Resident #2's right buttock, revealing two pressure ulcers, instead of one. One pressure ulcer was higher up on the right buttock. The base of the wound was not visible, as the wound contained slough (4). This wound measured 5 cm (centimeters) X (by) 3.5 cm X 1.5 cm. The second pressure ulcer was located lower on Resident #2's right buttock. The second ulcer was smaller than the first. The wound base was not visible, as it contained eschar (4). RN #1 cleansed both wounds with normal saline, and applied Santyl (5) to the upper wound with a sterile swab. He did not measure or apply any medication to the second ulcer. He covered both wounds with a foam dressing, removed his	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25 gloves, washed his hands, and left the room. An interview was conducted with RN [registered nurse] #1 on 12/3/19 at 5:05 p.m., immediately following the wound care observation. When asked to describe the wounds he observed, RN #1 stated the upper wound contained slough, and had a dark tissue center. He stated the lower wound was dark, with a slight opening on the left edge. When asked how many pressure ulcers he expected to find when he provided wound care to Resident #2, RN #1 stated, "Just one." He verified that the lower pressure ulcer was a new wound identified during the wound care. RN #1 stated, "I had not seen that one last week when I did rounds." When about asked the process staff follows when a nurse discovers a new pressure ulcer on a resident, RN #1stated, "We measure it and document it. Then we call and get an order for it." When asked about the importance of wound measurements and descriptions, RN #1 stated, "We have to have a way to know whether or not the wound is getting better." He stated the size of the wound is an important factor in determining the progress toward wound healing. When asked if he measured the new wound on Resident #2, RN #1 stated, "No, I did not. I know I should have. I will do that tomorrow when I make wound rounds." He stated he would call the NP (nurse practitioner) and get an order for a treatment for the new wound. When asked to describe the facility's process for identifying and assessing wounds, RN #1 stated the floor nurses generally do the daily wound care. If the floor nurses discover a new wound, they measure it, describe it, and write a progress note about it. The floor nurses also communicate with the RP (responsible party) and the MD	F 686		

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F 686	Continued From page 26 (medical doctor)/NP for the resident to obtain treatment orders. RN #1 stated that the unit managers make weekly rounds on all residents who have wounds, measuring and describing the wounds in a progress note. When asked who stages the wounds, RN #1 stated, "The staging is not done by the nurses. Beyond that, I'm not sure." When asked if it is possible to stage a wound in which the wound base is not visible because of the presence of eschar or slough, RN #1 stated, "No, it is not." When asked if both of Resident #2's wounds are *unstageable, RN #1 stated, "Yes." When asked if the upper wound was unstageable when initially identified, on 11/25/19, RN #1 stated he did not know, but he would find out. * Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. On 12/3/10 at 5:25 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated she has been taking care of Resident #2 on most days when she works. CNA #1 stated, "I haven't noticed the other wound. I only really noticed one." She stated Resident #2 is always incontinent of bladder and bowel, and "has to be changed pretty often." She stated since the resident returned from the hospital after her broken hip, it has been much more difficult to move and reposition the resident in bed. When asked what she would have done if she had noticed a new wound on Resident #2, she would have reported it to the nurse.	F 686		

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F 686	Continued From page 27 On 12/4/19 at 8:37 a.m., LPN #2, an MDS Coordinator, was interviewed. When asked how often residents are assessed for skin breakdown, LPN #2 stated, "On admission, weekly body audits, and on wound rounds." She stated residents are also observed whenever baths are given, and if wound care is done. LPN #2 stated CNAs perform the skin observations during incontinence care and bathing, and floor nurses provide the wound care and the body audits. She stated unit managers are responsible for doing weekly wound rounds. When asked what should be done when a new pressure ulcer is discovered, LPN #2 stated the wound should be assessed, and the doctor and RP should be notified. When asked what a wound assessment should include, LPN #2 stated that the wound, should be described, measured, and it should be determined where the wound came from. When asked who stages the wounds, LPN #2 stated, "Our nurses on the floor do not stage. I'm not sure who stages them." She stated the nurse who finds a new wound should write a progress note with the measurements, description, verification of notifying the MD and RP, and any new orders the MD or NP gives for the wound. LPN #2 stated the unit manager writes a weekly progress note describing the wound and giving the measurements. On 12/4/19 at 9:05 a.m., ASM (administrative staff member) #2, the DON (director of nursing for this facility) was interviewed by phone. She stated she has only been working at this facility for a few months. When asked about the process staff follows for resident skin assessments, ASM #2 stated residents receive head to toe skin assessments with baths/showers twice weekly,	F 686		

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F 686	Continued From page 28 and floor nurses perform a skin assessment (body audit) at least weekly. She stated if a resident has a wound, the unit managers perform a weekly assessment on wound rounds, and should be writing a progress note with measurements and a description of the wound. She stated the floor nurses are providing routine wound care. ASM #2 stated Braden assessments are done on admission and readmission. When asked what should be done when a new wound is discovered, ASM #2 stated the wound should be measured and described, the RP and MD should be notified, and a progress note should be written. On 12/4/19 at 10:35 a.m., LPN #4 was interviewed. When asked what should be documented when a new pressure area is identified on a resident, She stated the MD (medical doctor) and RR (resident representative) should be notified. She stated the nurse who discovers the wound should measure it, and include the measurements and a wound description in a progress note. LPN #4 stated the nurse should get an order from the MD or NP (nurse practitioner), and put the order into the electronic medical record. When asked how often a wound should be assessed, LPN #1 stated it should be assessed at least every day. She stated that she signs off on the TAR once she has completed a resident's wound care. She stated the unit managers do weekly wound rounds, and that sometimes, the NPs do wound rounds with the unit managers, but not always. On 12/4/19 at 10:55 a.m., RN (registered nurse) #2, a unit manager, was interviewed. She stated she is an agency employee, and has only been at the facility for a few weeks. She stated she would	F 686		

