

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/29/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834
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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the onsite complaint investigation, event ID# KRM111 ending 01/29/16.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to honor bathing preferences for 1 of 2 sampled Residents (Resident #89) reviewed for bathing choices. Findings included: Resident #89's Annual Minimum Data Set (MDS) dated 01/06/16 revealed she was admitted to the facility on 01/08/2008 with cumulative diagnoses of cerebrovascular accident, hemiplegia and muscle weakness. Resident #89 was cognitively aware and needed the extensive assistance of one person for bathing. Review of the undated Station 2 Shower Schedule posted on a bulletin board in the nursing station revealed Resident #89 was scheduled to receive a shower on Tuesday, Thursday, and Saturday on the 3-11 shift. The schedule also revealed the statement, "Showers are not optional, if you have any questions see your nurse manager or --- (Assistant Director of	F 242	Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it. 1) Resident #89 immediately offered a shower and received shower on 1/27/2016. 2)C.N.A.s and licensed Nurses will be re-educated before 2/26/2016 by the Director of Nurses and/or designee regarding resident choices. Emphasis during education will be placed on showering preferences for each resident,	2/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/19/2016
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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 242	Continued From page 1 Nursing)." Review of the Bathing Type Detail Report for November 2015 revealed Resident #89 received full bed baths and partial bed baths but no showers. Review of the Bathing Type Detail Report for December 2015 revealed Resident #89 received full bed baths and partial bed baths but no showers. Review of the Bathing Type Detail Report for January 1, 2016-January 27, 2016 revealed Resident #89 received three showers during that time. All other days Resident #89 received full bed baths or partial bed baths. In an interview on 01/25/16 at 3:13 PM Resident #89 stated she would like to receive a shower more often. She indicated she received bed baths but did not often receive showers. She stated she had informed staff she would like to receive showers more often. In an observation and interview on 01/27/16 at 4:25 PM Resident #89 was sitting in a wheelchair in her room. When asked if she had received a shower since we spoke on 01/25/16 she replied she needed a shower, and wanted a shower but had not received a shower. In an interview on 01/27/16 at 4:35 PM the Assistant Director of Nursing (ADON) stated according to the paperwork the last shower Resident #89 had was on 01/05/16. She indicated she had not been informed Resident #89 had not received showers as instructed. In an interview on 01/28/16 at 4:20 PM Nursing Assistant (NA) #1 stated Resident #89 was showered the night before and would get another shower that night to get her back on the correct shower schedule. She indicated she had only been working on the hall with Resident #89 for 2 ½ weeks and did not know why showers had not	F 242	and accomodating their choice for type of shower/bath to be given, and how often. All residents will be interviewed on or before 2/26/2016 to discuss their preference for frequency of showering. Those who decline showers will be care planned appropriately. All other residents will be offered showers based on their preference or choice for showering. All newly admitted residents will be interviewed regarding their choice /preference for showering upon admission. 3) DNS and/or designee will randomly interview 15 residents weekly to ensure staff compliance with resident choices. Monitoring will begin starting 2/26/2016,and will continue for 3 months.The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. 4) The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress.Plan will be adjusted according to the results and success of the plan implemented.		

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F 242	Continued From page 2 been given. In an interview on 01/29/16 at 5:16 PM the Director of Nursing (DON) stated she expected resident choices to be honored. She indicated she expected the 3-11 shift aides to shower residents as instructed and to notify the nurse or the ADON if it was not done.	F 242			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		2/26/16	

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F 278	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to correctly code the Minimum Data Set (MDS) for 2 of 2 residents identified as being Preadmission Screening and Resident Review (PASRR) level 2 (residents identified as having a serious mental illness or mental retardation as defined by state and federal guidelines) (Residents #18 and #45). Findings included: 1. Record review for Resident #18 indicated she had been readmitted on 4/27/2015 and had been identified as PASRR level 2. Resident #18's diagnoses included: altered mental status, cognitive deficit, generalized muscle weakness, dysphagia, debility, anxiety, schizophrenia, epilepsy and hypertension. Resident #18's most recent comprehensive MDS assessment was dated 5/4/2015 and indicated Resident #18 had severe cognitive impairment and required extensive to total assistance with activities of daily living (ADLs). The assessment did not indicate Resident #18 had been identified as PASRR level 2. An interview with Admissions Coordinator (AC) #1 was conducted on 1/27/2016 at 4:05 PM. The AC indicated before residents were admitted to the facility, each residents' PASRR status is obtained. The AC stated there were currently two PASRR level 2 residents (Residents #18 and #45) residing in the facility. An interview with MDS nurse #1 was conducted on 1/27/2016 at 4:47 PM. The nurse stated it had been the Social Worker's responsibility to code the PASRR level 2 information on the MDS. An interview with Social Worker (SW) #1 was	F 278	Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it. 1) All MDS's were audited, and modified to reflect accurate Passar levels, and submitted to CMS. 2)All Passar Level 2 residents have been identified, and have correct information entered into the MDS. 3) The Director of Resident Assessment will re-educate the Social Service Department and Admissions Department on the importance of promptly notifying the appropriate team member with current Passar information, and the importance of assuring the MDS is completed accurately. A monthly audit will be performed by the MDS department to assure all Passar numbers are available in the electronic Medical record. These audits will continue for 6 months, The results of the monitoring will be brought to the QAPI committee monthly for 6 months to insure quality improvement and to track progress. 4)The results of the monitoring will be brought to the QAPI committee monthly		

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F 278	<p>Continued From page 4</p> <p>conducted on 1/28/2016 at 11:56 AM. The SW stated it had been her responsibility to code the PASRR level 2 information on the comprehensive MDS assessment for Resident #18. The SW stated she was aware that Resident #18 had a PASRR level 2 and she missed coding the MDS correctly.</p> <p>An interview with the Director of Nursing (DON) was conducted on 1/29/2016 at 6:21 PM. The DON stated was her expectation that the MDS should be accurate, complete and correct.</p> <p>2. Record review for Resident #45 indicated he had been admitted on 12/04/2003 and had been identified as PASRR level 2. Resident #45's diagnoses included: moderate intellectual debility, gastro-esophageal reflux disease, Vitamin D deficiency, hyperlipidemia, anemia, hypertension, dementia, depression, peripheral vascular disease and diabetes. Resident #45's most recent comprehensive MDS assessment was dated 8/19/2015 and indicated Resident #45 had severe cognitive impairment and required limited to extensive assistance with ADLs. The assessment did not indicate Resident #45 had been identified as PASRR level 2.</p> <p>An interview with Admissions Coordinator (AC) #1 was conducted on 1/27/2016 at 4:05 PM. The AC indicated before residents were admitted to the facility, each residents' PASRR status is obtained. The AC stated there were currently two PASRR level 2 residents (Residents #18 and #45) residing in the facility.</p> <p>An interview with MDS nurse #1 was conducted on 1/27/2016 at 4:47 PM. The nurse stated it had been the Social Worker's responsibility to code the PASRR level 2 information on the MDS.</p> <p>An interview with Social Worker (SW) #1 was</p>	F 278	<p>for 6 months to insure quality improvement and to track progress. Plan will be adjusted according to the results and success of the plan implemented.</p>		

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F 278	Continued From page 5 conducted on 1/28/2016 at 11:56 AM. The SW stated it had been her responsibility to code the PASRR level 2 information on the comprehensive MDS assessment for Resident #45. The SW stated she was aware that Resident #45 had a PASRR level 2 and she missed coding the MDS correctly.	F 278			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide fingernail care for 1 of 1 sampled residents (Resident #7) whose hand hygiene was observed. Findings included: Resident #7's Quarterly Minimum Data Set (MDS) dated 11/12/15 revealed she was admitted to the facility on 08/01/14 with diagnoses of dementia, Parkinson's disease, and depression. Resident #7 had long and short term memory problems and was moderately impaired in cognitive skills for daily decision making. Resident #7 was totally dependent on one person for hygiene care.	F 312	Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it. 1) Nailcare immediately provided to resident #7 on 1/28/2016 2)All other residents were observed for cleanliness of nails on or before	2/26/16	

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F 312	Continued From page 6 In an observation on 01/25/16 at 5:14 PM Resident #7 was lying in bed. Dark matter was noted under her nails. In an observation on 01/27/16 at 12:35 PM Resident #7 was in a reclining high backed chair in the dining room. Resident #7 was noted to be sucking vigorously on the index finger of her right hand. Dark matter was seen under her other fingernails. In an observation on 01/27/16 at 2:44 PM Resident #7 was lying on her left side in bed. Dark matter was noted under the fingernails of both her hands. Nurse #5 was in the room with Resident #7 and observed the dark matter underneath her fingernails. Nurse #5 instructed Nursing Assistant (NA) #2 to soak Resident #7's fingernails and to clean them with an orange stick. In an observation on 01/27/16 at 5:25 PM Resident #7 was lying in bed in her room. Her fingernails still had dark matter underneath them. In an observation on 01/28/16 at 8:58 AM Resident #7 had dark matter underneath her fingernails. In an interview on 01/28/16 at 12:25 PM NA #2 stated she did not clean Resident #7's fingernails the previous day as instructed by Nurse #5. She indicated she had to finish her documentation and did not think about cleaning Resident #7's nails until she was in her car ready to leave the facility. NA #2 indicated it had simply slipped her mind. In an interview on 01/28/16 at 4:20 PM NA #1 stated fingernail care could be done on any shift. She indicated she performed fingernail care whenever it was needed. In an interview on 01/29/16 at 5:16 PM the Director of Nursing (DON) stated she expected fingernail care be provided as part of ADL (activities of daily living) care and as needed.	F 312	1/29/2016. Any resident found with grooming needs were corrected immediately. DNS and/or designee re-educated clinical staff members on or before 2/26/2016 regarding the importance of maintaining appropriate hygiene related to nail care. 3)The DNS and/or designee will randomly audit 15 residents to ensure nail care is provided. The monitoring will begin 2/26/2016, and will continue for 3 months.The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. 4) The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress.Plan will be adjusted according to the results and success of the plan implemented.		

