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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (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	{F 000}		
	An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted 12/3/2019 through 12/5/2019 was conducted 1/21/2020 through 1/23/2020. One complaint, VA 00048169, was investigated at the time of the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this record. Corrected deficiencies are identified on the CMS 2567 B The census in this 128 certified bed facility was 90 the time of the survey. The survey sample consisted of nine current record reviews and two closed record reviews.			
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide care in a dignified manner during a wound care observation for one of 11 residents in the survey sample, Resident #106. The facility staff wrote with their pen on the dressings that were attached to Resident #106's buttocks.	F 557		

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

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 557	Continued From page 1	F 557		

The findings include:

Resident #106 was admitted to the facility on 2/12/11; with a readmission on 1/17/19 with diagnoses that included but were not limited to: diabetes, GERD [backflow of the contents of the stomach into the esophagus. (1)], dementia, and bullous pemphigoid [an autoimmune disorder that occurs when the body's immune system attacks and destroys healthy body tissue by mistake. Specifically, the immune system attacks the proteins that attach the top layer of skin (epidermis) to the bottom layer of skin) (2)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/30/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #106 was coded as dependent on one staff member for bed mobility, toileting, bathing and transfers. The resident was coded as requiring extensive assistance to supervision for the rest of her activities of daily living. In Section M - Skin conditions, the resident was coded as having 1 stage II pressure injury and one stage IV pressure injury (3).

Observation was made of RN (registered nurse) #2 and RN #1, the unit manager, on 1/22/2020 at 10:08 a.m., performing the wound care for Resident #106. After the wound, care was completed and RN #2 had placed two dressings on Resident #106's pressure injuries, she took her pen out of her pocket and wrote the date and her initials directly on the dressings that were attached to Resident 106's buttocks.

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An interview was conducted with RN #2 on 1/22/2020 at 1:25 p.m. and the above wound observation was shared with RN #2. When asked how she would feel if someone wrote on her dressing while it was on her buttocks, RN #2 stated, "I guess that would be strange." When asked if she should do that, RN #2 stated, "No, Ma'am."

An interview was conducted with RN #1 on 1/22/2020 at 1:49 p.m., regarding the above wound observation. When asked if he observed anything that was not acceptable during the wound care observation, RN #1 stated the dressings should be dated prior to being put on the resident.

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m. A request was made for the facility dignity policy at this time.

ASM #1 informed this surveyor on 1/23/2020 at approximately 12:30 p.m. the facility did not have a policy on dignity. The facility policy, Dressing Change: Non Sterile documented in part, "15. Prepare clean field...Label tape used to secure dressing with caregiver initials and date."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000883.htm.

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

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions.
Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from the following website:

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F 557	Continued From page 4 https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf	F 557		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	{F 656}		

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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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for one of 11 residents in the survey sample, Resident #101.
The facility staff failed to develop and implement a comprehensive care plan for Resident #101, who left the building unsupervised on multiple occasions.

The findings include:

Resident #101 was admitted to the facility on 4/17/17 with diagnoses including, but not limited to, cancer of the larynx with a tracheostomy (1), difficulty swallowing with a PEG (percutaneous endoscopic gastrostomy) tube (2), COPD (chronic obstructive pulmonary disease) (3), and schizophrenia (4). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 1/8/2020, Resident #101 was coded as having no impairments with making himself understood and with understanding others. He was coded as having no cognitive impairment for making daily decisions according to his score of 15 out of 15 on the BIMS. He was coded as having demonstrated no evidence of an acute onset of

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{F 656}	Continued From page 6 mental status change during the look back period. He was coded as having scored a zero out of 27 on the resident mood interview, indicating no difficulties with mood. He was coded as having demonstrated no behavioral symptoms curing the look back period. He was coded as being independent for all ADLs (activities of daily living), except for requiring set up for eating, and supervision for toilet use. He was coded as needing no mobility devices for locomotion. He was coded as having received an antipsychotic medication on seven out of seven days during the look back period. A review of Resident #101's clinical record revealed a progress note dated 9/19/19. The note, written by OSM (other staff member) #2, the director of social services, documented: "SW (social worker) met with resident to educate on facility LOA (leave of absence) policy. Resident understood then signed education sheet. SW provided sign-in sheet to Administrator for education acknowledgement." Further review of the clinical record revealed the following note, written 11/14/19 by RN (registered nurse) #4, an MDS nurse: "Resident frequently walks over to the convenience store next to our facility. Spoke with resident about our policies regarding smoking and alcohol. Informed him that if he purchases smoking materials, he must turn them in to his nurse to be kept in a secure safe place and returned to him for use during designated smoking times. Discussed the importance of not purchasing alcohol as it is unsafe to consume alcohol while taking medications and alcohol/alcohol use is not permitted in our facility. Resident verbalized understanding of our policies regarding smoke	{F 656}		

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{F 656}	Continued From page 7 and alcohol." Further review of the clinical record revealed a leave of absence form for Resident #101. The form contained one entry, dated 11/24. There was no year. The form documented the sign out time as 11:20 a.m., Resident #101's signature, but the form did not document a sign in time. The remainder of the form was blank. A review of Resident #101's comprehensive care plan, dated 4/25/17 with a target date of 1/29/2020 revealed, in part, the following: "At risk for changes in mood r/t (related to) schizophrenia...Will accept care and medication as prescribed...Administer medication per physician orders...Observe for mental status/mood state changes when new medication is started or with dose changes...Offer choices to enhance sense of control." The care plan contained no information regarding the resident's ability to leave the building unaccompanied. A review of physicians' orders for Resident #101 revealed no order stating the resident could leave the building unaccompanied. On 1/22/2020 at 8:50 a.m., RN (registered nurse) #3 was interviewed. She stated she frequently was assigned to Resident #101. She stated he left the building a couple of days a week, at least. She stated his outings usually only lasted about an hour, as far as she was aware. RN #3 stated the resident would tell her he was leaving and what time he would return, and that he would return on time. She stated her understanding is that the resident would go out of the building, down the sidewalk, around the corner, to a small grocery store in the adjacent building. She stated	{F 656}		

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she did know what the resident purchased when he went out, and that she never asked him. When asked if the resident had an order indicating he was safe to leave the building, RN #3 stated, "Sometimes he signed out, sometimes not." She stated the protocol is to have residents sign out, and then sign back in. She stated most of the time, the resident refused to do so. RN #3 stated, "Often I was in the middle of something, and he took advantage of that."

On 1/22/2020 at 9:09 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated she frequently was assigned to care for Resident #101. She stated he often left the building to go across the street to the grocery store. She stated he bought cigarettes and snacks there. She stated she believed that Resident #101 informed the nurse when he left the building, but was not certain if he signed out. CNA #1 added, "They are supposed to sign out."

On 1/22/2020 at 11:35 a.m., RN #5, the consultant psychiatric nurse practitioner, was interviewed. She stated she had been treating Resident #101 for less than a year. She stated when she first met Resident 101 on 4/17/19, he was very reserved and quiet. She stated, "He definitely had a schizophrenic presentation." She stated the classic schizophrenic is reserved until the resident gets to know you, is polite, and answers questions when asked. She stated she always asked Resident #101 if he was hearing any voices, and if so, what the voices were telling him. She stated Resident #101 always denied hearing voices, as well as denying any hallucinations. She stated that in recent visits, Resident #101 felt comfortable enough to smile and to interact somewhat spontaneously with her.