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F 686	Continued From page 29 only be staying for one more week at the facility. When asked about the process staff follows for completing resident skin assessments, RN #2 stated, "Skin is assessed by the nurses on admission and readmission." She stated every resident should have an order for a body audit. RN #2 stated that if a pressure ulcer is found, it should be measured, and the measurement and description should be included in the progress note. RN #2 stated the nurse should let the MD and the family know. When asked if the floor nurse stages the wound, RN #2 stated, "I am not allowed to stage it. The floor nurse is not allowed to stage it. We are only allowed to measure it and describe it." She stated unit managers do weekly wound rounds for residents who have pressure ulcers. RN #2 stated, "I keep a wound book. I don't know if anybody else did before I came, or if anybody else is doing one here, because I haven't found anything like that. But when I came, I started a wound book." On 12/4/19 at 11:46 a.m., RN # 1 was interviewed. He stated he had gone back in to measure the new (lower) buttock wound on Resident #2, and had gotten a new order for both a treatment for the lower wound, and a new treatment and dressing for the upper wound. He stated the lower (new) wound measurements were 2 cm X 1.5 cm X 0.1 cm. When asked if he had staged the new (lower) buttock wound, RN #1 stated, "We are not allowed to stage. Only to describe." When asked who is responsible for staging the wounds, RN #1 stated, "I really am not sure." When asked if he had done additional documentation other than writing a progress note, RN #1 stated, "No." On 12/4/19 at 11:50 a.m., LPN #1 was	F 686		

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F 686	Continued From page 30 interviewed. She stated she had provided Resident #2's wound care on 12/2/19 [the day before the new wound, was observed by RN #1 and the surveyor]. LPN #1 stated, "If there was more than one wound there, I didn't see it." When asked what she would have done if she had discovered a new wound, LPN #1 stated, "I would have tried to measure it and describe it. I would have called the doctor or the NP." She stated she would have written a progress note. When asked if there is any other documentation for pressure ulcers, LPN #1 stated, "No." When asked if she remembered performing weekly or bi-weekly body audits on Resident #2 since the resident returned from the hospital following hip surgery, LPN #1 stated, "I don't really remember. You would have to look at the orders and the TAR." When shown the November and December 2019 TAR for Resident #2, LPN #1 stated, "I guess not." On 12/4/19 at 5:16 p.m., ASM #2 and ASM #3, the DON from a sister facility, were interviewed. When asked the purpose of the body audits ordered for residents, ASM #3 stated, "To assess the skin, to identify any areas that are there." When asked if any documentation accompanies the body audits, ASM #3 stated if there are any new areas, these areas are documented in the progress notes. She stated the purpose of the body audits are to identify new skin impairment areas. She stated if a new area is found, it should be measured and assessed, then described by measurement, location, and appearance in a progress note. When asked if there is any reason a resident should not be receiving body audits, ASM #3 stated, "No." Everyone receives them." When asked who is responsible for staging pressure ulcers in the facility, ASM #2 stated,	F 686		

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F 686	Continued From page 31 "The RN on the unit manager." When asked why it is important to stage a pressure ulcer, ASM #2 stated staging is one way to determine whether or not a wound is improving or not. She further stated that with each wound assessment made by the RN/unit manager, there should be a progress note and a PUSH tool (7) update. When asked if all pressure ulcers should be documented using a PUSH tool, ASM #2 stated, "Yes, they should." When asked about an acceptable stage for identification of a new pressure sore on a resident, ASM #3 stated, "That's hard to say." When asked what she would conclude about a resident having two new wounds identified at an unstageable level within 10 days, ASM #3 stated, "Obviously, that is not optimal." When asked if Resident #2 was receiving preventative skin care and body audits prior to the discovery of an unstageable pressure ulcer on 11/25/19 and 12/3/19, ASM #3 and ASM #2 stated they would need to check. When asked if a PUSH tool had been initiated for the unstageable pressure ulcer discovered on 11/25/19, ASM #3 and ASM #2 stated they would need to check. "The Pressure Ulcer Scale for Healing (PUSH Tool) was developed by the National Pressure Ulcer Advisory Panel (NPUAP) as a quick, reliable tool to monitor the change in pressure ulcer status over time...The NPUAP recommends use of the PUSH Tool at "regular intervals." (7) On 12/4/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, ASM #3, and LPN #2 were informed of the concern Resident #2's, two pressure wounds were discovered as unstageable within 10 days of each other and of	F 686		