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F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, physician assistant interview, staff interview, and record review the facility failed to avoid delays in obtaining an order to test for Clostridium difficile (C. diff), in changing pressure sore treatments for wounds which were not healing, in providing protein supplementation to promote healing, in scheduling a consult with the wound clinic for debridement, in re-culturing for C. diff, and in addressing leakage around a rectal tube for 1 of 2 sampled residents (Resident #346) reviewed for pressure ulcers. Before the facility provided Resident #346 with wound clinic consultation/debridement on 01/15/16 the resident's sacral pressure ulcer deteriorated from a stage I to a stage IV pressure ulcer, and the resident's gluteal crease/buttock deep tissue injury (DTI) opened and deteriorated/enlarged into two stage III pressure ulcers to the bilateral buttocks. Findings included:</p> <p>A hospital Discharge Summary documented Resident #346 was hospitalized from 11/27/15 until 12/11/15. The reported noted, "Pt (patient)</p>	F 314	<p>Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.</p> <p>1)Resident #346 immediately re-assessed by DNS on 1/28/2106 to ensure all Physician orders in place, with timely follow through, treatment order to sacral area appropriate and coordinated with wound clinic recommendations, review of protein offered daily to promote wound healing, and to address leakage around the rectal tube with the Physician for recommendations. The resident was discharged to the Hospital on 1/28/2016 for abnormal lab results prior to obtaining the c-diff stool culture. The Hospital did obtain the c-diff culture, with results being negative.</p>	2/26/16	

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F 314	<p>Continued From page 8</p> <p>has persistent leukocytosis (an increase in the number of white cells in the blood, frequently a sign of inflammation and/or infection). Remained elevated despite receiving 7 days of empiric Meropenem (broad spectrum antibiotic that can treat both Gram-positive and Gram-negative bacteria). Afebrile (without elevated temperature) throughout. Urine culture negative, CXR (chest x-ray) normal. Blood cultures from outside hospital (11/25) negative." Labs drawn on 11/27/15 documented Resident #346 had low total protein (at 5.6 grams per deciliter with normal being 6.2 - 8.3) and albumin (at 3.1 grams per deciliter with normal being 3.4 - 4.9) levels.</p> <p>Resident #346 was admitted to the facility on 12/11/15 with diagnoses which included pressure ulcers to the sacrum and gluteal crease/buttocks, persistent leukocytosis, cerebrovascular accident with left hemiparesis, atrial fibrillation, congestive heart failure, gastrostomy, and enterocolitis due to C. diff.</p> <p>A 12/11/15 Clinical Health Status documented the resident had blanchable redness to the sacrum, and redness to the gluteal folds.</p> <p>The registered dietitian's (RD's) 12/11/15 Nutrition Assessment documented the resident's total calorie needs were 1468 - 1615, her protein needs were 74 - 89 grams, and her fluid needs were 2220 cubic centimeters (cc) per day.</p> <p>A 12/11/15 RD progress note documented the resident was admitted to facility receiving Osmolite 1.5, a low-residue formula, at 45 cc/hour providing 1620 calories and 2130 cc of total fluid including flushes. The formula also</p>	F 314	<p>2) All Licensed nurses will be re-educated on or before 2/26/2016 to ensure all newly admitted residents have initial skin assessment upon admission, and any skin concerns will be reported to the Nurse manager who wil assess the area of concern, abd ensure communication with the Physician.The Unit manager , in collaboration with the Physician, will ensure treatment orders recommended by the Physician are implemented.</p> <p>All Licensed nurses will be re-educated on or before 2/26/2016 to ensure all other residents have weekly skin assessments completed, and any concerns reported to the Unit Manager who will assess the area of concern, and ensure communication with the Physician.The Unit manager , in collaboration with the Physician, will ensure treatment orders recommended by the Physician are implemented.</p> <p>All Licensed nurses will be re-educated on or before 2/26/2016 to assure Physician orders are carried out timely. In the event there is a delay in obtaining a stool specimen or a consult, the Center will notify the Physician of the delay.</p> <p>Treatment nurse will be re-educated to ensure the Physician is notified when a wound does not show progress towards healing 2 weeks in a row, and seek input from Physician for any recommended changes in the treatment plan.</p> <p>All licensed nurses will be re-educated to report any rectal tube leakage to the Physician, and seek input from Physician for any recommended changes in the treatment plan.</p>		

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F 314	<p>Continued From page 9 provided 68 grams of protein.</p> <p>A 12/15/15 RD progress note documented, "Receiving ST (speech therapy) services w (with)/trials of puree, NTL (nectar thick liquid) diet. To facilitate participation in therapy and provide fiber recommend change...feedings to Jevity 1.5 ,a fiber blend formula, 237 cc QID (four times daily)...to provide 1422 kcal (calories) and 2048 cc (to) total fluid including flushes. This formula also provided 60 grams of protein.</p> <p>A 12/15/15 4:40 PM nursing progress note documented the resident's pleasure feedings by mouth were discontinued, and the resident was made NPO (nothing by mouth) by ST.</p> <p>A 12/17/15 Wound Evaluation Flow Sheet documented Resident #346 had a 4 x 4 centimeter (cm) suspected deep tissue injury (DTI) to her lower gluteal crease/buttocks. The wound bed was described as "red". It was documented on 12/17/15 the Treatment Nurse ordered "soap and water zinc oxide cream bid (twice daily)" for the ulcers to the sacrum and gluteal crease.</p> <p>A 12/17/15 10:21 PM nursing progress note documented the resident had an episode of vomiting and diarrhea during the shift.</p> <p>A 12/18/15 7:38 AM nursing progress note documented, "resident is noted having loose stools after feeding is administered..."</p> <p>A 12/18/15 physician order began the use of a low air loss mattress for Resident #346.</p> <p>The resident's 12/18/15 admission minimum data</p>	F 314	<p>All education will be provided by the DNS and/or designee.</p> <p>3) The DNS and/or ADNS will monitor all newly admitted residents for 3 months to ensure all skin concerns have been assessed by the Unit managers with treatment initiated. The DNS and/or ADNS will randomly audit 20 residents weekly for 3 months to ensure weekly skin assessments are completed. The DNS and/or designee will monitor all new orders during the daily clinical start up meeting for 6 months to ensure there are no delays in carrying out orders. In the event a delay occurs that is unavoidable, the Physician will be notified.</p> <p>4) The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. Plan will be adjusted according to the results and success of the plan implemented.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GREENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834		
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F 314	<p>Continued From page 10</p> <p>set (MDS) documented her short and long term memory could not be assessed, she was severely impaired in decision making, she was dependent on one or staff members for her activities of daily living, she was always incontinent of bowel and bladder, she had a feeding tube, she had one stage I pressure ulcer and one deep tissue injury, and she had pressure relieving devices for her chair and bed.</p> <p>The care plan generated by the 12/18/15 assessment identified, "Pressure ulcer actual: Pressure Ulcer Present - admitted with stage I on sacrum and unstageable (suspect deep tissue injury) on inner lower gluteal crease" as a problem. Interventions to this problem included weekly skin inspection, weekly wound assessments, consults as needed, air mattress as order--monitor proper placement and functioning each shift and PRN (as needed), pressure reducing wheelchair cushion, provide thorough skin care after incontinent episodes and apply barrier cream, and turning and repositioning.</p> <p>The resident's Bowel and Bladder Detail Report documented she had five episodes of diarrhea on 12/19/15 and six episodes of diarrhea on 12/20/15.</p> <p>Progress notes on 12/21/15 - 12/23/15 documented the resident was having loose watery stools and watery diarrhea.</p> <p>12/22/15 Wound Evaluation Flow Sheets documented Resident #346 had a 2 x 2 cm stage I red area to her sacrum and a 3 x 3 cm suspected DTI to her lower gluteal crease/buttocks.</p>	F 314			