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She stated she specifically asked him if anyone was bothering him, which the resident denied. She stated that on her last visit with Resident #101 in December 2019, he was very positive, again denying hallucinations, and hearing voices. When asked if she thought Resident #101, was placed appropriately in a long-term care facility, RN #5 stated he could not care for himself because of his [schizophrenia] diagnosis. She stated his cognitive abilities were limited in higher-level thinking, such as judgment and reasoning. She stated Resident #101 was a very concrete thinker, and had limited ability to think in the abstract. She stated she did not think any other setting, in which he would have had more independence, would have been appropriate for him. When asked if she was aware that Resident #101 had been leaving the building unsupervised, RN #5 said she was not. RN #5 stated, "I would have difficulties with him going out by himself. I would have had some concerns." She stated the resident would have a right to leave the facility unsupervised, but the facility would still be responsible for the resident's safety. RN #5 stated, "If I had been aware he was leaving, I would have maybe asked social services to try to get guardianship. I feel that strongly."

On 1/22/2020 at 1:37 p.m., RN #4, an MDS nurse, was interviewed. RN #4 stated, "I had a close relationship with [Resident #101]." She stated the resident frequently left the building independently and went to the grocery store in the building next door. When asked if she was certain that, the resident went only to the building next door, RN #4 stated, "I never actually saw where he went. It's a community. When he left the building, he would stop and talk." She stated the resident bought cigarettes and snacks when he

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{F 656}	Continued From page 10 went out. When asked if the resident was safe to leave the building unsupervised, RN #4 stated, "He was safe, like me and you. All he had was a trach (tracheostomy)." When asked if a care plan had been developed for Resident #101's leaving the building unsupervised, RN #4 stated, "I don't know that we care plan for that." She stated the resident should have a physician's order to leave the building, and that the resident would then be responsible for signing in and out. When asked about the reason for the note she had written on 11/14/19, RN #4 stated another ambulatory resident who, at that time, was also leaving the building to go to the grocery store in the adjacent building, was purchasing alcohol. She stated all residents who were known to go to that grocery store were re-educated on the leave of absence policy, and instructed not to buy alcohol. She stated Resident #101 was not ever known to purchase alcohol. On 1/22/2020 at 2:04 p.m., RN #1, the unit manager, was interviewed. He stated he has only been employed at the facility for four or five weeks, and did not know Resident #101 very well. He stated any resident who leaves the building unsupervised would need a physician's order to do so. He stated residents who leave the building must sign in and out. When asked if the facility assessed residents for safety to leave the building unsupervised, RN #1 stated, "The IDT (interdisciplinary team), physician, and the psychiatrist should make the decision whether or not the resident is safe to leave unsupervised." When asked if a resident's ability to leave the building unsupervised safely should be on the care plan, RN #1stated, "It definitely should be on the care plan."	{F 656}		

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On 1/22/2020 at 2:21 p.m., OSM #1 was interviewed. She stated she was aware that Resident #101 was leaving the building unsupervised. She stated he went out to the store in the building next door, and was safe to do so. She stated his BIMS score of 15 out of 15 qualified him to do so. She stated she was not certain if Resident #101 had a physician's order to leave the building unaccompanied. She stated she knew that Resident #101 left the building at least once a week.

On 1/22/2020 at 3:26 p.m., ASM (administrative staff member) #2, the director of nursing was interviewed. She stated she was not aware that Resident #101 had been leaving the building unsupervised. ASM #2 stated, "I never saw him leave the building." When asked how the facility determines who is safe to leave the building, she stated the physician is supposed to write an order. When asked if the consultant psychiatry provider should be involved in making that decision, ASM #2 stated, "Yes, if the resident is having any behaviors." She stated she was not aware that Resident #101 was not signing out, and that he should have been doing so. She stated the nurse who is assigned to the resident is responsible for assuring the resident signs out and back in. She stated the care plan should contain information regarding the resident's ability to leave the facility independently.

On 1/22/2020 at 4:43 p.m., ASM #1, the administrator, was interviewed. She stated she was aware that Resident #101 was leaving the building unsupervised. She stated he would go to the grocery store in the building next door. She stated the receptionist is trained to monitor who leaves the building and how long the resident is

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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 656}	Continued From page 12 gone. When asked if the receptionist documents this information, ASM #1 stated, "No." When asked who provides this monitoring when the receptionist is away from the desk or after hours, she stated no one monitors the front doors. When asked how the facility determines who is safe to leave the building unsupervised, ASM #1 stated, "It is based off the BIMS, and if they are able to tell us where they are going. Can they contact us? Can they call 911?" She stated if they are deemed competent, then it is up to the physician to make the determination and to write an order. When asked if the facility had conducted any such assessment to include the questions she had just outlined, ASM #1 stated the facility had not. When asked if psychiatric services should be involved in the safety decision for a resident with a mental illness, ASM #1 stated, "It would be a conversation. It should be initiated by the physician." When shown the above-referenced leave of absence form for Resident #101 and asked whether or not Resident #101 was compliant with the facility's policy, ASM #1 stated, "He had been educated, and he said he understood. Yes, he was following the leave of absence policy because he never left [name of long term Care Corporation] property." She stated the resident left the direct supervision of facility staff. She then stated that the reason there was no physician's order was that the resident was not leaving facility property. At this time, ASM #1 was informed of the survey team's concerns regarding Resident #101's leaving the building unsupervised. On 1/23/2020 at 9:53 a.m., a follow-up interview was conducted with ASM #1. When asked what constituted facility property, ASM #1 stated, "In my vision, once you come through the security	{F 656}		

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{F 656}	Continued From page 13	{F 656}		

gates, all of these buildings are our property." When asked if the long-term care corporation owns all the buildings within the gates, ASM #1 stated, "No. Actually, [name of other senior living services provider] owns all the buildings. They own this one. [Name of long term Care Corporation] just rents this building and the parking lots from them." When asked if the staff in the adjacent building [Assisted living facility] containing the grocery store is a part of her facility staff, ASM #1 stated, "No."

On 1/23/2020 at 10:35 a.m., a follow-up interview was conducted with RN #5. When asked if it would alter her thinking regarding Resident #101's leaving the building unsupervised if he was going to a nearby building that might be technically on the same property as the facility, RN #5 stated, "It does not matter to me who owns what building. It matters to me that he was leaving this building unsupervised." She stated it still comes down to being out of the building is being out of sight, and that was not safe for resident.

A review of the facility policy, "Interdisciplinary Care Planning," revealed, in part, "The facility must develop and implement a comprehensive person-centered care plan for each patient that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment."

No further information was provided prior to exit.

References:

(1) "A tracheostomy is a surgical procedure to

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{F 656}	Continued From page 14 create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube." This information is taken from the website https://medlineplus.gov/ency/article/002955.htm. (2) "A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm. (3) 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. (4) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html	{F 656}		

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{F 657}	Continued From page 15	{F 657}		
{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 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 the facility staff failed to review and revise the comprehensive care plan for one of 11 residents in the survey sample, Resident #109. The facility staff failed to revise Resident #109's comprehensive care plan to reflect the	{F 657}		

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completion of antibiotics for a urinary tract infection.

The findings include:

Resident #109, was admitted to the facility 11/27/19; with a recent readmission on 1/9/2020 with diagnoses that included but were not limited to: multiple sclerosis [a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover. (1)], heart disease, high blood pressure, and clostridium difficele (C-diff) [A bacterium that causes diarrhea and more serious intestinal conditions such as colitis. (2)]

The most recent MDS (minimum data set) assessment, an admission assessment with an assessment reference date of 12/3/19 coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for all of his activities of daily living except eating in which he was coded as independent after set up assistance was provided.

Review of the comprehensive care plan dated 12/18/19, documented a focus area, "The resident is on Antibiotic therapy r/t (related to) UTI (urinary tract infection)."

The physician orders documented an order dated, 1/21/2020 for Vancomycin (antibiotic) 125 mg (milligrams); give 1 capsule by mouth every 6 hours for C-diff for 13 days." There was no antibiotic prescribed for a urinary tract infection.