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F 686	Continued From page 32 the lack of preventative measures, including body audits and the concern for harm. On 12/5/19 at 10:38 a.m., RN #1 was interviewed. He stated ASM #4 had seen Resident #2 on 12/4/19 in the afternoon. He stated she changed the order for the upper wound, and wrote an order for the lower wound at that time. When asked if Resident #2 had been receiving preventative skin care since she had returned from the hospital following the surgery for her broken hip, RN #1 stated, "I have looked. I don't see anything in November once she got back from the hospital. It looks like we have been putting Zinc Oxide cream on her once a shift since December 1." When asked what sort of interventions should have been implemented to prevent the skin breakdown, RN #1 stated, "Some kind of barrier cream, at least. She is always incontinent." He stated that barrier cream should have been applied after each and every incontinent episode. He stated he would get an order for the barrier cream immediately. When asked if Resident #2 should have been receiving bi-weekly body audits, RN #1 stated, "Yes. Absolutely." When asked if Resident #2's wound identified on 11/25/19 was being tracked using a PUSH tool, RN #1 stated, "We are getting one done now." [ASM #4, the nurse practitioner was unavailable for interview before exit.] On 12/5/19 at 11:38 a.m., ASM #2 stated the facility relied on their policy as their standard of practice for pressure ulcer management. A review of the policy, "Skin Practice Guide," revealed, in part, the following: "If a pressure ulcer is identified, a Pressure Ulcer Scale for Healing (PUSH tool) is initiated by a member of the wound team for each site identified. A	F 686		

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F 686	Continued From page 33 comprehensive evaluation is completed and documented in the patient's clinical record and may include, but is not limited to: location, depth, appearance of surrounding skin, presence and location of tunneling, presence and location of undermining, evidence of infection, pain. Daily skin evaluations are completed by the licensed nurse for any patient with a pressure ulcer. Weekly skin evaluations are completed by the licensed nurse for any other patient. Skin evaluations are documented in the medical record...Any new ulcer development suggests a need to reevaluate the plan of care of preventing further development of pressure ulcers...Each center establishes a designated wound management team...The wound management team reevaluates pressure ulcers and complex wounds weekly and other types of wounds as clinically indicated. Documentation of findings is completed on the PUSH Tool." When asked who comprises the wound team in the facility, ASM #2 stated, "Right now, it's the nurses, the unit manager who makes the weekly rounds." When asked the NP/MD's role in wound care, ASM #2 stated, "They provide the orders and they look at the wound when they come in to see the resident. They will stage it then if they look at it." "Importance of staging. A pressure ulcer classification system is used to aid in the description of the extent of skin and tissue damage presenting as a pressure ulcer. Numerous classification systems have been developed and used over the years, informed by evolving understanding of the etiology of pressure ulcers; anatomical knowledge of skin, tissue and muscle layers; and diagnostic and assessment	F 686		

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F 686	Continued From page 34 technology. The use of a reliable classification system: improves communication between health professionals, contributes to the development of an appropriate pressure ulcer prevention plan, including allocation of pressure redistribution support surfaces; informs the selection of pressure ulcer treatments." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/2014_guideline.pdf. No further information was provided prior to exit. Complaint deficiency References: * This information is taken from the National Pressure Ulcer Advisory Panel website at https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (1) "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear." This information is taken from the National Pressure Ulcer Advisory Panel website at https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (2) "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed." This information is taken from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.	F 686		

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F 686	Continued From page 35 (4) The wound bed may be covered with necrotic tissue (non-viable tissue due to reduced blood supply), slough (dead tissue, usually cream or yellow in color), or eschar (dry, black, hard necrotic tissue). Such tissue impedes healing. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/ (5) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information is taken from the manufacturer's website https://www.santyl.com/. (6) "The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. A lower Braden Scale Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development." This information is taken from the website https://www.nlm.nih.gov/research/umls/sourcerele	F 686		

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F 686	Continued From page 36 asedocs/current/LNC_BRADEN/. (7) "The Pressure Ulcer Scale for Healing (PUSH Tool) was developed by the National Pressure Ulcer Advisory Panel (NPUAP) as a quick, reliable tool to monitor the change in pressure ulcer status over time...The NPUAP recommends use of the PUSH Tool at "regular intervals". The AHCPR Treatment Guideline recommends assessments be performed "at least weekly" and "if the condition of the patient or of the wound deteriorates". The PRESSURE ULCER HEALING CHART (which is attached to the PUSH Tool) will allow you to graph PUSH Tool scores over time for each ulcer. You should be able to "tell at a glance" whether the ulcer is healing, remains unchanged, or is deteriorating. The PUSH Tool is designed to monitor the three critical parameters that are the most indicative of healing. In developing specific treatment plans, you will need to assess additional parameters (e.g., foul odor, color of exudate, undermining, and tunneling). Any increase in the PUSH Tool score (indicating wound deterioration) requires a more complete assessment of the ulcer and the patient's overall condition." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/push_tool_information_form.pdf. 2. Resident #4 was admitted to the facility on 4/25/11, and was most recently readmitted on 11/15/19, with diagnoses including, but not limited to dementia (1), high blood pressure, and history of a stroke. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/22/19, she was	F 686		

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F 686	Continued From page 37 coded as having both short-term and long-term memory problems, and as being severely cognitively impaired for making daily decisions. The resident was coded as being completely dependent on the assistance of staff for bed mobility, toileting, personal hygiene and bathing. The resident was coded as transferring out of bed only one or two times during the look back period. The resident was coded as having an indwelling urinary catheter, and as being always incontinent of bowel. The resident was coded as being at risk for developing pressure ulcers, and as having one unstageable pressure ulcer. A review of Resident #4's progress notes revealed a note dated 10/23/19. The note documented, in part, the following: "Apply Hydrogel Gel to buttocks topically every evening shift for wound care. Cleanse affected area of buttocks with normal saline, apply hydrogel and cover with foam dressing daily." Further review of the progress notes revealed the following note dated 11/5/19 (13 days since the previous wound note): "Open area to right buttocks that measures 1.5 cm (centimeters) X 1.0 cm X 0.2 cm, 100% beefy red wound bed, no drainage, no odor. Periwound (area around wound) is normal. Continue with hydrogel and foam dressing." Further review of the clinical record revealed documentation that Resident #4 was discharged to the hospital on 11/10/19, and was readmitted to the facility on 11/16/19. A progress note dated 11/16/19, which was part of the readmission assessment, documented, in part: "Resident readmitted under hospice...DSG	F 686		