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F 314	Continued From page 11 The resident's Bowel and Bladder Detail Report documented she had two episodes of diarrhea on 12/22/15 and four episodes of diarrhea on 12/23/15. A 12/23/15 RD progress note documented the resident's formula was being changed back to Osmolite 1.5 at 45 cc/hour. The resident's Bowel and Bladder Detail Report documented she had three episodes of diarrhea on 12/24/15 and 12/25/15, four episodes on 12/26/15, and three episodes on 12/27/15, one episode on 12/28/15, and three episodes on 12/29/15. In a 12/29/15 8:41 AM progress note the Treatment Nurse documented, "... noted with wound care that area on inner gluteal crease has increased in size and extends to both rt (right) and lt (left) inner buttock dark red in color and dark pink in middle of wound. Upper area on sacrum has opened and is a dark pink...Primary nurse also aware and stated she noted the difference on the 24th of this month. All interventions in place for pressure relief, air matt(ress), pillows..." In her 12/29/15 assessment Resident #346's primary physician documented, "Buttox...appears to be 2 large red and violaceous (violet in color) areas seen on left sacral and right sacral regions. Left is larger than right at approximately 2 x 2 inches and inferior portion of the left wound is open....Inner gluteal fold, buttox and inner thigh posteriorly and anteriorly have coalescing redness and satellite lesions."	F 314			

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F 314	<p>Continued From page 12</p> <p>A 12/29/15 physician order started Resident #346 on vitamin C 500 milligrams (mg) twice daily (BID) x 14 days and zinc sulfate 220 mg daily x 14 days.</p> <p>A 12/29/15 physician order documented, "Stool for C. diff as soon as possible."</p> <p>A 12/29/15 physician order documented, "Apply Nystatin cream to reddened areas on buttocks, groin, thighs to clean dry skin BID."</p> <p>12/30/15 Wound Evaluation Flow Sheets documented Resident #346's sacral pressure measured 2 x 2 x 2 cm and declined to a stage III wound with dark red tissue and scant red drainage. It was documented the resident's gluteal/buttock DTI now measured 9 x 8 x 0.1 cm with scant serous exudate. The treatment for both wounds was still noted to be "soap and water zinc barrier cream bid and prn."</p> <p>Per surveyor calculation, this decline in the resident's wounds increased her protein needs to 87 - 109 grams of protein daily.</p> <p>12/30/15 lab results documented Resident #346's total protein and albumin levels were now lower than when hospital labs were drawn on 11/27/15. On 12/30/15 the resident's total protein was 5.0 grams per deciliter (g/dL), with normal being 6.2 - 8.3 g/dL, and her albumin was 2.7 g/dL, with normal being 3.4 - 4.9 g/dL.</p> <p>The resident's Bowel and Bladder Detail Report documented she had three episodes of diarrhea on 12/30/15 and two episodes on 12/31/15.</p> <p>A 12/31/15 10:49 PM nursing progress note</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>documented when entering Resident #346's room the nurse noted for the first time a smell associated with C. diff, and observed loose stool which was mustard yellow with a mucous film.</p> <p>A 01/01/16 9:35 AM nursing progress noted documented, "...Buttocks area color changing from red to grayish appearance..."</p> <p>A 01/01/16 8:06 PM nursing progress note documented, "Stool specimen was obtained by this shift and taken to the hospital at 5 pm."</p> <p>The resident's Bowel and Bladder Detail Report documented she had three episodes of diarrhea on 01/01/16.</p> <p>A 01/02/16 11:37 AM nursing progress note documented lab results revealed Resident #346 was positive for C. diff, placed on contact isolation, and was started on Flagyl 500 mg TID (milligrams three times daily) x 14 days.</p> <p>The resident's Bowel and Bladder Detail Report documented she had three episodes of diarrhea on 01/02/16.</p> <p>A 01/03/16 2:34 PM nursing progress note documented, "...pt's buttock showing very little signs of healing, wound bed noted to have large amount yellowish, gray, tan tissue. Will have day shift treatment nurse to reevaluate on tomorrow."</p> <p>The resident's Bowel and Bladder Detail Report documented she had two episodes of diarrhea on 01/03/16.</p> <p>A 01/04/16 physician order documented, "Please schedule an appt (appointment) at Wound Clinic</p>	F 314			

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F 314	<p>Continued From page 14 for evaluation, possible debridement of sacral ulcers ASAP (as soon as possible)."</p> <p>A 01/04/16 1:33 PM nursing progress documented, "Resident bottom area viewed by the ADON (assistant director of nursing). Patient buttocks raw and open in two areas. Greenish/brown layer visible in the open area. Patient receiving barrier cream around the open wound daily..."</p> <p>The resident's Bowel and Bladder Detail Report documented she had one episode of diarrhea on 01/04/16.</p> <p>A 01/05/16 RD progress note documented with the possibility of malabsorption Resident #346's formula was being changed to Vital 1.5, a peptide-based formula, 55 cc/hour with one scoop of Propass protein supplement TID providing 2070 calories, 107 grams of protein, and 2670 cc of fluid including water flushes.</p> <p>A 01/05/16 1:42 PM nursing progress note documented, "Unit receptionist made contact with the Wound Clinic by phone to schedule appt. The office stated they would call the facility back with the date and time by the end of this week....Greenish and grayish appearance to the two open wounds. Barrier cream applied around the open areas...."</p> <p>A 01/05/15 Wound Evaluation Flow Sheet documented the resident's stage III sacral pressure ulcer measured 2.5 x 2 x 1.2 cm with scant serous drainage and pungent odor. The wound bed was described as 100% slough.</p> <p>A 01/05/15 physician order changed the</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>treatment to clean with soap and water and apply Santyl ointment with moist gauze and cover with dry dressing daily and as needed (prn).</p> <p>The resident's Bowel and Bladder Detail Report documented she had two episodes of diarrhea on 01/05/16, 01/06/16, and 01/07/16.</p> <p>In a 01/07/16 12:34 PM progress note the Treatment Nurse documented, "Wound below sacrum increased in size to cover gluteal crease and extends to both rt and left buttocks. No dressing can stay in place for this area due to resident's incontinence. Writer (Treatment Nurse) suspected both wounds may be infected due to the worsening condition of both wounds and has voiced this to ____ (name of physician's assistant)..."</p> <p>A 01/07/16 Wound Evaluation Flow Sheet documented the resident's gluteal/buttock stage III ulcer measured 9 x 3 x 0.2 cm with pungent odor. The wound bed was described as 10% granulation tissue and 90% slough. The current treatment was documented as "soap and water zinc oxide barrier cream bid and prn." "Wound continues to worsen despite interventions, resident continues to have constant loose watery foul stools," was documented under the current wound status.</p> <p>The resident's Bowel and Bladder Detail Report documented she had one episode of diarrhea on 01/08/16, three episodes on 01/09/16, one episode of diarrhea on both 01/10/16 and 01/11/16, no episodes on 01/12/16, and two episodes on 01/13/16.</p> <p>A 01/13/16 6:34 PM nursing progress note</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>documented, "Resident is incontinent of bladder and has a rectal tube in place this shift and brown watery stool is passing in the tubing."</p> <p>01/14/16 Wound Evaluation Flow Sheets documented the resident's sacral pressure ulcer had declined to a stage IV wound measuring 4 x 2 x 1.8 cm. The wound had minimal sanguineous exudate with strong odor, and the wound bed was described as 100% slough. Santyl was the treatment being utilized for the sacral wound. It was documented that the resident's gluteal/buttocks pressure ulcer had declined to a stage IV wound measuring 9 x 6 x 0.3 cm. The wound had minimal sanguineous exudate with strong odor, and the wound bed was described as 60% granulation tissue and 40% slough. Current treatment for the gluteal/buttocks wound was "clean with soap and water apply zinc oxide and cover with dry dressing."</p> <p>A 01/14/16 2:42 PM progress note written by the Treatment Nurse documented, "...Rectal tube placed late yesterday and is in place however resident continues to have stool seep out around tubing getting into wound...."</p> <p>The resident's Bowel and Bladder Detail Report documented she had two episodes of diarrhea on 01/14/16.</p> <p>Review of consults revealed Resident #346 was first seen at the wound clinic on 01/15/16. Consult notes documented, "The wounds on her buttock area were 3 separate wounds. The wound on the sacrum measured 3.1 x 1.6 x 2.4 cm. Undermining was present. At the 3 o'clock position the undermining was 0.6 cm. at the 6 o'clock position the undermining was 0.8 cm, and</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>at the 9 o'clock position undermining was 1.6 cm. The base of this ulcer was covered with fibrinous exudate and necrotic fat that needed removal. The sacral ulcer initially appeared to be a stage III, but with debridement we found these sacral ligaments to be exposed making it actually a stage IV. The right buttock ulcer measured 4 x 5.3 x 0.7 cm. It was fairly clean and did not need debridement. The stage III ulcer on the left buttock measured 5 x 4.7 x 0.7 cm. It was covered with fibrinous exudate and did need debridement....The wounds should be treated with topical Santyl changed on a daily basis (this meant changing the treatment to the gluteal crease/buttocks from zinc oxide to Santyl and continuing Santyl to the sacrum)....There was no evidence of infection in the wounds...."</p> <p>A 01/15/16 physician order requested a re-culture of a stool sample for C. diff (results were not available during the survey).</p> <p>The resident's Bowel and Bladder Detail Report documented she had one episode of diarrhea on 01/15/16, two episodes on 01/16/16 and 01/17/16, one episode on 01/18/16, two episodes on 01/19/16, and five episodes on 01/20/16.</p> <p>01/20/16 Wound Evaluation Flow Sheets documented Resident #346's stage IV sacral wound measured 4 x 2.2 x 3 cm with undermining of 1.3 cm at 12 and 2 cm at 6:00 PM. There was thin watery serous exudate with a strong odor, and the wound bed was described as 60% granulation tissue and 40% slough. The resident's gluteal/buttocks stage IV pressure ulcer measured 8.5 x 6 x .3 cm with thin watery serous exudate with a strong odor. The wound bed was described as 80% granulation tissue and 20%</p>	F 314			