Review of the MAR (medication administration

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record) for January 2020 failed to evidence documentation of an antibiotic for a urinary tract infection given in the month of January.

An interview was conducted with LPN (licensed practical nurse) #4 on 1/22/2020 at 12:45 p.m., regarding review and revisions of resident comprehensive care plans. LPN #4 stated, "I know MDS tells me to update the care plan. Nurses on the floor can update the care plan if someone goes on an antibiotic. Unit managers and MDS update the care plan." When asked if Resident #109 was on an antibiotic for a urinary tract infection (UTI), LPN #4 stated, "No, he's on Vancomycin for C-diff." LPN #4 reviewed Resident #109's care plan documented above. LPN #4 stated, "That should be updated. The nurses should be updating the care plan."

An interview was conducted with RN (registered nurse) #6 on 1/22/2020 at 1:09 p.m. When asked who updates the care plan, RN #6 stated everyone. She stated if a resident falls, the care plan should be updated immediately. If it's a new admission, the floor nurses start the care plan based on the needs of the patient. When asked if a resident was prescribed an antibiotic for a urinary tract infection, should the comprehensive care plan be updated when it is resolved, RN #6 stated yes, the care plan should be marked as resolved. It may need to be updated to say at risk for after they have finished their course of antibiotics.

The facility policy, "Interdisciplinary Care Planning" documented in part, "A comprehensive care plan must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive, quarterly and

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significant change review assessments."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.
(2) This information was obtained from the following website: https: https://medlineplus.gov/clostridiumdifficileinfections.html.

{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 the facility staff failed to provide services per professional standards of quality, for two of 11 residents in the survey sample, Residents #107, and #110. The facility staff failed to clarify physician orders for multiple as needed pain medications, to include pain scale rating parameters for which and when each medication should be administered to Resident #107 and #110.

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The findings include:

1. Resident # 107 was admitted to the facility on 9/11/19 with a recent readmission on 1/18/2020 with diagnoses that included but were not limited to: paraplegia (paralysis of the lower limbs) (1), morbid obesity, diabetes, high blood pressure, depression, anxiety and Bipolar disorder (a mental disorder characterized by episodes of mania and depression) (2).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/3/2020, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance to being dependent upon one or more staff members for all of her activities of daily living except eating in which she was coded as independent. In Section J -Health Conditions, the resident was coded as having pain frequently with a pain level of "5."

The physician orders dated, 1/18/2020 documented, "Acetaminophen (Tylenol) [used to treat mild to moderate pain (3)]; give 650 mg by mouth every 4 hours as needed for pain. Hydrocodone-Acetaminophen (Vicodin) tablet [used to treat moderate to severe pain (3)] 5-325 mg; give 1 tablet by mouth every 4 hours as needed for pain."

The January 2020 MAR documented the above physician medication orders. The Tylenol was not documented as administered to Resident #107. The Vicodin was documented as administered on

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{F 658}	Continued From page 20 the dates, and times, for pain level ratings as follows: 1/18/2020 at 9:00 p.m. - pain level - 4 1/21/2020 at 5:45 p.m. - pain level - 4 The comprehensive care plan dated, 12/20/19, for Resident #107, documented in part, "Focus: Pain in back." The "Interventions" documented in part, "Administer pain medication per physician orders." An interview was conducted with RN (Registered nurse) #2; a nurse that cares for Resident #107, on 1/22/2020 at 1:25 p.m. regarding administering as needed pain medication when more than one medication is prescribed without pain level parameters for when and which medication to administer. RN #2 stated she would ask the resident the location, intensity and to describe the pain. She stated she would ask the history of the pain and she then would look at the choices of medications to give. RN #2 stated she would offer the Tylenol first and then check back later to see if it helped. If not effective, RN #2 stated she would give the Vicodin. When asked if is in her scope of practice to make the decision of what medication to administer, RN #2 stated, no. When asked about the process she follows when Resident #107 complains of pain, RN #2 stated Resident #107 says she hurts all over or her "tushy" hurts. An interview was conducted with RN #1, the unit manager, on 1/22/2020 at 1:49 p.m. When asked how staff knows which as needed pain medication to administer, if a resident has two pain medications prescribed, such as Tylenol and Vicodin, without pain level parameters for administration, RN #1 is stated it depends on the	{F 658}		

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pain assessment and pain scale of the resident that determines which one to give. When asked if it is within a nurse's scope of practice to make that decision about which medication to administer, RN #1 stated, "Yes." When asked if the physician orders should have the pain scale parameters in the orders, RN #1 stated, "yes, they (the medication orders) need to be clarified.

An interview was conducted with RN (registered nurse) #6, the unit manager, on 1/22/2020 at 1:09 p.m. When asked how staff knows which as needed pain medication to administer if a resident has two as needed pain medications ordered, RN #6 stated, "Good question. The orders should say the pain level for which one is to be given." When asked if it is within a nurse's scope of practice to decide which medication to give, RN #6 stated, "No."

The facility policy, "Medication and Treatment Administration Guidelines" documented in part, "Medication and Treatment Orders: A complete medication order includes...Medication specific parameters, if applicable."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m.

No further information was provided prior to exit.

References:

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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Chapman, page 72.
(3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601006.html.

2. Resident #110 was admitted to the facility on 1/18/2020; diagnoses that include but are not limited to: morbid obesity, gastroesophageal reflux disease [GERD -backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs. (1)], high blood pressure, and surgical aftercare following a colectomy [surgery to remove all or part of the large bowel (2)].

A MDS (minimum data set) assessment had not yet completed for Resident #110 at the time of the survey. The admission evaluation dated 1/18/2020 documented the resident was alert and oriented to time, person, situation and place.

The physician orders dated,1/18/2020 documented, "Acetaminophen (Tylenol)(used to treat mild to moderate pain) (3) 8 hours tablet extended release 650 MG; give 1300 mg by mouth every 8 hours as needed for pain. Oxycodone Tablet (used to treat moderate to severe pain) (4) 5 mg; give 5 mg by mouth every 6 hours as needed for pain for 12 days."

Review of the MAR (medication administration record) for January 2020 documented the above physician orders for medications. The Tylenol was documented as administered on the following dates, times for pain level ratings as follows:
1/18/2020 at 9:50 p.m. - pain level - 4

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1/20/2020 at 4:23 a.m. - pain level - 4
1/22/2020 at 5:47 a.m. - pain level - 8
The Oxycodone was documented as administered on the following dates, times for pain level ratings as follows:
1/21/2020 at 1:15 p.m. - pain level - 5
1/22/2020 at 8:45 a.m. - pain level - 6

The comprehensive care plan dated 1/18/2020, documented, "Focus: Pain related to recent surgery." The "Interventions" documented, "Report nonverbal expression of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc."

An interview was conducted with LPN (licensed practical nurse) #4, a nurse that cares for Resident #110, on 1/22/2020 at 12:45 p.m. When asked how staff knows which as needed pain medication to administer if a resident has two as needed pain medications ordered, LPN #4 stated, "If the doctor doesn't specify mild to severe pain then I usually go with the Tylenol first and if that is not effective, then I go to the Oxycodone. Most residents on my hall are alert and oriented and tell me what they want. When asked if it is within her scope of practice to decide which medication to administer, LPN #4 responded, no. When asked how she knows which and when to administer each as needed pain medication without ordered pain level parameters, LPN #4 stated the nurse needs to have the doctor to write the pain scale range in the orders.