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F 686	Continued From page 38 (dressing) to coccyx is unstageable, dsg replaced." Review of the full readmission assessment dated 11/16/19 failed to reveal any additional information regarding Resident #4's pressure ulcer. A progress note dated 11/28/19 (12 days since the previous note related to Resident #4's pressure ulcer), documented, in part, the following: "Late entry for 11/27/19. Wound note: Sacral wound measuring 6.5 X 3.0 X 0.2. Wound bed is 95% yellow slough and black exchar (sic) with purulent (containing pus) mild drainage and foul odor. Hospice nurse in at time of dressing change. Current treatment in place." This note, written by RN (registered nurse) #2, a unit manager. A review of Resident #4's October 2019 TAR (treatment administration record) revealed blanks on 10/25/19, 10/27/19, 10/31/19 for the following treatment administration: "Hydrogel Gel Apply to buttocks topically every evening shift for wound care. Cleanse affected area of buttocks with normal saline, apply hydrogel and cover with foam dressing daily." A review of Resident #4's October 2019 TAR revealed the treatment, "Barrier cream to peri (perineal) area, buttocks and scar tissue, BID (twice a day) and prn (as needed) after incontinent episodes every day and evening shift." There were blanks for the treatment as evidenced by no staff initials evidencing the treatment was administered on the following dates and shifts: -Day shift: on 10/7/19, 10/10/19, 10/15/19, 10/25/19, and 10/29/19. - Evening shift: on 10/4/19, 10/9/19, 10/10/19,	F 686		

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F 686	Continued From page 39 10/19/19, 10/20/19, 10/25/19, 10/27/19, and 10/31/19. A review of Resident #4's comprehensive care plan dated 4/13/11 and updated 11/7/19 revealed, in part, the following: "Right buttocks area...Administer treatment per physician orders...Pressure reducing surface on bed and wheelchair." On 12/4/19 at 9:05 a.m., ASM (administrative staff member) #2, the DON (director of nursing for this facility) was interviewed by phone. ASM #2 stated she has only been working at this facility for a few months. When asked the process for skin assessment for all residents, ASM #2 stated residents receive head to toe skin assessments with baths/showers twice weekly, and floor nurses perform a skin assessment (body audit) at least weekly. ASM #2 stated if a resident has a wound, the unit managers perform a weekly assessment on wound rounds, and should be writing a progress note with measurements and a description of the wound. On 12/4/19 at 10:35 a.m., LPN #4 was interviewed. She was asked what should be documented when a new pressure area is identified on a resident. LPN #4 stated the MD (medical doctor) and RR (resident representative) should be notified. She stated the nurse who discovers the wound should measure it, and include the measurements and a wound description in a progress note. LPN #4 stated the nurse should get an order from the MD or NP (nurse practitioner), and put the order into the electronic medical record. When asked how often a wound should be assessed, LPN #4 stated it should be assessed at least every day. She	F 686		

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F 686	Continued From page 40 stated that she signs off on the TAR once she has completed a resident's wound care. LPN #4 stated the unit managers do weekly wound rounds, and that sometimes, the NPs do wound rounds with the unit managers, but not always. On 12/4/19 at 10:55 a.m., RN (registered nurse) #2, a unit manager, was interviewed. She stated she is an agency employee, and has only been at the facility for a few weeks. She stated she would only be staying for one more week at the facility. When asked the process for skin assessment, RN #2 stated, "Skin is assessed by the nurses on admission and readmission." She stated every resident should have an order for a body audit. She stated if a pressure ulcer is found, it should be measured, and the measurement and description should be included in the progress note. She stated the nurse should let the MD and the family know. When asked if the floor nurse stages the wound, RN #2 stated, "I am not allowed to stage it. The floor nurse is not allowed to stage it. We are only allowed to measure it and describe it." She stated unit managers do weekly wound rounds for residents who have pressure ulcers. RN #2 stated, "I keep a wound book. I don't know if anybody else did before I came, or if anybody else is doing one here, because I haven't found anything like that. But when I came, I started a wound book." RN #2 presented a document from a notebook. The document, "Pressure Ulcer Healing Chart," contained columns for the date, measurements, tissue type, and progress toward healing for residents' wounds. RN #2 stated she had started this document for Resident #4, beginning with 11/27/19 when she first observed and assessed Resident #4's wound. She stated she would be adding the next column on 12/5/19 when she did	F 686		