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F 314	<p>Continued From page 18 slough.</p> <p>In a 01/21/16 2:43 PM progress note the Treatment Nurse documented, "...Anal tube in place for loose stools however stool continues to seep around tubing and gets into wound bed...."</p> <p>The resident's Bowel and Bladder Detail Report documented she had two episodes of diarrhea on 01/21/16.</p> <p>A 01/22/16 Wound Clinic consult documented, "She has 3 decubitus ulcers. The sacral ulcer today measured 5.5 x 2 x 2.6 cm. There was debriding around the full circumference of the wound to a depth of 3.8 cm. The right buttock wound measured 4.5 x 4 x 0.8 cm and the left buttock wound measured 5.2 x 4.5 x 0.7 cm. All 3 of these ulcers were covered with fibrinous exudate that needed removal....There was no evidence of infection in the wounds...."</p> <p>The resident's Bowel and Bladder Detail Report documented she had two episodes of diarrhea on 01/22/16, three episodes on 01/23/16, four episodes on 01/24/16, two episodes on 01/25/16, one episode on 01/26/16, and four episodes on 01/27/16.</p> <p>During observation of Resident #346's wound care on 01/27/16 at 8:48 AM the Treatment Nurse removed dressings with scant serous drainage. The Treatment Nurse stated the wound dressing required frequent changes because of numerous loose stools the resident continued to experience. A rectal tube was draining liquid stool, but there was also liquid stool oozing around the tube. The Treatment Nurse reported the resident usually oozed bowel movement around the rectal tube</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>but today seemed worse than usual. The nurse asked a nursing assistant (NA) to alert the unit manager that the resident needed a new rectal tube. The sacral wound was approximately a half dollar in size, slightly oval shaped, approximately 1/2 inch deep, red with an area of yellow slough with white edges. The wound was irrigated with normal saline (NS), Santyl was applied, NS-moistened gauze was packed into the wound, and a dry dressing was applied. The intergluteal cleft wound on the right and left buttocks was approximately a dollar bill size altogether, being irregularly shaped (like a butterfly with a wing on each buttock), 1/4 inch deep, and beefy red with white edges. The wound was irrigated with NS, Santyl was applied, NS-moistened gauze was packed into the wound, and a dry dressing was applied.</p> <p>01/27/16 lab results documented Resident #346's white blood count rose to 19.40 k/uL (thousands of cells per microliter of blood) from 11.90 k/uL on 01/13/16, with normal being 4.5 - 11.0 k/uL.</p> <p>At 11:07 AM on 01/28/15 the Treatment Nurse stated Resident #346 had diarrhea and loose stools from admission forward. However, she reported it was not until the end of December 2015 that an odor indicative of C. diff was noted (and still persisted). She commented the rectal tube leaked a little bit since it was inserted, but that seepage had worsened recently. She stated dressings would not stay on the resident's wounds because of all the diarrhea. For example, she reported that a hydrocolloid/tegaderm dressing would bunch up and make the wounds worse. According the Treatment Nurse, she used zinc oxide on stage II and a lot of stage III wounds with minimal depth.</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>She stated the zinc oxide was frequently rubbed off Resident #346's wounds because of the constant incontinent care that had to be provided. This nurse also commented she had products such as wound gel, Granulex spray, Vasolex, and Medihoney available for use, but had not tried any of those for Resident #346. She reported the wounds continually had minimal exudate, but this exudate did not smell of infection. However, the nurse explained she suspected underlying infection due to the rapid decline of the wounds. According to the Treatment Nurse, once wounds had yellow, tan, or brown slough in them she began to use Santyl to try and clean out the wound beds. However, she stated if the zinc content of barrier cream was high enough, and the resident was eating well, sometimes she did not change treatments even if the wounds were not healing. The Treatment Nurse commented that if she needed their help the director on nursing (DON) and physician assistant (PA) would view wounds with her, and she stated they both would sometimes ask to see certain wounds if they had concerns, residents had concerns, or family members had concerns. She stated she was primarily responsible for determining the treatment products used on wounds.</p> <p>At 2:45 PM on 01/28/16 Nurse #6, who cared for Resident #346 on first shift, stated the resident was nonverbal. She reported the resident, from admission to now, would usually have two to four episodes of diarrhea or at least loose stools on first shift. She commented at first the facility thought formula toleration was causing the gastrointestinal problem, but when tube feeding adjustment did not work, the resident was checked for and eventually treated for C. diff. She reported on first shift the Treatment Nurse</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>did all pm dressing changes so she had not seen the resident's wounds herself. According to Nurse #6, to try and keep stool out of the wounds a rectal tube was inserted, but stool would seep around the tube.</p> <p>At 2:50 PM on 01/28/16 NA #3, who cared for Resident #346 on first shift, stated the resident had two or three episodes of diarrhea or very loose stools about two or three times on first shift daily. She commented the stools and diarrhea always had foul odor, but more so toward the end of December 2015. She reported prior to wound clinic visits, she thought the resident was receiving Nystatin in the front perineum, zinc barrier cream to the buttocks, and zinc barrier cream and then Santyl to the sacrum. Before getting the rectal tube, NA #3 stated the Treatment Nurse averaged doing a couple of pm dressing changes daily on first shift.</p> <p>At 4:48 PM on 01/28/16 Resident #346's PA stated she probably viewed Resident #346's wounds with the Treatment Nurse five or six times during the resident's stay. She reported the wounds declined rapidly with the sacrum presenting as a stage I and declining to a Stage IV, and the gluteal crease/buttocks presenting as a DTI (deep purple but not black in color). She remarked even though the wound on the buttocks was not truly over a bony prominence, she considered the wound to be a DTI due to its coloring. The PA commented treatment options for wound care were not her area of expertise so she left those decisions up to the Treatment Nurse. However, the PA stated zinc barrier cream was only appropriate for stage I ulcers or intact skin. Once a pressure wound opened, she reported the treatment product should change.</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>She commented the time period for changing treatments when there was no healing progress varied greatly from resident to resident depending on their nutritional status and co-morbidities. In addition, the PA reported adequate caloric and protein intake played an important role in wound healing. She stated odor was not the definitive criteria in testing for C. diff. The PA explained after a couple of days of having three and four episodes of diarrhea or very loose stools she would expect to see a resident checked for C. diff. She commented if green tissue was noted in the wound bed, she would expect the facility to check for infection. The PA also commented Resident #364 was sent out to the wound clinic because no progress was being made by the facility in healing the wounds, even with the use of Santyl. According to the PA, she was never approached about helping to get the resident in to the wound clinic more quickly. She reported there were larger sizes of rectal tubes available than the one inserted into Resident #346, but then comfort became an issue. The PA stated a follow-up stool culture to check for C. diff was desirable for this resident because she was continuing to experience diarrhea with foul odor. She explained another round of Flagyl would be possible for the resident.</p> <p>At 5:24 PM on 01/28/16 the Treatment Nurse clarified that on Thursdays she communicated to the DON whose wounds she might want to look at, but the DON did not routinely go with her on wound rounds. She stated occasionally the DON or PA would ask to see the wounds of particular residents, especially certain stage III and IV wounds.</p> <p>A 01/28/16 physician order sent Resident #346 to</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>the emergency room (ER) to evaluate elevated labs (elevated white blood cell count).</p> <p>A hospital Discharge Summary documented Resident #346 was hospitalized from 01/28/16 until 02/04/16. Her primary discharge diagnoses included atrial fibrillation, severe protein-calorie malnutrition, urinary tract infection, sepsis (likely due to C. diff colitis), sacral decubitus stage IV with exposed sacral ligaments, and stage III pressure ulcers to the right and left buttocks. 01/28/16 testing revealed the resident's stool sample was negative for C. diff, and her albumin and total protein levels were within normal limits.</p> <p>At 11:30 AM on 01/29/16 the Medical Director (MD), and Resident #346's primary physician, stated she observed the resident's wounds on 12/29/15 and found the sacral wound to have opened and a DTI to the gluteal crease/buttocks. She explained the DTI was disturbing because there was no way of knowing what lay beneath. The MD stated zinc barrier cream was appropriate for treating moist areas, small stage II ulcers, and opened blisters. However, she reported she expected the wound beds of stage III and IV ulcers to be packed with absorbent dressings or enzymatic agents/dressings. The MD also commented odor was not the only criteria for testing to determine the presence of C. diff. She explained that testing for C. diff was a good idea if residents were experiencing watery stools and had received antibiotic therapy in the last 30 days. According to the MD, the resident was referred to the wound clinic for debridement of her wounds, especially with documentation of green tissue in the wound beds to determine whether infection was present. However, she reported she was not approached to help get</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>Resident #346 into the wound clinic more quickly. She also stated she had one contact at the wound clinic who would even make facility visits if residents were too compromised to make the trip to the clinic. According to the MD, follow-up stool cultures for C. diff were not always recommended because there could be false positive results due to antigens that had built up. The MD reported Resident #346 was sent to the hospital on 01/28/16 due to an elevated white blood cell count. She explained the resident might need strong intravenous (IV) antibiotics, IV fluids, and blood cultures, and the hospital needed to rule out sepsis and Methicillin-resistant Staphylococcus aureus (MRSA) bacteria.</p> <p>At 12:23 PM on 01/29/16 the facility's RD stated Resident #346 was just started on tube feeding in the hospital on 12/10/15, and was admitted to the facility on 12/11/15. Even though she reported she did review hospital discharge documents which contained information about low protein and total albumin levels, the RD commented the primary consideration of the facility was to make sure the resident's formula toleration improved and to stop the diarrhea. She explained albumin levels could be lowered and greatly influenced by infection and inflammation both of which Resident #346 suffered from. The RD also added that when completing her initial nutrition assessment on 12/15/15 the resident did not have any open wounds so the need to increase protein intake was not yet paramount. According to the RD, the plan was to gradually increase the rate of the tube feeding after the diarrhea was controlled.</p> <p>At 1:57 PM on 01/29/16 the DON reported she observed all wounds greater than a stage II weekly even though it might not be with the Treatment Nurse. She stated there was a quick</p>	F 314			