An interview was conducted with RN (registered nurse) #6, the unit manager, on 1/22/2020 at 1:09 p.m. When asked how staff knows which as needed pain medication to administer if a resident has two as needed pain medications ordered, RN

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{F 658}	Continued From page 24 #6 stated, "Good question. The orders should say the pain level for which one is to be given." When asked if it is within a nurse's scope of practice to decide which medication to give, RN #6 stated, "No." Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m. No further information was provided prior to exit References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/002941.htm. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html.	{F 658}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	{F 686}		

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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 the facility staff failed to provide care and services in a manner to prevent infection and promote healing of pressure injuries for two of 11 residents in the survey sample, Residents #107 and #106. The facility staff failed to implement treatment, after identifying a pressure injury on 1/20/2020, for Resident #107. The facility staff failed to clean the scissors used during Resident #106's pressure injury wound care.

The findings include:

1. Resident # 107 was admitted to the facility on 9/11/19 with a recent readmission on 1/18/2020 with diagnoses that included but were not limited to: paraplegia (paralysis of the lower limbs) (1), morbid obesity, diabetes, high blood pressure, depression, anxiety and Bipolar disorder (a mental disorder characterized by episodes of mania and depression) (2).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 1/3/2020, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating

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the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance, to being dependent upon one or more staff members for all of her activities of daily living except eating in which she was coded as independent. In Section M - Skin Conditions, the resident was coded as having two stage III pressure injuries.

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

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (3)

A Pressure Ulcer Healing Chart (PUSH) documented on 1/20/2020 that Resident #107 had a pressure injury on the sacral buttock between the fold. The wound measured 2.7 cm

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(centimeter) in length by 0.6 in width. The form documented the area had slough with pink tissue present. Slough (dead tissue, usually cream or yellow in color) (4).

Review of the physician orders failed to reveal a treatment order for the wound with slough.

Review of the TAR (treatment administration record) for January 2020, revealed a physician order that documented, "Apply to between the folds buttocks routine, cleanse with normal saline and apply Santyl to wound bed and apply optifoam daily. One time a day for Wound." This order was documented on the TAR to start on 1/22/2020. Further review of the TAR failed to evidence any treatment documented for the treatment of the wound in the gluteal fold or any barrier creams since the resident returned from the hospital on 1/18/2020.

Review of the comprehensive care plan dated 12/30/19 documented in part, "Focus: Open area to sacrum." The "Interventions" documented in part, "Administer treatment per physician orders.

Observation was conducted with RN (registered nurse) #2 and RN #1 on 1/22/2020 at 11:00 a.m. of Resident #107's wound care. Observation of Resident #107, while turned over, revealed there was no dressing on the gluteal fold wound documented above. Resident #107 stated that the nurse just put on an ointment and said she was leaving it to air out. There was blood noted on the paper/plastic protective pad under the resident where the resident's buttock were, positioned prior to the staff turning the resident for wound care. RN #1 cleansed the gluteal fold area with normal saline and measured the wound. RN

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#1 stated the wound measured as 1.4 cm in length, 0.3 cm in width and 0.2 in depth. When asked what stage the wound was, RN #1 stated it was a stage III. RN #2 applied the Santyl and covered the wound with a dry dressing.

An interview was conducted with RN #2 on 1/22/2020 at 1:25 p.m. When asked if she performed a treatment, where would that be documented, RN #2 stated it should be documented on the MAR (medication administration record) or the TAR. Sometimes the treatment will hang over to the next shift.

An interview was conducted with RN #1 on 1/22/2020 at 1:49 p.m. When asked if there was a dressing in place when Resident #107, was turned over, RN #1 stated no. RN #1 was informed that there was no documentation in the clinical record that any treatment was provided after, he (RN #1) completed the wound measurements on 1/20/2020. RN #1 stated he would have to check on this.

On 1/22/2020 at 2:04 p.m., an interview was conducted with LPN (licensed practical nurse) #3, the nurse who cared for the resident on 1/21/2020 in the evening. LPN #3 was asked, if she had taken care of Resident #107, at all since the resident, was admitted on 1/18/2020. LPN #3 stated that last night (1/21/2020) was her first evening back. When asked what she applied to Resident #107's buttocks last night, LPN #3 stated the resident's wound, was all healed up and she stated just put some barrier cream on it. When asked if she documented that anywhere, LPN #3 stated, "No, it's a standard of practice to apply barrier cream.

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A second interview was conducted with RN #1 on 1/22/2020 at 4:57 p.m. When asked if he had located any documentation of treatments applied to Resident #107's wound, since 1/20/2020, when he completed the wound measurements, RN #1 stated that he did the measurements and called the doctor for orders. When asked if he applied a dressing to the wound on 1/20/2020, RN #1 stated he did not. When shown the order for the Santyl to start today, 1/22/2020, RN #1 stated that it was his fault; it was a computer error. It should have started before that date. When asked if there was documentation that any dressing was applied to Resident #107's wound since 1/20/2020, RN #1 stated, "No, I can't find any." When asked what stage the wound was when he measured it on 1/20/2020, RN #1 stated it was a stage III."

The facility policy, "Skin Practice Guide" documented in part, "If a resident has a skin alteration the wound team/designee will be contacted. If it is pressure, complete the PUSH tool and stage the wound. Contact the physician/ advanced practice nurse for orders. Initiate the plan of care."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m.

No further information was provided prior to exit.

References:

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435.
(2) Barron's Dictionary of Medical Terms for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.
(3) This information was obtained from the following website:
https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf
(4) This information was taken from the following website:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360405/

2. Resident #106 was admitted to the facility on 2/12/11; with a readmission on 1/17/19 with diagnoses that included but were not limited to: diabetes, GERD [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs. (1)], dementia, and bullous pemphigoid [Bullous pemphigoid is an autoimmune disorder that occurs when the body's immune system attacks and destroys healthy body tissue by mistake. Specifically, the immune system attacks the proteins that attach the top layer of skin (epidermis) to the bottom layer of skin (2)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/30/19 coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #106 was coded as being dependent on one staff member for bed mobility, toileting, bathing and transfers. The resident was coded as requiring extensive assistance to supervision for the rest of her activities of daily living. In Section M - Skin conditions, the resident was coded as having one

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stage II pressure injury and one stage IV pressure injury (3).

The physician order dated, 1/8/2020 documented, "Maxorb Extra Rope (Ca [calcium] Alginate-Carboxymethylcell); Apply to right gluteal fold topically every evening shift for wound care clean wound with NS (normal saline), pack with maxorb extra rope and cover with dry dressing."

Observation was made of RN (registered nurse) #2 and RN #1, the unit manager, on 1/22/2020 at 10:08 a.m., performing the wound care for Resident #106. RN #1 proceeded to perform the wound care to the first wound located in the ischial/upper thigh area. RN #1 measured the wound. The wound measured 3.0 cm (centimeters) in length and 1.8 cm in width and the depth was measured at 4.5 cm. RN #1 stated the wound was a stage IV pressure injury. The wound was cleaned. RN #2 proceeded to apply the dressing to the sacral wound. The sacral wound was being packed with an AG rope. RN #1 proceeded to push the rope into the wound with a sterile cotton tip applicator. The rope was too large for the wound and kept falling out of the wound. RN #2 took her scissors out of her pants pocket and used them to cut the rope. RN #2 used the cotton tip applicator to push the end of the rope cut with the scissors, into the wound so that the rope was flush with the skin, and inside the wound. The outer dressing was then applied per the physician order. RN #2 washed her hands and obtained the supplies to perform the next dressing change on the resident's sacral area. RN #1 removed the soiled dressing and cleaned the wound. He then measured the wound. RN #1 measured the wound as 2 cm in length by 2.0 cm in width and 0.2 cm in depth. RN #1 stated the