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F 686	Continued From page 41 weekly wound rounds. When asked to review the wound documentation for Resident #4, beginning with 10/23/19, RN #2 reviewed the notes. RN #2 stated, "I can't really speak to what did or didn't happen before I got here." On 12/4/19 at 11:10 a.m., LPN #5 was interviewed. She stated she was the nurse who had initially discovered Resident #4's pressure ulcer. She stated that usually, when she discovers a new pressure ulcer, she measures it, and includes the measurements and description in a progress note. LPN #5 stated she calls the provider, gets, an order, and then notifies the family. She stated the unit manager does weekly rounds on the wounds, and floor nurses see the wound as often as the wound care is due. When asked why she did not measure or describe Resident #4's wounds on 10/23/19, LPN #5 stated, "I really cannot recall." On 12/4/19 at 5:30 p.m., ASM #1, the administrator, ASM #2, ASM #3, and LPN #2 were informed of these concerns. On 12/5/19 at 10:32 a.m., LPN #3 was interviewed regarding documentation of treatments administered to residents. She stated she was an agency nurse. LPN #3 stated, "We document everything on [name of electronic health record software]." She stated each nurse has his or her own log-in identification. When asked what it means if a resident's TAR has blanks where there should be a nurse signature, LPN #3 stated, "If it's not documented, it was not given. Everybody knows that. If you do it, you document it." On 12/5/19 at 10:38 a.m., RN #1 was interviewed	F 686		

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F 686	Continued From page 42 regarding the blank spaces on the TARs. He stated nurse's document on the computer when they administer a treatment. When asked what the blank spaces mean, RN #1 stated, "It means that the treatments weren't given." A review of the facility policy "Medication Administration: Medication Pass" revealed, in part, the following: "Administer medication according to specific procedure...Document initials on MAR for each medication administered." No further information was provided prior to exit. References: (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.	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 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	F 842		

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F 842	Continued From page 43 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when 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-	F 842		

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F 842	Continued From page 44 (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, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for one of eight residents in the survey sample, Resident #7. For Resident #7, the facility staff failed to accurately document treatments that were being provided for the resident's pressure ulcers in November 2019. The findings include: Resident #7 was admitted to the facility on 9/1/11, and most recently readmitted to the facility on 1/17 19, with diagnoses including, but not limited to history of a stroke and diabetes type 2. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/18/19, Resident #7 was coded as being severely impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). The resident was coded as being completely dependent on the assistance of two staff members for bed mobility, toileting, and	F 842		

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F 842	Continued From page 45 personal hygiene, and as being completely dependent on the assistance of two staff members for transferring between surfaces. The resident was coded as always being incontinent of bladder and bowels. Resident #7 was coded as being at risk for developing pressure ulcers, and as having one unstageable pressure ulcer. A review of Resident #7's progress notes revealed the following note dated 10/23/19: "CNA reported to me that resident had bloody area to buttocks. Resident assessed and open area measuring 2 X 2 X 0.1 cm (centimeters) noted under right gluteal fold, wound base red with bloody drainage. Area cleaned and protective dressing applied." A review of Resident #7's physician's orders and October 2019 TAR (treatment administration record) revealed the following order dated 10/23/19: "Clean right gluteal fold with NS (normal saline). Apply wound gel and cover with dry dressing every evening shift for wound." The TAR contained nurses' initials at all opportunities for this order to be followed, indicating the treatments were completed as ordered. Further review of Resident #7's progress notes revealed the following note dated 10/30/19: "Chart check done new order noted. Cleansed affected area of right ischium with normal saline. Apply Hydrogel and cover with foam dressing every other day and PRN (as needed) for soiling." Further review of Resident #7's progress notes revealed a note dated 11/11/19, that documented: "Resident presents with an area under the right sacral fold that's 4 cm long and 4 1/2 cm wide with full thickness tissue loss in which actual	F 842		

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depth is completely obscured by slough and eschar in the wound bed. MD made aware and writer left a voicemail with RP. Awaiting call back. Resident has treatment in place. Facility director also made aware. Resident presents with some discomfort to touch. Resident medicated with prn pain medication. Resident in bed and will be turned and repositioned q2hrs (every two hours). Will continue to monitor."

Further review of Resident #7's progress note revealed a note dated 11/20/19. The note documented: "Resident has open wound to right Ishim (sic). Area measuring 4.5 X 4.0 X 2. 50% slough, 50% granulation (healthy, healing) tissue. Moderate amount of purulent (containing pus) drainage. Treatment completed, procedure tolerated well. MD/RP notified. New orders to D/C (discontinue) current orders. Cleanse wound with normal saline, apply santyl and guaze (sic) to affected area and cover with foam dressing daily." LPN (licensed practical nurse) #3, wrote this note.

A review of Resident #7's NP (nurse practitioner) notes revealed a note dated 10/29/19. The note, written by ASM (administrative staff member) #4, the NP, documented, in part, the following: "4 cm in diameter open area to right ischium, without surrounding erythema...Cleanse affected area with normal saline, apply hydrogel, cover with foam dressing q 48h (every 48 hours)."

Further review of the NP notes revealed a note dated 11/19/19. The note documented, in part, the following: "Unstageable wound to right ischium. [Approximately] 6 cm in diameter with mild surrounding erythema. Wound bed with 60% slough...Pressure injury of right buttock, unstageable...Nursing to cleanse affected area of