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F 314	Continued From page 25 decline in Resident #346's wounds. According to the DON, zinc barrier cream to the edges and surrounding tissue of stage III and IV wounds would be appropriate, but if there was slough in the wound bed, she would expect there to be a debriding agent used on it. She stated even though she observed Resident #346's wounds she had not observed the Treatment Nurse perform wound care on the resident. The DON also commented even though it was unusual to find DTIs to the buttocks, they could form anywhere. The DON reported she could not explain why it took so long to collect a stool sample and check for C. diff or why a stool re-culture was not collected as ordered on 01/15/16. She commented the referral was made to the wound clinic because Resident #346's wounds were not healing. She remarked when a physician order requested wound clinic consult "ASAP", her expectation would be that the resident be seen within two days. She stated she was not notified that there was any trouble getting the resident an appointment at the wound clinic. The DON reported every wound was different so it could be two days to two weeks before changing treatments if wounds were not healing. According to the DON, she was not notified that the rectal tube was leaking/seeping until 01/27/16 when the surveyor was making her wound treatment observation. At 2:30 PM on 01/29/16 the Treatment Nurse stated she thought there was a mistake in her documentation because she thought she changed the treatment to Resident #346's gluteal crease/buttocks to Santyl on 01/07/16. However, she was unable to explain why her Wound Evaluation Flow Sheets and the Treatment Administration Record (TAR) documented only zinc barrier cream was used on the buttocks	F 314			

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F 314	Continued From page 26 wound until after the resident returned from her first wound consult on 01/15/16. At 2:45 PM on 01/29/15 the Administrator, after meeting with an interdisciplinary team, stated Resident #346 had a persistent leukocytosis diagnosis in the hospital, but the source could not be identified during her hospitalization. He commented the Treatment Nurse diagnosed a DTI to the gluteal crease/buttocks on admission, and the physician confirmed the DTI during her 12/29/15 assessment. He explained the rapid decline of the DTI might have been caused by all this infection underneath. The Adminsitrator stated, if this was the case, the outcome would not have been good for the resident's wounds no matter how proactive the facility was in it's treatment of the pressure sores. At 4:08 PM on 01/29/18, during at telephone interview with the Wound Center Director, she stated it was not apparent what the nursing home was treating Resident #346's wounds with upon her 01/15/16 initial assessment, but the resident did have dressings on both wounds when she was first seen. She reported the clinic recommended continued use of Santyl to the wounds because the clinic had the best success utilizing this debriding agent. According to the director, no signs and symptoms of infection were noted in the wound beds, and the wounds were clean (not contaminated with fecal matter). According to the Wound Center Director, it was not apparent that the nursing home had done anything wrong in the treatment of the wounds, but the resident's wounds were definitely in need of debridement of slough and necrotic tissue to promote wound healing. Once the wound beds were cleaned through the debridement process, she reported the wound center wanted Resident #346 placed on wound vac therapy.	F 314			

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F 314	Continued From page 27 At 5:04 PM on 01/29/16 Nurse #8, who cared for Resident #346 on second shift, stated the resident received high powered antibiotics in the hospital which probably contributed to the development of C. diff. This nurse commented the resident had watery stools with odor since admission and through the evening of 01/28/16 when she was discharged to the hospital. During the prn dressing changes she had to make due to soilage, Nurse #8 stated the treatment ordered for the gluteal crease/buttocks was zinc barrier cream around the edges of the wounds, even when the wound was staged as III with slough. She commented she was told that the Treatment Nurse had consulted with the PA about this treatment. According to the nurse, Resident #346 usually had a couple of loose stools/diarrhea nightly on second shift. She reported she heard third shift complaining that the rectal tube was leaking, but she thought the tube did cut down on fecal contamination of the wounds. The nurse stated no product would stay on the buttocks well due to the diarrhea, but this changed after the wound clinic ordered Santyl dressings on the buttocks. At 5:15 PM NA # 4, who sometimes cared for Resident #346 on second shift, stated no NA was permanently assigned to this resident on second shift. However, she reported when she worked with the resident the resident had a couple of bouts of diarrhea on second shift. She commented the rectal tube leaked since it was inserted. She also remarked the resident had watery stools with odor since she first worked with her and continued until the resident was discharged to the hospital during the survey.	F 314			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		2/26/16	

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F 325	<p>Continued From page 28</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interviews the facility failed to provide interventions that were put in place to prevent continued weight loss for 1 of 5 residents (Resident #7) reviewed for nutrition needs. Findings included:</p> <p>Resident #7's Quarterly Minimum Data Set (MDS) dated 11/12/15 revealed she was admitted to the facility on 08/01/14 with diagnoses of dementia, Parkinson's disease, and depression. Resident #7 had long and short term memory problems and was moderately impaired in cognitive skills for daily decision making. Resident #7 needed the extensive assistance of one person for eating. Review of Resident #7's Care Plan showed a problem of inadequate oral intake. Interventions included supplements with medication pass and meals, diet as ordered, and monitoring for significant weight changes through the weight committee. Review of the monthly weights for Resident #7 revealed the following:</p>	F 325	<p>Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.</p> <p>1)Resident #7 was provided the additional supplement on 1/27/2106 during the evening meal.</p> <p>2)Clinical Team members, dietary staff, and staff that deliver meals to residents will be re-educated by the Registered Dietitian and/or designee to ensure the tray cards are reviewed prior to the delivery of the meal to the resident, to ensure all supplements ordered are provided to the resident. Inservices will be completed by 2/26/2016</p>		

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F 325	Continued From page 29 08/14/15 134 pounds 09/02/15 130 pounds 10/16/15 123 pounds 11/16/15 120 pounds 12/24/15 120 pounds 01/13/16 112 pounds Review of the Nutrition Data V2.1 Quarterly report dated 08/10/15 revealed Resident #7 had a weight loss greater than or equal to 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. Resident #7 was fed by staff and consumed an average of 56% of meals. Resident #7 received a regular puree diet with nectar thick liquids, 120 ml (milliliters) of a 2.0 kcal (kilocalorie) supplement 3 times each day with medications, and a house supplement (shake) three times each day with meals. Resident #7's significant weight change was followed by the weight committee. Review of the Nutrition Data V2.1 Quarterly report dated 10/26/15 revealed Resident #7 had a weight loss greater than or equal to 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. Resident #7 was fed by staff and consumed an average of 30% of meals. Resident #7 received a regular puree diet with nectar thick liquids, 120 ml of a 2.0 kcal supplement 3 times each day with medications, and a house supplement (shake) three times each day with meals. Resident #7's significant weight change was followed by the weight committee. Review of the Nutrition Data V2.1 Quarterly report dated 01/21/16 revealed Resident #7 had a weight loss greater than or equal to 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. Resident #7 was fed by staff and consumed an average of 67% of meals. Resident #7 received a regular puree diet with nectar thick liquids, 120 ml of a 2.0 kcal supplement 3 times each day with medications, and a house supplement (shake)	F 325	3)Registered Dietitian and Nurse Leadership will randomly audit 15 trays weekly, for 3 months, to ensure accuracy of the items provided on the trays to the resident.The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. 4)The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress.Plan will be adjusted according to the results and success of the plan implemented.		