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{F 686}	Continued From page 32 wound was a stage II pressure injury. RN #2 proceeded to apply the dressing to the sacral wound. An interview was conducted with RN #2 on 1/22/2020 at 1:25 p.m. When asked if the dressing change had gone as planned, RN #2 stated the piece of rope was longer than she had expected and she had to cut it. RN #2 stated that the end of the dressing had hit an area that was unclean. When asked what was in her pants pocket on her right leg, RN #2 stated she had her scissors in it. When asked if she had cleaned the scissors prior to cutting the dressing used for Resident #106's wound care, RN #2 stated no, that she did not clean them. An interview was conducted with RN #1, the unit manager, on 1/22/2020 at 1:49 p.m. When asked if he observed any problem with the dressing change observed, RN #1 stated he would have liked to see the nurse wash her scissors before cutting the rope dressing. The facility policy, Dressing Change: Non Sterile documented in part, "15. Prepare clean field: arrange supplies on table. Open packages to reveal supplies. If dressings need to be cut to size, use clean scissors (disinfect the scissors with an EPA approved disinfectant before and after using). Label tape used to secure dressing with caregiver initials and date. 16. Perform hand hygiene." Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m.	{F 686}		

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{F 686}	Continued From page 33 No further information was provided prior to exit.	{F 686}		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide adequate supervision for one of 11 residents in the survey sample, Resident #101. With the staff's knowledge and without signing out or back in, Resident #101 left the building multiple times unaccompanied, and was out of line of sight supervision by facility staff. Resident #101 did not have a physician order approving unsupervised leave of absences from the building, and the facility staff had not completed any assessment to determine if the resident was safe to leave the building unsupervised. The findings include: Resident #101 was admitted to the facility on 4/17/17 with diagnoses including, but not limited to, cancer of the larynx with a tracheostomy (1), difficulty swallowing with a PEG (percutaneous endoscopic gastrostomy) tube (2), COPD (chronic obstructive pulmonary disease) (3), and	F 689		

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schizophrenia (4). On the most recent MDS, a quarterly assessment with an assessment reference date of 1/8/2020, Resident #101 was coded as having no impairments with making himself understood and with understanding others. He was coded as having no cognitive impairment for making daily decisions according to his score of 15 out of 15 on the BIMS. He was coded as having demonstrated no evidence of an acute onset of mental status change during the look back period. He was coded as having scored a zero out of 27 on the resident mood interview, indicating no difficulties with mood. He was coded as having demonstrated no behavioral symptoms curing the look back period. He was coded as being independent for all ADLs (activities of daily living), except for requiring set up for eating, and supervision for toilet use. He was coded as needing no mobility devices for locomotion. He was coded as having received an antipsychotic medication on seven out of seven days during the look back period.

A review of Resident #101's clinical record revealed a progress note dated 9/19/19. The note, written by OSM (other staff member) #2, the director of social services, documented: "SW (social worker) met with resident to educate on facility LOA (leave of absence) policy. Resident understood then signed education sheet. SW provided sign-in sheet to Administrator for education acknowledgement."

Further review of the clinical record revealed the following note, written 11/14/19 by RN (registered nurse) #4, an MDS nurse: "Resident frequently walks over to the convenience store next to our facility. Spoke with resident about our policies regarding smoking and alcohol. Informed him that

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if he purchases smoking materials, he must turn them in to his nurse to be kept in a secure safe place and returned to him for use during designated smoking times. Discussed the importance of not purchasing alcohol as it is unsafe to consume alcohol while taking medications and alcohol/alcohol use is not permitted in our facility. Resident verbalized understanding of our policies regarding smoke and alcohol."

Further review of the clinical record revealed a leave of absence form for Resident #101. The form contained one entry, dated 11/24. There was no year. The form documented the sign out time as 11:20 a.m., Resident #101's signature, but the form did not document a sign in time. The remainder of the form was blank.

A review of Resident #101's comprehensive care plan, dated 4/25/17 with a target date of 1/29/2020 revealed, in part, the following: "At risk for changes in mood r/t (related to) schizophrenia...Will accept care and medication as prescribed...Administer medication per physician orders...Observe for mental status/mood state changes when new medication is started or with dose changes...Offer choices to enhance sense of control." The care plan contained no information regarding the resident's ability to leave the building unaccompanied.

A review of physicians' orders for Resident #101 revealed no order stating the resident could leave the building unsupervised.

A review of the consultant Psychiatric Evaluations for Resident #101 revealed an evaluation dated 4/17/19. The evaluation, written by RN (registered

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F 689	Continued From page 36 nurse) #5, the consultant psychiatric nurse practitioner, a PhD, documented, in part, the following: "Past Medical History: Malignant neoplasm (cancer) of the larynex (sic), ...schizophrenia...Past Psychiatric Admission: He denies any hospitalizations but this is questionable with the diagnosis of schizophrenia. Past Psychiatric Outpatient Treatment: He is unable to identify outpatient treatment but carries a diagnosis of schizophrenia which is a chronic mental illness. Past Suicide Attempt: Denies. Past Use of Psychotropic Medications: Unable to identify different medications she (sic) has taken. Legal History: Did not identify any legal difficulties...Type of Visit: Initial evaluation...Information Obtained From: Patient, Chart Review, Nursing Staff...Chief Complaint/Nature of Presenting Problem: Schizophrenia. History of Present Illness: 64-year-old male with diagnoses (sic) of schizophrenia seen today per request of staff for evaluation status review of medications. Today he is seen in the room, fair eye contact and interaction appropriate but limited at times and a little guarded. He denies any difficulty with eating or sleeping, denies any significant symptoms of anxiety or depression and denies suicidality. He denies any current hallucinations and there is no evidence of him respond (sic) to internal stimuli, cognition appears to be grossly intact. No noted or reported side effects to medications. He identifies that he is doing well and has no concerns. No distress noted and staff identified no behavioral issues. Support given during interview...Current Psychiatric Medications General Benztropine (11) 2 mg po (by mouth) nightly for EPS (extra-pyramidal side effects) (12). Risperdal 2 mg po nightly for schizophrenia...Mood Symptoms: He denies any	F 689		

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significant symptoms of anxiety or depression, no psychotic symptoms noted, denies suicidality, no agitation or aggression noted or reported, cognition appears to be grossly intact, no evidence of pseudobulbar (13) affect symptoms and no reports of noncompliance with medications or treatments...Appearance/Behaviors: Calm, cooperative, groomed...Mood: pleasant, Affect: appropriate, Thought process: organized, Hallucinations: none evident, Delusions: none evident, Short-term memory: fair to good, Long-term memory: fair to good, Concentration: fair, Insight: fair, Judgment: fair, Suicidal ideation: denies, Homicidal ideation: denies...Description of Associations: intact...Recommendations: Continue medication(s) as prescribed, the patient is stable at current dose. Dose reduction attempted and/or reduction will cause decompensation of patient. Monitor for changes in mood or behaviors and notify [name of psychiatric services provider]. Will continue to follow and provide consultation. Follow up: as needed."

Review of Resident #101's clinical record revealed psychiatric evaluations completed by RN #5 on 5/1/19, 6/26/19 and 8/21/19. These evaluations contained no deviations from the findings and recommendations for care as the evaluation from 4/17/19.