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F 842	Continued From page 47 right ischium daily with normal saline, apply Santyl and gauze and cover with foam dressing daily and prn soiling...Nursing to continue to monitor closely and notify MD/NP of any change in condition." Further review of the NP notes revealed a note dated 11/20/19. The note documented, in part, the following: "Unstageable wound to right ischium measuring 4.5 cm X 4 cm X 2 cm, wound bed with 50% slough, 50% granulation tissue, mild surrounding erythema (redness)...Nursing to continue local wound care: cleanse affected area of right ischium daily with normal saline, apply Santyl and gauze and cover with foam dressing daily and prn soiling." A review of Resident #7's November 2019 TAR revealed that the first order (initiated 10/23/19) for wound dressing change daily was never discontinued. The facility staff continued to sign off on the daily wound dressing change from 11/1/19 through 11/13/19, as well as signing off on the dressing change every other day (initiated 10/30/19) from 11/2/19 until 12/2/19. Additionally, once the 11/20/19 order for Santyl was initiated, both previous orders remained active, and the facility staff signed off on the Santyl order from 11/19/19 through 11/25/19. A review of Resident #7's comprehensive care plan dated 8/16/12 and updated 10/23/19 revealed, in part, the following: "Open area under right gluteal fold ...Will heal within the limits of the disease process ...Administer analgesia (pain medications) per physician orders (offer prior to treatment/therapy) ...Administer treatment per physician orders ...Encourage and assist as needed to turn and reposition; use assistive	F 842		

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F 842	Continued From page 48 devices as needed." On 12/4/19 at 10:35 a.m., LPN (licensed practical nurse) #4 was interviewed. When asked what needs to be done if a new order is written for a resident's pressure ulcer treatment, she stated the old order should be discontinued and the new order placed on the TAR. When asked if the old order would disappear from the TAR if it was discontinued, LPN #4 stated, "Yes it would." When asked what she would do if she encountered multiple active orders for one pressure ulcer treatment, LPN #4 stated, "I would definitely call the doctor and clarify that order." On 12/4/19 at 5:30 p.m., ASM (Administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing at a sister facility, and ASM #5, an MDS coordinator, were informed of the concerns regarding the discrepancies in the TAR for Resident #7's pressure ulcer treatment in November 2019. On 12/5/19 at 10:38, RN (registered nurse) #1, a unit manager, was interviewed regarding the discrepancies in Resident #7's TAR. He reviewed the November 2019 TAR. RN #1 then stated, "It looks like there are multiple treatments for the same wound at the same time." He stated it was hard to believe all those treatments were administered at the same time. He stated the floor nurse should have clarified the orders on the TAR to determine which one was active, and should have discontinued the rest. On 12/5/19 at 11:38 a.m., ASM #2 stated she had identified the agency nurse responsible for signing off on multiple treatments for the same	F 842		

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wound for Resident #7 in November 2019. She stated she had spoken with the nurse, who confirmed she administered the normal saline/foam treatment until the Santyl was ordered. Once the Santyl was ordered, she only administered the Santyl. ASM #2 stated the nurse should not have signed off on treatments she had not given, and that the nurse should have discontinued the old orders after clarifying with the NP or physician. ASM #2 stated she would be writing the overlapping TAR sign-offs as med (medication) errors.

The agency nurse who signed off on the treatments was not available for interview prior to exit.

On 12/5/19 at 11:43 a.m., LPN #6 was interviewed regarding the November 2019 TARs for Resident #7. LPN #6 stated she (the nurse who documented providing multiple treatments) is an agency nurse, and she knows the other agency nurse who signed off on the multiple treatments. LPN #6 stated, "You cannot have more than one order at a time. You cannot sign off on both of the treatments. I don't know why she did that."

On 12/5/19 at 11:45 a.m., RN #2, a unit manager, was interviewed. She was shown the November 2019 TARs and stated, "I would have called the doctor to clarify and discontinue whichever ones are not correct." RN #2 stated a nurse should only sign off on one order at a time for pressure ulcer.

A review of the facility policy "Medication Administration: Medication Pass" revealed, in part, the following: "Administer medication

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F 842	Continued From page 50 according to specific procedure...Document initials on MAR for each medication administered." No further information was provided prior to exit. The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received .....Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it."	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:	F 849		

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F 849	Continued From page 51 (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and	F 849		

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F 849	Continued From page 52 nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the	F 849		

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F 849	Continued From page 53 facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's	F 849		

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F 849	Continued From page 54 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain a current plan of care from the providing hospice provider for two of eight residents in the survey sample, Residents #1 and #4. For Resident #1, the facility staff failed to obtain the hospice provider's plan of care and place it on the clinical record when she elected a hospice provider on 10/15/18. For Resident #4, the facility staff failed to obtain the hospice provider's plan of care and place it on the clinical record when she elected a hospice provider on 11/16/19. The findings include: 1. Resident #1 was admitted to the facility on 8/8/18 with diagnoses including, but not limited to	F 849		

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heart failure (1), high blood pressure, and COPD (chronic obstructive pulmonary disease) (2). On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 10/22/18, Resident #1 was coded as being moderately cognitive impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as being under the care of a community hospice provider.

Resident #1 was discharged from the facility on 11/27/18.

A review of Resident #1's clinical record revealed a progress note written 10/15/18. The note documented, in part: "Alert and verbal. Admitted to [name of community hospice provider]."

Further review of the clinical record revealed documents detailing the resident's contractual agreements with the community hospice provider, including the resident's election of the hospice Medicare benefit.

Further review of the clinical record failed to review any care plan or visit notes from the community hospice provider's nurses or aides.

On 12/4/19 at 10:25 a.m., CNA (certified nursing assistant) #2 was interviewed regarding coordinating care with a community hospice provider. CNA #2 stated, "I just do the residents myself." When asked if she is given information regarding coordination with the hospice plan of care, CNA #2 stated, "Yes. Sometimes I will talk to the hospice nurse." She stated that just this week, a new hospice aide had come into the facility, and they had discussed division of tasks

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F 849	Continued From page 56	F 849		

for the resident who was receiving hospice services. She stated she was not aware of hospice care plans from the hospice providers.