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F 325	<p>Continued From page 30</p> <p>three times each day with meals. Resident #7's significant weight change was followed by the weight committee. The report revealed Resident #7's continuing weight loss appeared related to her overall declining condition.</p> <p>Review of Resident #7's September Medication Administration Record revealed Remeron (a medication used to stimulate appetite) had been discontinued on 09/02/15.</p> <p>Review of the January 2016 Order Summary Report revealed Resident #7 received a regular puree diet with nectar thick liquids. Resident #7 was also allowed to have bananas and eggs. The orders showed Resident #7 was to receive 120 ml of a 2.0 kcal product three times each day with medications at 10:00 AM, 4:00 PM and at bedtime. 2 house supplements (shakes) three times each day with meals was also ordered as a supplement.</p> <p>In an observation on 01/27/16 at 1:00 PM resident #7 was sitting in a high backed wheelchair in the dining room with other residents awaiting lunch. All the residents had assorted fluids in front of them. Resident #7 had orange juice, ice tea, and a strawberry shake all in 4 ounce glasses in front of her. For lunch Resident #7 received puree chicken with gravy, mashed potatoes with gravy, and puree vegetables. Resident #7 received only 1 of the 2 supplements (shakes) that were ordered and listed on her meal card. Resident #7 was fed by staff and did not consume her full meal.</p> <p>In an observation on 01/27/16 at 5:55 PM staff was in the dining room preparing meal trays. Resident #7 was not in the dining room. Resident #7's dinner meal tray was prepared and contained puree beef, rice, and broccoli in a 3 section plate. There was also a "sippy" type cup with water and a 4 ounce glass with a house</p>	F 325			

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F 325	<p>Continued From page 31</p> <p>supplement (shake). Staff indicated Resident #7's meal tray was complete and ready to be served. Three staff members were standing at the counter and when asked about the second shake a carton was placed on Resident #7's tray. NA #5 indicated she was not aware Resident #7 should receive 2 shakes.</p> <p>In an interview on 01/27/16 at 6:15 PM the Unit Manager acknowledged the ordered supplements (shakes) had been missing from Resident #7's meal trays. She indicated it was the responsibility of the staff preparing the trays to read the meal cards and to provide the correct items that were ordered.</p> <p>In an observation on 01/28/16 at 1:15 PM Resident #7 was in the day room with a visitor and a student nurse. Resident #7 had eaten 75% of the meal and 2 empty supplement (shake) glasses were noted. Full cups of tea and water were noted.</p> <p>In an interview on 01/29/16 at 3:50 PM the Registered Dietician (RD) stated in July 2015 Resident #7's weight was 134 pounds. Supplements of 2.0 kcal 120ml three times a day and a house supplement (shake) three times each day were ordered. She indicated the diet provided, plus the supplements, provided greater than needed nutrition if consumed. She indicated Resident #7 spit out some food while she was being fed. The RD stated the physician and the Responsible Party (RP) were aware of the weight loss. The RD revealed that Resident #7's weight in August 2015 was 134 pounds and she was still being followed by the weight committee. She indicated in September 2015 Resident #7's weight was 130 pounds and was being followed by the weight committee. The RD indicated the 4 pound weight loss was insignificant. She stated Resident #7's intake was 80% and sweets and</p>	F 325			

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F 325	Continued From page 32 supplements were taken better than meals. The RD indicated house supplements (shakes) were increased to 2 with each meal and the appetite stimulant was discontinued because it did not appear to be effective. She indicated after the discontinuation of the appetite stimulant Resident #7 began to lose more weight. The RD stated in October 2015 Resident #7's weight was 123 pounds and she consumed about 69% of meals. Resident #7 continued to spit out some foods. In November 2015 Resident #7 weighed 120 pounds and ate 64% of the ordered diet. She stated the physician and RP were aware of Resident #7's continued weight loss. The RD stated on 11/16/15 Resident #7 was sent to a physician ' s appointment and information was returned that no feeding tube was desired. The RD indicated Resident #7's weight in December 2015 was 120 pounds and the weight was stable. She stated Resident #7's weight in January 2016 was 112 pounds. Resident #7 had decreased cognition, was spitting out food and there were no changes to her diet. The RD indicated supplements such as ice cream, fortified foods, magic cups or regular milk shakes were not attempted to increase Resident #7's weight. She also indicated a different appetite stimulant was not tried. She indicated Resident #7 was being followed by the weight committee but no formal "minutes" were kept of the meetings. Worksheets were used and it was more of a round robin meeting. The RD stated she did not feel anything else could have been done for Resident #7. In an interview on 01/29/16 at 5:16 PM the Director of Nursing stated weekly risk management meetings for weight loss were held on Tuesdays. She indicated the RD could recommend and implement diet orders and then notify the physician. She indicated she expected	F 325			

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F 325	Continued From page 33 the RD to put interventions in place for a resident with weight loss. She indicated she expected the staff to provide meals to residents as ordered and written on the meal card including providing 2 supplements (shakes) if needed.	F 325			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 28 opportunities, resulting in a medication error rate of 7.14% for 2 of 4 residents (Resident #366 and Resident #367) observed during medication pass. These errors included wrong dosages. Findings included: 1. Resident #366's Minimum Data Set (MDS) dated 01/21/16 revealed he was admitted to the facility on 01/14/16 with cumulative diagnoses of heart failure, Parkinson's disease and a cervical spine injury. Resident #366 was moderately cognitively impaired. Review of Resident #366's Medication Administration Record (MAR) revealed an order for potassium 15 mEq (milliequivalents) by mouth two times a day. A Medication Administration observation was conducted for Resident #366 on 01/27/16 at 9:30 AM. 15 mEq of liquid potassium to equal 11.25 milliliters (ml) was poured into a graduated medicine cup which was not calibrated for one	F 332	Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it. 1) Nurse #2 was immediately re-educated on 1/27/2016 regarding administering liquid Medications that are ordered in milliliters. Nurse #3 was immediately re-educated on 1/27/2016 regarding the five rights of medication administration, to include insulin dosing. 2) All licensed Nurses will be re-educated by the DNS and/or designee prior to 2/26/2016 regarding the five rights of medication administration, to include insulin dosing and administering solutions	2/26/16	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GREENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834		
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F 332	<p>Continued From page 34</p> <p>quarter (0.25) mls. Nurse #2 indicated she was prepared to provide the potassium to the resident as poured. The Medication Administration was stopped and Nurse #2 was asked if the medicine cup provided for a measurement of 0.25ml. She indicated it did not and Nurse #2 requested another staff member bring her a syringe. Nurse #2 obtained the syringe and provided Resident #366 with 11.25 mls of potassium.</p> <p>In an interview on 01/27/16 at 3:35 PM Nurse #2 stated giving a resident too much or too little potassium could cause a problem with the rhythm of the heart. She indicated that even a small amount of difference could cause heart problems. She stated potassium should be measured in a more precise manner and she was going to ask for a supply of syringes so she could measure more carefully.</p> <p>In an interview on 01/29/16 at 11:45 AM Pharmacist #1 stated medication cups were not calibrated for, and should not be used for, a liquid dose of 11.25ml. She indicated the nurse should have used a syringe to draw up the unusual amount of medication. Pharmacist #1 stated the pharmacy would not have dispensed a syringe with the medication as they would have expected the nurse to know one was needed. She stated by using the medicine cup there was a risk that too much or not enough potassium was given.</p> <p>In an interview on 01/29/16 at 5:16 PM the Director of Nursing (DON) stated she expected the nurses to give medications as ordered. She indicated she expected the nurses to use a syringe to draw up unusual amounts of liquid medications and that a medicine cup was not good enough.</p> <p>2. Resident #367's MDS dated 01/21/16 revealed she was re-admitted to the facility on 01/14/16 with cumulative diagnoses of diabetes,</p>	F 332	<p>ordered in milliliters.</p> <p>3)The DNS and/or designee will randomly observe and monitor 4 nurses weekly, on different shifts, to assure compliance with the five rights of medication administration, to include observation of insulin administration and administration of liquids ordered in milliliters. The monitoring will continue for 3 months, with The results of the monitoring brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress.</p> <p>4)The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. Plan will be adjusted according to the results and success of the plan implemented.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 332	<p>Continued From page 35</p> <p>hypertension and cerebrovascular accident. Resident #367 was moderately cognitively impaired.</p> <p>Review of Resident 367's MAR showed an order to inject 9 units of Humalog insulin subcutaneously twice a day before lunch and dinner. There was also an order to inject Humalog insulin on a sliding scale with meals using the formula: "FSBS-140/45= # units insulin to be given" (finger stick blood sugar-140 divided by 45=amount of units to inject).</p> <p>A Medication Administration observation was conducted for Resident #367 on 01/27/16 at 11:40 AM. Nurse #3 obtained Resident #367's blood sugar which was 293 and made the calculations according to the order. She indicated she would be giving Resident #367 3 units of Humalog insulin from the sliding scale in addition to the 9 units that were scheduled for a total of 13 units. She dialed the insulin pen to show 13 units. When asked if she was ready to proceed with the injection she stated yes. At that time she was stopped and was asked to check her addition. Nurse #3 again stated she was going to give 13 units of insulin to Resident #367. Nurse #3 was asked to check her addition again and realized she had made an error. She indicated she should give 12 units of insulin not 13 units to Resident #367. She corrected the dose at that time and 12 units of insulin was given to Resident #367.</p> <p>In an interview on 01/27/16 at 3:40 PM Nurse #3 indicated giving too much insulin could cause the blood sugar to drop and the resident could get sick. She stated she needed to slow down and be more diligent when she administered medications.</p> <p>In an interview on 01/29/16 at 11:45 AM Pharmacist #1 stated it was very important the correct dosage of insulin be provided to residents.</p>	F 332			