RN #5's final psychiatric evaluation of Resident #101 was dated 12/11/19. This evaluation documented, in part: "History of Present Illness: 65-year-old male with diagnoses (sic) of schizophrenia seen for evaluation status review of medications. Today he is seen in the room, fair eye contact and interaction appropriate. He

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denies any difficulty with eating or sleeping, denies any significant symptoms of anxiety or depression and denies suicidality. He denies any current hallucinations and there is no evidence of him responding to internal stimuli, cognition appears to be grossly intact. No noted or reported side effects to medications. He identifies that he is doing well and has no concerns other than being ready to go smoking at 10:30 a.m., smiled as he related this. Presents in a positive manner and denies any difficulties, no distress noted. Staff identified no behavioral issues. Support given during interview...Current Psychiatric Medications General Benztropine (11) 2 mg po (by mouth) nightly for EPS (extra-pyramidal side effects) (12). Risperdal 2 mg po nightly for schizophrenia...Appearance/Behaviors: Calm, cooperative, adequately groomed...Mood: pleasant, Affect: appropriate, Thought process: organized, Hallucinations: none evident, Delusions: none evident, Short-term memory: fair to good, Long-term memory: fair to good, Concentration: fair, Insight: fair, Judgment: fair, Suicidal ideation: denies, Homicidal ideation: denies...Description of Associations: intact...Recommendations: He is currently stable on his Risperdal for his schizophrenia. Dose reduction attempted and/or reduction will cause decompensation of patient. Monitor for changes in mood or behaviors and notify [name of psychiatric services provider]. Will continue to follow and provide consultation. Follow up: as needed."

On 1/22/2020 at 8:50 a.m., RN (registered nurse) #3 was interviewed. She stated she frequently was assigned to Resident #101. She stated he [Resident #101] left the building a couple of days a week, at least. RN #3 stated his outings usually

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only lasted about an hour, as far as she was aware. She stated Resident #101 would tell her he was leaving and what time he would return, and that he would return on time. She stated her understanding is that the resident would go out of the building, down the sidewalk, around the corner, and to a small grocery store in the adjacent building. RN #3 stated she did know what the resident purchased when he went out, and that she never asked him. When asked if the resident had an order indicating he was safe to leave the building, RN #3 stated, "Sometimes he signed out, sometimes not." She stated the protocol is to have residents sign out, and then sign back in. She stated most of the time, the resident refused to do so. RN #3 stated, "Often I was in the middle of something, and he took advantage of that."

On 1/22/2020 at 9:09 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated she frequently was assigned to care for Resident #101. She stated he often left the building to go across the building across the street to the grocery store. CNA #1 stated he bought cigarettes and snacks there. She stated she believed that Resident #101 informed the nurse when he left the building, but was not certain if he signed out. CAN #1 added, "They are supposed to sign out."

On 1/22/2020 at 11:35 a.m., RN #5, the consultant psychiatric nurse practitioner, was interviewed. She stated she had been treating Resident #101 for less than a year. She stated when she first met Resident 101 on 4/17/19; he was very reserved and quiet. RN #5 stated, "He definitely had a schizophrenic presentation." She stated the classic schizophrenic is reserved until

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the resident gets to know you, is polite, and answers questions when asked. She stated she always asked Resident #101 if he was hearing any voices, and if so, what the voices were telling him. RN #5 stated Resident #101 always denied hearing voices, as well as denying any hallucinations. She stated that in recent visits, Resident #101 felt comfortable enough to smile and to interact somewhat spontaneously with her. She stated she specifically asked him if anyone was bothering him, which the resident denied. RN #5 stated that on her last visit with Resident #101 in December 2019, he was very positive, again denying hallucinations and hearing voices. When asked if she thought Resident #101, was appropriately placed in a long-term care facility, she stated he could not care for himself because of his [schizophrenia] diagnosis. She stated his cognitive abilities were limited in higher-level thinking, such as judgment and reasoning. She stated Resident #101 was a very concrete thinker, and had limited ability to think in the abstract. She stated she did not think any other setting, in which he would have had more independence, would have been appropriate for him. When asked if she was aware that Resident #101 had been leaving the building unsupervised, she said she was not. RN #5 stated, "I would have difficulties with him going out by himself. I would have had some concerns." She stated the resident would have a right to leave the facility unsupervised, but the facility would still be responsible for the resident's safety. RN #5 stated, "If I had been aware he was leaving, I would have maybe asked social services to try to get guardianship. I feel that strongly."

On 1/22/2020 at 1:37 p.m., RN #4, an MDS nurse, was interviewed. RN #4 stated, "I had a

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close relationship with [Resident #101]." She stated the resident frequently left the building independently and went to the grocery store in the building next door. When asked if she was certain, that Resident #101 only went to the building next door, RN #4 stated, "I never actually saw where he went. It's a community. When he left the building, he would stop and talk." She stated the resident bought cigarettes and snacks when he went out. When asked if the resident was safe to leave the building unsupervised, RN #4 stated, "He was safe, like me and you. All he had was a trach (tracheostomy)." When asked if a care plan had been developed for Resident #101's leaving the building unsupervised, RN #4 stated, "I don't know that we care plan for that." She stated the resident should have a physician's order to leave the building, and that the resident would then be responsible for signing in and out. When asked about the reason for the note she had written on 11/14/19, RN #4 stated another ambulatory resident who, at that time, was also leaving the building to go to the grocery store in the adjacent building, was purchasing alcohol. She stated all residents who were known to go to that grocery store were re-educated on the leave of absence policy, and instructed not to buy alcohol. RN #4 stated Resident #101, was not ever known to purchase alcohol.

On 1/22/2020 at 2:04 p.m., RN #1, the unit manager, was interviewed. He stated he has only been employed at the facility for four or five weeks, and did not know Resident #101 very well. He stated any resident who leaves the building unsupervised would need a physician's order to do so. He stated residents who leave the building must sign in and out. When asked if the facility assessed residents for safety to leave the

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F 689	Continued From page 42 building unsupervised, RN #1 stated, "The IDT (interdisciplinary team), physician, and the psychiatrist should make the decision whether or not the resident is safe to leave unsupervised. When asked if a resident's ability to leave the building safely unsupervised should be on the comprehensive care plan, RN #1 stated, "It definitely should be on the care plan." On 1/22/2020 at 2:21 p.m., OSM #1, the Social Services Cordinator, was interviewed. She stated she was aware that Resident #101 was leaving the building unsupervised. She stated he went out to the store in the building next door, and was safe to do so. OSM #1 stated his [Resident #101's] BIMS score of 15 out of 15 qualified him to do so. She stated she was not certain if Resident #101 had a physician's order to leave the building unaccompanied. OSM #1 stated she knew that Resident #101 left the building at least once a week. On 1/22/2020 at 3:26 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated she was not aware that Resident #101 had been leaving the building unsupervised. ASM #2 stated, "I never saw him leave the building." When asked how the facility determines who is safe to leave the building, ASM #2 stated the physician is supposed to write an order. When asked if the consultant psychiatry provider should be involved in making that decision, ASM #2 stated, "Yes, if the resident is having any behaviors." She stated she was not aware that Resident #101 was not signing out, and that he should have been doing so. She stated the nurse who is assigned to the resident is responsible for assuring the resident signs out and back in. She stated the care plan should	F 689		

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reason there was no physician's order was that the resident was not leaving facility property. At this time, ASM #1 was informed of the survey team's concerns regarding Resident #101's leaving the building unsupervised.

On 1/23/2020 at 9:53 a.m., a follow-up interview was conducted with ASM #1. When asked what constituted facility property, ASM #1 stated, "In my vision, once you come through the security gates, all of these buildings are our property." When asked if the long-term care corporation owns all the buildings within the gates, ASM #1 stated, "No. Actually, [name of other senior living services provider] owns all the buildings. They own this one. [Name of long term Care Corporation] just rents this building and the parking lots from them." When asked if the staff in the adjacent building [Assisted living] containing the grocery store is a part of her facility staff, ASM #1 stated, "No."

On 1/23/2020 at 10:35 a.m., a follow-up interview was conducted with RN #5. When asked if it would alter her thinking regarding Resident #101's leaving the building unsupervised if he was going to a nearby building that might be technically on the same property as the facility, RN #5 stated, "It does not matter to me who owns what building. It matters to me that he was leaving this building unsupervised." She stated it still comes down to being out of the building is being out of sight, and that was not safe for resident.