On 12/4/19 at 10:28 a.m., LPN (licensed practical nurse) #4 was interviewed. She stated hospice nurses come in and talk to the floor nurses about how patients are doing. She stated hospice nurses ask about supply availability, and will deliver needed supplies to residents who are under their care. She stated hospice nurses inform them of new orders. When asked if hospice care plans should be available to facility staff, LPN #4 stated, "Yes. And progress notes from the nurses should also be in the chart."

On 12/4/19 at 10:49 a.m., RN (registered nurse) #2, a unit manager, was interviewed. She stated the facility nurses call hospice nurses with any change in condition. She stated hospice nurses make regular visits. When asked if hospice care plans should be available to facility staff, RN #2 stated, "Yes." When asked if notes from nurses and aides who visit residents should also be accessible to staff, RN #2 stated, "Yes."

On 12/4/19 at 5:30 p.m., ASM #1 (administrative staff member), the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing at a sister facility, and ASM #5, an MDS coordinator, were informed of these concerns. A policy regarding hospice care plans was requested.

On 12/5/19 at 9:15 a.m., ASM #3 brought several policies to the surveyor. ASM #3 stated the policy "Clinical Record Resource Manual" contained information regarding the hospice care plans. A review of this policy failed to reveal any

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F 849	Continued From page 57 information related to hospice care plans being a part of the facility record. On 12/5/19 at 11:45 a.m., ASM #2 provided the surveyor with copies of the hospice care plan, nurse visit notes, and CNA visit notes for Resident #1. No further information was provided prior to exit. (1) "Heart failure is a condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body...As the heart's pumping becomes less effective, blood may back up in other areas of the body. Fluid may build up in the lungs, liver, gastrointestinal tract, and the arms and legs. This is called congestive heart failure." This information is taken from the website https://medlineplus.gov/ency/article/000158.htm (2) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 2. Resident #4 was admitted to the facility on 4/25/11, and most recently readmitted on 11/15/19, with diagnoses including, but not limited to dementia (1), high blood pressure, and history of a stroke. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/22/19, she was coded as having both short-term and long-term memory problems, and as being	F 849		

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F 849	Continued From page 58 severely cognitively impaired for making daily decisions. The resident was coded as receiving hospice services from a community provider. A review of Resident #4's physician's orders revealed the following order, written 11/15/19: "Admit to hospice [name of community hospice provider]." Further review of the clinical record failed to review any care plan or visit notes from the community hospice provider's nurses or aides. On 12/4/19 at 10:25 a.m., CNA (certified nursing assistant) #2 was interviewed regarding coordinating care with a community hospice provider. CNA #2 stated, "I just do the residents myself." When asked if she is given information regarding coordination with the hospice plan of care, CNA #2 stated, "Yes. Sometimes I will talk to the hospice nurse." She stated that just this week, a new hospice aide had come in to the facility, and they had discussed division of tasks for the resident who was receiving hospice services. She stated she was not aware of hospice care plans from the hospice providers. On 12/4/19 at 10:28 a.m., LPN (licensed practical nurse) #4 was interviewed. She stated hospice nurses come in and talk to the floor nurses about how patients are doing. She stated hospice nurses ask about supply availability, and will deliver needed supplies to residents who are under their care. She stated hospice nurses inform them of new orders. When asked if hospice care plans should be available to facility staff, LPN #4 stated, "Yes. And progress notes from the nurses should also be in the chart."	F 849		

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F 849	Continued From page 59 On 12/4/19 at 10:49 a.m., RN (registered nurse) #2, a unit manager, was interviewed. She stated the facility nurses call hospice nurses with any change in condition. She stated hospice nurses make regular visits. When asked if hospice care plans should be available to facility staff, RN #2 stated, "Yes." When asked if notes from nurses and aides who visit residents should also be accessible to staff, RN #2 stated, "Yes." When asked if Resident #4's clinical record included a hospice care plan, she reviewed the record and then stated, "I don't see one. I will look." On 12/4/19 at 5:30 p.m., ASM #1 (administrative staff member), the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing at a sister facility, and ASM #5, an MDS coordinator, were informed of these concerns. ASM #2 stated, "This resident has only been on hospice for a few weeks." When asked if the community hospice provider's plan of care should be a part of the resident's clinical record to guide the facility staff, she stated it should. On 12/5/19 at 11:45 a.m., ASM #2 provided the surveyor with copies of the hospice care plan, nurse visit notes, and CNA visit notes for Resident #4. No further information was provided prior to exit.	F 849		
F 880 SS=D	COMPLAINT DEFICIENCY Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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F 880	Continued From page 60 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 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	F 880		

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F 880	Continued From page 61 (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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, and clinical record review, it was determined that the facility staff failed to provide incontinence care in a manner to prevent the development and transmission of infections for one of eight residents in the survey sample, Resident #2. CNA (certified nursing assistant) #1 failed to change gloves, after removing soiled incontinence products, and performing incontinence care and was observed applying a clean brief and touching Resident #2 wearing soiled gloves, and failed to remove a sheet observed with fecal smears. In addition, CNA #1 failed to use soap when washing her hands on one occasion and washed	F 880		