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F 332	Continued From page 36 In an interview on 01/29/16 at 5:16 PM the DON stated she expected insulin to be given as ordered. She indicated she expected the nurse to double check the formula and their addition prior to injecting insulin. The DON stated she expected the facility medication error rate to be below 5%.	F 332			
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to discontinue a medication which resulted in the administration of 26 doses of an anti-psychotic medication for 1 of 6 sampled residents (Resident #81) reviewed for unnecessary medications. Findings included: Resident #81 was admitted to the facility on 10/24/14 with cumulative diagnoses of psychotic disorder, muscle weakness and heart disease. Resident #81's Quarterly Minimum Data Set (MDS) dated 12/02/15 revealed he was moderately cognitively impaired. During the seven day look back period Resident #81 had no behaviors, did not reject care and received anti-psychotic medications all seven days. Review of the General Progress Notes from 10/05/15-01/28/16 revealed no behaviors for Resident #81. Review of the December 2015 Medication Administration Record revealed an order for Haldol (an anti-psychotic) 0.5 mg (milligrams) to be given by mouth daily for evening confusion. The medication was given to Resident #81 from	F 333	Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it. 1)Nurse #1 was immediately re-educated on 1/28/2016 by the DNS regarding transcription of physician orders. 2)All licensed nurses will be re-educated regarding transcription of physician orders on or before 2/26/2016 by the DNS and/or designee.All handwritten physician orders are written on carbon copy paper. The "pink" portion of the carbon will be placed in a container designated for such, at each nurse station. The pink copies will be reviewed each night by a licensed nurse, and compared to to the electronic	2/26/16	

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F 333	Continued From page 37 12/01/15-12/30/15. Review of the Physician's Telephone Orders dated 12/04/15 at 4:30 PM revealed an order to D/C (discontinue) the scheduled Haldol. The order requested Haldol now be given as needed for agitation at night time at a dose of 0.5mg. In an interview on 01/28/16 at 4:35 PM Nurse #1 stated when a telephone order was received by the nurse it was entered into the computer and faxed to the pharmacy. He indicated a copy was placed in the physician's box or mailed to the physician for their signature. He confirmed that on 12/04/15 he had written the order for the discontinuation of Resident #81's Haldol and to change the medication to an as needed dose. He indicated he had "missed" it and did not know how it had happened but it had not made it to the Medication Administration Record which resulted in Resident #81 receiving multiple doses of the discontinued Haldol. Nurse #1 stated residents should not receive medications that were discontinued. In an interview on 01/29/16 at 4:30 PM the Assistant Director of Nursing (ADON) stated when the December and January orders were compared it was discovered the anti-psychotic medication had not been discontinued as ordered. She indicated she had gone into the computer and discontinued the medication herself. In an interview on 01/29/16 at 5:16 PM the Director of Nursing (DON) stated she expected the nurses to discontinue medications as ordered. She stated she spoke to the nurse who took the order and he did not know what had happened as he had added the as needed dose as ordered to Resident #81's Medication Administration Record.	F 333	record, to ensure all orders have been input correctly into the electronic record. This will be a permanent process change to assure accuracy. 3)The pink carbon copies of the handwritten Physician orders will be collected each morning by DNS and or Nurse managers, and audited to ensure all orders are recorded in the electronic record as written by the Physician.The DNS and the Nurse managers will assure this practice occurs.This will be a permanent process change to assure accuracy. 4) The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress.Plan will be adjusted according to the results and success of the plan implemented.		

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F 364 F 364 SS=E	Continued From page 38 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to prepare and serve pureed foods that were palatable and appetizing in appearance for 5 of 15 sampled residents (Resident #37, #50, #109, #334, and #368) who were currently or recently receiving pureed foods. Findings included: At 12:38 PM on 01/25/16 Resident #368 was eating lunch in dining room #1. She received puree pork, sweet potato, and lima beans in a non-sectional plate. The foods were running together, and the resident was attempting to eat with a fork. Very little of the food stayed on the fork, most running through the tines. The resident appeared frustrated. At 12:45 PM on 01/25/16 Resident #37 was in her room being fed her puree meal by the staff. The resident received puree pork, sweet potato, and lima beans in a non-sectional plate. The puree foods were running together, and the staff used a spoon for feeding the resident. At 12:49 PM on 01/25/16 Resident #50 was eating lunch in dining room #5. She received mashed potatoes, puree pork, and puree lima	F 364 F 364	Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it. 1)The Dietary staff were immediately inserviced on 1/28/2016 to assure the puree food had appropriate thickness and appearance. 2)The Dietary staff were immediately inserviced on 1/28/2016 to assure the puree food had appropriate thickness and appearance. Modified recipes have been put in place to assure appropriate thickness and appearance. Thickener made available in all serving areas if needed. 3) Dietary Staff, Clinical team, and Department Heads who assist in serving residents will monitor all meals to assure puree food is the appropriate thickness,	2/26/16	

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F 364	<p>Continued From page 39</p> <p>bean in a non-sectional plate. The mashed potatoes kept their form on the plate, but the other two foods were running together. The resident used her spoon to eat with even though the resident had difficulty keeping her spoon filled with the thin puree foods.</p> <p>At 12:53 PM on 01/25/16 Resident #109 was eating lunch in dining room #6. She received puree pork, sweet potato, and lima beans in a non-sectional plate. The foods were running together, but the resident was able to eat them with her spoon.</p> <p>At 12:02 PM on 01/27/16 the cook stated there were corporate recipes for puree foods, and she always followed them. She reported only water or food juices and thickening powder were added to foods when pureeing them.</p> <p>Between 12:26 PM and 12:55 PM on 01/27/16 Resident #368, #50, #109 were eating lunch in the facility dining rooms, and Resident #37 was being fed by staff in her room. These residents received puree chicken, potatoes, and mixed vegetables in non-sectional plates. The foods were running together. The puree chicken was almost white in color, and the puree mixed vegetables were translucent and very pale yellow/gold. All the puree foods had a sheen to them.</p> <p>At 3:20 PM on 01/27/16 the speech therapist (ST) stated puree foods should not be so thick that it takes strenuous movement to move them to the back of the mouth and into the throat, but at the same time they should be thick enough that they hold their shape on a plate without running into other foods. At this time the ST was</p>	F 364	<p>and proper appearance. A sample puree plate will be prepared in the main kitchen for The Dietary Manager, Assistant Manager, RD, or Lead Cook, in the absence of the Dietary Manager, RD or Assistant Manager, to inspect, and approve, prior to delivery to residents. In addition, the Dietary RD Consultant will observe the sample plate when visiting the Center. This practice will continue for 3 months. Any concerns noted will be immediately addressed with the Dietary staff for correction. The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress.</p> <p>4) The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. Plan will be adjusted according to the results and success of the plan implemented.</p>		