A review of the facility policy, "Leave of Absence: Patient," revealed, in part, the following: "Purpose: To provide a system for notification and documentation of a patient's leave of absence

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from the center if authorized by the medical practitioner...Procedure: Obtain medical practitioner order for leave of absence from the center and communicate to the patient/representative any restrictions or recommendations of the medical practitioner. Patient and/or authorized representative reads and signs acknowledgement statement on Leave of Absence form in the presence of a witness who also signs the form. Patient or representative (if patient is not own responsible party) signs out of the center on Leave of Absence form completing all fields (date, time, anticipated time of patient return, patient/representative signature). Upon return to the center, the patient or representative signs the patient back into the center on the Leave of Absence form including date and time of return."

No further information was provided prior to exit.

References:

(1) "A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube." This information is taken from the website https://medlineplus.gov/ency/article/002955.htm.

(2) "A PEG (percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. PEG feeding tube insertion is done in part using a procedure called endoscopy. Feeding tubes are needed when you are unable

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to eat or drink. This may be due to stroke or other brain injury, problems with the esophagus, surgery of the head and neck, or other conditions." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000900.htm.

(3) 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.

(4) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html.

F 695 SS=D — F 695

Respiratory/Tracheostomy Care and Suctioning
CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility

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document review, and clinical record review, it was determined that the facility failed to store respiratory equipment in a manner consistent with professional standards of practice for two of 11 residents in the survey sample, Residents #111 and #110. The facility staff failed to secure an empty oxygen tank in Resident #111's room. The empty oxygen cylinder was free-standing between the back wheels of the resident's wheelchair on multiple observations on 1/21/2020. The facility staff failed to store Resident #110's nebulizer mask and CPAP [Continuous Positive Airway Pressure] machine mask in a sanitary manner. The masks were observed during multiple observation on the residents nightstand uncovered.

The findings include:

1. Resident #111 was admitted to the facility on 4/21/15, and most recently readmitted on 4/4/19 with diagnoses including, but not limited to high blood pressure and heart failure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 10/19/19, he was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring oxygen therapy during the look back period.

On 1/21/2020 at 10:41 a.m., 11:07 a.m., and 1:40 p.m., Resident #111's room was observed. At each observation, a free-standing oxygen cylinder stood unsecured between the back wheels of the resident's wheelchair. The oxygen cylinder's gauge indicated there was little to no oxygen in the tank. At each observation, the resident was asleep.

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On 1/21/2020 at 2:05 p.m., CNA (certified nursing assistant) #1 was interviewed. When she saw the oxygen cylinder, CNA #1 stated, "It should not be on the floor." When asked why, CNA #1 stated, "If it gets loose, it might blow up."

On 1/21/2020 at 2:08 p.m., LPN (licensed practical nurse) #1 was interviewed. When she saw the oxygen cylinder, she picked it up, and stated, "I need to put this away." She stated a free-standing oxygen cylinder is a safety hazard because it is highly flammable.

On 1/21/2020 at 4:50 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy "Oxygen Administration" revealed, in part: "Preparation of Equipment: Ensure that cylinder is secured in stand or cart."

No further information was provided prior to exit.

2. Resident #110 was admitted to the facility on 1/18/2020 with diagnoses that included but were not limited to: morbid obesity, gastroesophageal reflux disease [GERD -backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs (1)], high blood pressure, and surgical aftercare following a colectomy [surgery to remove all or part of the large bowel (2)].

At the time of the survey an MDS (minimum data set) assessment had not yet been completed for

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Resident #110. The admission evaluation dated 1/18/2020 documented the resident was alert and oriented to time, person, situation and place.

Observation was made of Resident #110's room on 1/21/2020 at approximately 11:00 a.m. a nebulizer mask and a CPAP [Continuous Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. A C-Pap machine increased air pressure in the throat so that the airway does not collapse when you breathe in. (3)] machine with mask were observed on the residents nightstand uncovered. The nebulizer mask and the CPAP mask were observed on 1/21/1010 at 2:27 p.m. and again at 4:11 p.m. During each observation the Nebulizer mask and CPAP, machine and mask were observed on the residents nightstand uncovered.

An interview was conducted with RN (registered nurse) #7 on 1/21/2020 at 4:13 p.m. RN #7 was shown Resident #110's room with the nebulizer and CPAP masks uncovered. When asked if these masks were stored appropriately, RN #7 stated that both masks should be covered. When asked why the masks are covered when not in use, RN #7 stated to keep them clean and away from germs.

The facility policy, "BiPap/CPAP" documented in part, "Procedure: 9. Return equipment to designated area and clean/dispose as indicated."

ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the above information on 1/21/2020 at 4:51 p.m.

A request for the policy on the storage of

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F 695	Continued From page 50 nebulizer masks was made on 1/22/2020 at 5:42 p.m. No policy was provided prior to exit. In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/002941.htm. (3) This information was obtained from the following website: www.webmd.com/sleep-disorders/sleep-apnea	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		

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use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review it was determined the facility staff failed to ensure the drug regimen for one of 11 residents in the survey sample was free of unnecessary medications, Resident #110. The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed pain medication to Resident #110.

The findings include:

Resident #110 was admitted to the facility on 1/18/2020 with diagnoses that included but were not limited to: morbid obesity, gastroesophageal reflux disease [GERD -backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs. (1)], high blood pressure, and surgical aftercare following a colectomy [surgery to remove all or part of the large bowel (2)].

A MDS (minimum data set) assessment had not yet been completed for Resident #110, at the time of the survey process. The admission evaluation dated 1/18/2020 documented the resident was alert and oriented to time, person, situation and

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place.

The physician orders dated,1/18/2020 documented, "Acetaminophen (Tylenol) [used to treat mild to moderate pain (3)] 8 hours tablet extended release 650 MG; give 1300 mg by mouth every 8 hours as needed for pain. Oxycodone Tablet [used to treat moderate to severe pain (4)] 5 mg; give 5 mg by mouth every 6 hours as needed for pain for 12 days."

Review of the MAR (medication administration record) for January 2020 documented the above physician medication orders. The Tylenol was documented as administered on the following dates, and times for pain level ratings as follows:
1/18/2020 at 9:50 p.m. - pain level - 4
1/20/2020 at 4:23 a.m. - pain level - 4
1/22/2020 at 5:47 a.m. - pain level - 8
The Oxycodone was documented as administered on the following dates, and times for pain level ratings as follows:
1/21/2020 at 1:15 p.m. - pain level - 5
1/22/2020 at 8:45 a.m. - pain level - 6

The comprehensive care plan dated 1/18/2020 documented, "Focus: Pain related to recent surgery." The "Interventions" documented, "Report nonverbal expression of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc."

Review of the progress notes for the above documentation of pain medication administered did not evidence documentation of any non-pharmacological interventions provided prior to the administration of the as needed pain medications.

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An interview was conducted with LPN (licensed practical nurse) #4 on 1/22/2020 at 12:45 p.m. regarding the process staff follows for resident complaints of pain, LPN #4 stated that first she does a pain assessment and has the resident rate their pain on the pain scale, and asks for the location. LPN #4 stated she would try to reposition the resident if the pain, could be related to positioning to make them more comfortable. When asked, where she would document that she attempted and offered to reposition the resident prior to administering as needed pain medication, LPN #4 stated it would be documented in a progress note.

An interview was conducted with RN (registered nurse) #6, the unit manager, on 1/22/2020 at 1:09 p.m. When asked about the process staff follows for resident complaints of pain, RN #6 stated the nurse should assess for the location, type of pain and have the resident rate the pain on the pain scale. The nurse should then look at the prn (as needed) medications or if they are due for a scheduled pain medication. If not your call the doctor. When asked if there is anything done for the resident prior to the administration of as needed pain medication, RN #6 stated they should try repositioning, warm pack, or non-pharmacological interventions. When asked where staff document the attempted non-pharmacological interventions, RN #6 stated it should be documented in the progress notes.