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F 880	Continued From page 62 her hands for less than five, seconds and 15 seconds on 2 occasions. The findings include: Resident #2 was admitted to the facility on 11/20/14, and most recently readmitted on 11/13/19, with diagnoses including, but not limited to history of a broken hip and diabetes type 2 (1). The resident was discharged from the facility and admitted to a local hospital from 11/3/19 until 11/13/19 for surgical repair of a broken hip On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 11/18/19, Resident #2 was coded as being moderately cognitively impaired for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). The resident was coded as being completely dependent on the assistance of two staff members for bed mobility and transferring between surfaces. The resident was coded as being dependent on the assistance of two staff members for toileting and bathing. On 12/3/19 at approximately 4:50 p.m., CNA (certified nursing assistant) #1 entered Resident #2's room to assist RN (registered nurse) #1 with changing the resident's pressure ulcer dressing. CNA #1 put on gloves assisted with turning the resident to one side to expose her pressure ulcer dressing. When the CNA did this, she realized that Resident #1 had been incontinent of both bladder and bowel. While RN #1 went to wash his hands and get additional supplies, CNA #1 provided incontinence care to Resident #2. She removed Resident #2's soiled adult incontinence	F 880		

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F 880	Continued From page 63	F 880		

product as much as possible. She used wet wipes to clean Resident #2's perineal area. She completely removed the soiled brief and threw it in the trashcan. Without changing her gloves, she picked up a clean brief and placed it under Resident #2. She touched the resident's legs and buttocks multiple times with the gloves as she worked to position the brief. Once the new brief was in position for the wound care, CNA #1 went to the bathroom and removed the gloves. She ran her hands under water for less than five seconds (without using soap), dried her hands, and put on a fresh pair of gloves. She continued to stand beside the resident while RN #1 completed wound care. Once RN #1 had finished with the treatment and dressing, CNA #1 rolled Resident #2 onto the resident's back. There were two sections of bowel movement smear on Resident #2's blanket. When the resident rolled to a position on the resident's back, the clean brief was in direct contact with the bowel movement smear. CNA #1 pulled Resident #2's blanket back up to chin level and said, "I will be back later with your dinner tray." She went in the bathroom, removed her gloves, and washed her hands with soap for less than 15 seconds before drying them. She exited Resident #2's room, and went to answer another resident's call bell.

A review of Resident #2's comprehensive care plan dated 3/11/16 and updated 11/21/19 revealed, in part, the following: "Urinary and bowel incontinence. At risk for skin breakdown, infection and changes in bowel elimination...Apply skin moisturizers/barrier creams as needed...Provide incontinent care as needed...Report changes in amount, frequency, color or odor of urine...Report changes in skin integrity found during daily care...Report S&S

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495283	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-IMPERIAL	1719 BELLEVUE AVENUE RICHMOND, VA 23227

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F 880	Continued From page 64 (signs and symptoms) of UTI (urinary tract infection) such as flank pain, c/o (complaints of) burning/pain, fever, hematuria (blood in urine), change in mental status, etc." On 12/3/19 at approximately 5:20 p.m., CNA #1 was interviewed. When asked if she could think of anything she might have done differently in Resident #2's room while providing the incontinence care, CNA #1 stated, "No." When asked if she remembered when she changed her gloves, CNA #1 stated, "When I put on the clean diaper." When asked if she remembered that she had not changed her gloves between handling the soiled brief and touching the new brief, CNA #1 stated, "Oh, I guess I didn't. I should have changed them." When asked if she used soap when she washed her hands between the first glove removal and putting on the second pair, CNA #1 stated, "I thought I did." CNA #1 was informed that she was not observed using soap at that time, and that she held her hands under the water for less than five seconds. When asked how long she should wash her hands with soap and water, CNA #1 stated, "Long enough to get them really clean, I guess." On 12/4/19 at 10:35 a.m., LPN (licensed practical nurse) #4 was interviewed. When asked when gloves should be changed while providing incontinence care to a resident, LPN #4 stated, "Between dirty and clean." When asked if it is okay to touch a clean brief with the same gloves that have been used to remove a soiled brief and clean a resident, LPN #4 stated, "Never." When asked the proper procedure to be followed for washing hands, LPN #4 stated, "You have to use warm or hot water and soap. And you have to do it for at least 20 seconds." When asked why it is	F 880		

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F 880	Continued From page 65 important to practice good hand hygiene when providing incontinence care for a resident with a pressure ulcer, LPN #4 stated wounds could become, infected easily. Skin or wounds should not come into contact, with bacteria from urine or stool. On 12/4/19 at 5:30 p.m., ASM (Administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing at a sister facility, and ASM #5, an MDS coordinator, were informed of the concerns. A review of the facility policy "Incontinence Care" revealed, in part, the following: "Apply latex fee non-sterile gloves...If feces present, remove with toilet paper or disposable wipe by wiping from front of perineum toward rectum. Discard soiled materials and gloves. Perform hand hygiene. Apply latex free non-sterile gloves...Apply skin protectant products, if needed, and/or as ordered, per manufacturer's instructions. Remove and discard gloves. Perform hand hygiene. Apply clean linen or brief of other incontinent products, as needed." According to the CDC (Centers for Disease Control), "Hand hygiene is required regardless of whether gloves are used or changed. Failure to remove gloves after patient contact or between "dirty" and "clean" body-site care on the same patient must be regarded as nonadherence to hand-hygiene recommendations..." This information is taken from the website http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm. No further information was provided prior to exit.	F 880		

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F 880	Continued From page 66 References: (1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.	F 880		