An interview was conducted with Resident #110 on 1/22/2020 at 4:45 p.m. Resident #110 was asked if the staff offer to do anything such as reposition her, rub the area that hurts or apply heat when she complains of pain, Resident #110 stated the staff doesn't offer anything, they just

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give her pain medication when she asks.

The facility policy, "Pain Practice Guide" documented in part, "Interventions include non-pharmacological as well as pharmacologic. Non-pharmacologic approaches used as initial interventions can minimize the need for medications, permit use of the lowest dose or result in the discontinuation of medication."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/article/002941.htm.
(3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html
(4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html.

{F 880} SS=D Infection Prevention & Control {F 880}
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program

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{F 880}	Continued From page 55 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 (B) A requirement that the isolation should be the	{F 880}		

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{F 880}	Continued From page 56 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, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain an infection control program to prevent the spread of infection for two of 11 residents in the survey sample, Residents #106, and #109. The facility staff failed to provide wound care in a manner to prevent infection. RN (registered nurse) #2 failed to clean her scissors prior to cutting a dressing, which was then applied directly into Resident #106's pressure wound. The facility staff failed to ensure signage was posted to indicate Resident #109 was on isolation precautions.	{F 880}		

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The findings include:

1. Resident #106 was admitted to the facility on 2/12/11 with a readmission on 1/17/19 with diagnoses that included but were not limited to: diabetes, GERD (gastroesophageal reflux disease, is backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs. (1), dementia, and bullous pemphigoid (Bullous pemphigoid is an autoimmune disorder that occurs when the body's immune system attacks and destroys healthy body tissue by mistake. Specifically, the immune system attacks the proteins that attach the top layer of skin (epidermis) to the bottom layer of skin) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/30/19 coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #106 was coded as being dependent on one staff member for bed mobility, toileting, bathing and transfers. The resident was coded as requiring extensive assistance to supervision for the rest of her activities of daily living. In Section M - Skin conditions, the resident was coded as having one stage II pressure injury and one stage IV pressure injury.

The physician order dated, 1/8/2020 documented, "Maxorb Extra Rope (Ca [calcium] Alginate-Carboxymethylcell); Apply to right gluteal fold topically every evening shift for wound care clean wound with NS (normal saline), pack with

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{F 880}	Continued From page 58 maxorb extra rope and cover with dry dressing." Observation was made of RN (registered nurse) #2 and RN #1, the unit manager, on 1/22/2020 at 10:08 a.m., performing the wound care for Resident #106. RN #1 proceeded to perform the wound care to the first wound located in the ischial/upper thigh area. RN #1 measured the wound. The wound measured 3.0 cm (centimeters) in length and 1.8 cm in width and the depth was measured at 4.5 cm. RN #1 stated the wound was a stage IV pressure injury. The wound was cleaned. RN #2 proceeded to apply the dressing to the sacral wound. The sacral wound was being packed with an AG rope. RN #1 proceeded to push the rope into the wound with a sterile cotton tip applicator. The rope was too large for the wound and kept falling out of the wound. RN #2 took her scissors out of her pants pocket and used them to cut the rope. RN #2 used the cotton tip applicator to push the end of the rope dressing cut with the scissors, into the wound so that the rope was flush with the skin, and inside the wound. The outer dressing was then applied per the physician order. An interview was conducted with RN #2 on 1/22/2020 at 1:25 p.m. When asked if the dressing change had gone as planned, RN #2 stated the piece of rope was longer than she had expected and she had to cut it. She stated that the end of the dressing had hit an area that was unclean. When asked what was in her pants pocket on her right leg, RN #2 stated she had her scissors in it. When asked if she had cleaned the scissors prior to cutting the dressing placed into Resident #106's wound, RN #2 stated no, that she did not clean them.	{F 880}		

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An interview was conducted with RN #1, the unit manager, on 1/22/2020 at 1:49 p.m. When asked if he observed any problem with the dressing change observed, RN #1 stated he would have liked to see the nurse wash her scissors before cutting the rope dressing.

The facility policy, Dressing Change: Non Sterile documented in part, "15. Prepare clean field: arrange supplies on table. Open packages to reveal supplies. If dressings need to be cut to size, use clean scissors (disinfect the scissors with an EPA approved disinfectant before and after using). Label tape used to secure dressing with caregiver initials and date. 16. Perform hand hygiene."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000883.htm.
(3) Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The

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tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (3)

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

Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (3)
This information was obtained from the following website:
https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf

2. Resident #109 was admitted to the facility 11/27/19; with a recent readmission on 1/9/2020 with diagnoses that included but were not limited

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to: multiple sclerosis (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover) (1), heart disease, high blood pressure, and clostridium difficele, (C-diff), [a bacterium that causes diarrhea and more serious intestinal conditions, such as colitis. Symptoms include watery diarrhea (at least three bowel movements per day for two or more days), fever, loss of appetite, nausea, abdominal pain or tenderness. You might get C. difficile disease if you have an illness that requires prolonged use of antibiotics. Increasingly, the disease can also be spread in the hospital. The elderly are also at risk. Treatment is with antibiotics.] (2)

The most recent MDS (minimum data set) assessment, an admission assessment with an assessment reference date of 12/3/19 coded Resident #109 as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for all of his activities of daily living except eating in which he was independent after set up assistance was provided.

Observation was made during the initial tour on 1/21/2020 at approximately 11:15 a.m. of Resident #109's room. There was a small two drawer plastic container with isolation gowns in one drawer and masks in the other drawer. Sitting on top of the container was three different size of gloves in boxes. There was no evidence of posted signage on the door, outside the door or on the doorframe to indicate that, the resident was in isolation precautions.

Observations were made on 1/21/2020 at 1:51

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB (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
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p.m. and 4:15 p.m. of the resident's room. There was no signage posted indicating the resident was on isolation precautions. On 1/22/2020 at 8:30 a.m., the room was again observed and there was no signage posted related to the resident being on isolation precautions.

The physician order dated, 1/9/2020 documented, "C-Diff precautions."

The comprehensive care plan dated 1/13/2020 documented in part, "Focus: Infection with c-diff." The "Interventions" documented in part, "Maintain precautions as indicated."

An interview was conducted with LPN (licensed practical nurse) #4 on 1/22/2020 at 12:45 p.m. When asked why Resident #109 was on isolation, LPN #4 stated he had C-diff. When asked if there is, any signage outside his room to inform staff or visitors that he is on isolation, LPN #4 stated there would be a sign to tell visitors to come to the nurse's station for instructions. LPN #4 was informed that no posted sign for isolation precautions for Resident #109 had been observed since the survey team arrived on site, on 1/21/2020.

An interview was conducted with RN (registered nurse) #6, the unit manager, on 1/22/2020 at 1:09 p.m. When asked if a resident is on isolation, is there any type of posting or instructions to visitors, RN #6 stated there should be a sign at the door that states, Stop, contact nurse before entering room. RN #6 was informed that no posted sign for isolation precautions for Resident #109 had been observed since the survey team arrived on site, on 1/21/2020.

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 ______	R-C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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The facility policy, "Infection Control" documented in part, "Transmission Based Precautions: Signage and Notice - To protect patient confidentiality and provide a safe and healthful environment, a 'Stop, see nurse for instructions, sign is posted on patient room door for any transmission-based precautions."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/22/1010 at 5:42 p.m.

No further information was provided prior to exit.

References:

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.
(2) This information was obtained from the following website: https: https://medlineplus.gov/clostridiumdifficileinfections.html.