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F 364	<p>Continued From page 40</p> <p>experimenting with the thickness of puree broccoli to be served at the 01/27/16 supper meal. The puree broccoli was almost an electric green with a sheen to it.</p> <p>At 11:45 AM on 01/28/16 review of the corporate recipe for puree mixed vegetables revealed wheat bread was to be used as a thickening agent, and the recipe for puree broccoli called for the use of margarine. At this time the dietary manager (DM) stated the staff was not aware of the need to use wheat bread in the preparation of the puree mixed vegetables. She explained the delivery truck was late on Monday, 01/25/16, and the facility was running low on thickener. The DM also commented the kitchen supervisor felt the "shine" on the puree foods was caused by using too much thickener and liquid and not enough real food.</p> <p>At 10:28 AM on 01/29/16 the DM stated she expected her cooks to follow the corporate recipes, including those for puree foods. She reported puree foods should hold their shape on resident plates, and should not drip off a spoon during preparation or meal consumption. According to the DM, there were 14 residents currently residing in the building who received puree diets, but they had moderate to severe cognitive impairment.</p> <p>At 10:45 AM on 01/29/16 the assistant dietary manager (ADM) stated puree foods should have the consistency of real mashed potatoes and should hold their shape on a plate. She reported if puree foods were runny the cook was supposed to add more thickener.</p> <p>At 4:58 PM on 01/29/16 Resident #334,</p>	F 364			

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F 364	Continued From page 41 documented to have no cognitive impairment in her 12/07/15 admission minimum data set (MDS) assessment, stated she was on a puree diet for awhile due to throat problems. She reported her diet had been upgraded, and she was very glad because the puree food she received was often "soupy" and did not have a natural color of it. The resident explained saying that what she received "did not look like real food."	F 364			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep slaw made with mayonnaise at or below 41 degrees Fahrenheit during operation of the tray line in auxiliary kitchens, failed to air dry kitchenware before stacking it in storage, failed to cover cooling bread products to protect them from contamination, and failed to monitor food storage practices and labeling/dating in storage areas. Findings included: 1. On 01/28/16, during the operation of three auxiliary kitchen tray lines which were serving six	F 371	Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it. 1)The slaw in the dining areas identified were immediately placed in the freezer to reach the appropriate temperature. The pan that was identified that had moisture	2/26/16	

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F 371	<p>Continued From page 42</p> <p>dining rooms the lunch meal, slaw was found to be above 41 degrees Fahrenheit in three of the dining rooms.</p> <p>At 12:32 PM on 01/28/16 two of three thermometers placed in a slurry of ice and water were found to be incorrectly calibrated. The thermometer which registered 32 degrees Fahrenheit in the slurry was the only one used to take subsequent temperatures.</p> <p>At 12:36 PM on 01/28/16 slaw found in the kitchen's reach-in refrigerator registered 46 degrees Fahrenheit using the correctly-calibrated thermometer.</p> <p>At 12:48 PM on 01/28/16 slaw found sitting on the counter in the kitchen, while residents were still receiving their food, registered 50 degrees Fahrenheit using the correctly-calibrated thermometer.</p> <p>At 12:55 PM on 01/28/16 regular slaw and puree slaw were stored in the kitchen's reach-in refrigerator. The regular slaw registered 46 degrees Fahrenheit and the puree slaw registered 48 degrees Fahrenheit using the correctly-calibrated thermometer.</p> <p>At 10:28 AM on 01/29/16 the dietary manager (DM) stated all cold salads containing protein were supposed to be kept at or below 41 degrees Fahrenheit during the entire operation of the tray line. She reported the facility made its own slaw which contained green cabbage, vinegar, mayonnaise, and sometimes shredded carrot and red cabbage depending on which of the two slaw recipes were utilized. She commented cold salads were prepared the day before they were</p>	F 371	<p>in it was re-washed, and placed in the drying rack until dry. Dietary Staff were in-serviced on 1/28/2016 to assure all items removed from the oven or steam table must be covered immediately to prevent contamination. Staff were re-educated on 1/25/2106 regarding proper labeling and dating guidelines.</p> <p>2)Temperatures of cold foods will be taken prior to leaving the main kitchen, and again prior to the beginning of tray preparation, to assure proper temperature. Kitchen staff will monitor every dish or pan before it is placed in storage, to assure complete dryness. Each shift will check dishes from previous shifts, and report concerns to the Dietary Manager. All kitchen staff will monitor items taken out of the oven, or off the steam table for immedaite covering, and report concerns to dietary Manager. Staff were re-educated on 1/25/2106 regarding proper labeling and dating guidelines.</p> <p>3)The Dietary Leadership will monitor the temperatures of the walk in refrigerator daily for 3 months to assure it is at the appropriate temperature. Temperatures of cold food will be taken by Dietary staff prior to leaving the main kitchen for each meal, for 3 months. Each shift, the cook will monitor all dishes and pans for complete dryness, and report concerns to the Dietary Manager for 3 months. The main kitchen has been rearranged to allow parchment paper to be on the shelf next to prep tables and ovens. Pantries will also have parchment paper available</p>		

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F 371	<p>Continued From page 43</p> <p>served to the residents. The DM explained these salads were stored overnight in the main kitchen's walk-in refrigerator, and if they were being served for lunch the next day, they were placed in individual serving bowls and transferred to the refrigerators in the dining rooms adjacent to the auxiliary kitchens before breakfast the day of being served. According to the DM, her expectation was for dietary staff to take the temperature of the salads as the tray lines started up, and if they registered above 41 degrees Fahrenheit they should be transferred to the freezer section of the kitchen reach-in refrigerators until they were sufficiently chilled. She reported the thermometers used to check food temperatures were supposed to be calibrated weekly and as needed.</p> <p>At 10:45 AM on 01/29/16 the assistant dietary manager (ADM) stated all cold salads should be made the day before being served and stored in refrigeration until the tray lines began operation. She reported if the salads could not be kept at 41 degrees Fahrenheit or below during meal service, they should be disposed of and a comparable alternate should be served in their place.</p> <p>2. During initial tour of the main kitchen beginning at 11:15 AM on 01/25/16 1 of 12 tray pans stacked in storage had moisture still trapped inside of it.</p> <p>At 10:28 AM on 01/29/16 the dietary manager (DM) stated she was not sure whether the tray pan found stacked wet on 01/25/16 was placed in storage that morning or the night before. She reported the practice of stacking wet pieces of kitchenware on top of one another was dangerous because bacteria could start growing</p>	F 371	<p>for use.</p> <p>A new checklist developed to assure proper dating and labeling of all items are in compliance. Large colorful examples of proper labels have been posted in multiple locations. Checklist will be monitored daily by Dietary management for 3 months, and tracked for performance. The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress.</p> <p>4) The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. Plan will be adjusted according to the results and success of the plan implemented.</p>		

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F 371	<p>Continued From page 44</p> <p>in the trapped moisture. She commented staff was trained to air dry all kitchenware before stacking it on storage racks.</p> <p>At 10:45 AM on 01/29/16 the assistant dietary manager (ADM) stated dietary staff were trained to let kitchenware air dry on drying racks in the kitchen before stacking the pieces on top of one another on storage racks. She reported bacteria could grow in trapped moisture, and this could make residents sick if the kitchenware was not heated to temperatures high enough to kill the bacteria.</p> <p>3. From 11:50 AM until 12:07 PM on 01/27/16 two large baking pans of wheat rolls were cooling and uncovered in the main kitchen. The rolls and the pans were room temperature to the touch.</p> <p>At 11:45 AM on 01/28/16 two muffins pans containing corn muffins were sitting uncovered on the food preparation counter of the main kitchen.</p> <p>At 11:50 AM on 01/28/16 these corn muffins were removed from their baking pans and placed into a large tray pan where they remained uncovered.</p> <p>At 11:52 AM on 01/28/16 the muffin pans and tray pan were slightly warm, but not hot to the touch.</p> <p>At 12:28 PM on 01/28/16 a tray pan of corn muffins was sitting uncovered on top of a meal cart in an auxiliary kitchen.</p> <p>At 10:28 AM on 01/29/16 the dietary manager (DM) stated her dietary staff had been in-serviced in the past to cover baked goods that were under 135 degrees Fahrenheit so flies and gnats would not contaminate them. She reported if foods</p>	F 371			

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F 371	<p>Continued From page 45</p> <p>were not hot enough to kill the germs and bacteria spread by insects and pests then this contamination could cause residents to get sick.</p> <p>At 10:45 AM on 01/29/16 the assistant dietary manager (ADM) stated dietary staff were supposed to cover cooling baked goods with pieces of parchment paper to prevent contamination from flies and gnats. She reported the dietary staff were reminded that this practice was important by the health inspector.</p> <p>4. During initial tour of the main kitchen and storage areas, beginning at 11:15 AM on 01/25/16, an opened two-pound container of confectioner's sugar and an opened 32-ounce container of cheese sauce mix were found in the dry storage room without labels and dates to indicate when they were opened. The walk-in refrigerator in the main kitchen contained a partially used tray of boiled eggs which was without a label and a date. The walk-in freezer in the main kitchen contained a bag of grilled chicken breast and a bag of cinnamon rolls which were opened and without labels and dates. In auxiliary kitchen/pantry #2 a 24-ounce package of lemonade drink mix and a bag of vanilla wafers were found opened but without labels and dates. In auxiliary kitchen/pantry #1 a bottle of Thousand Island dressing which was opened was found unrefrigerated, and sliced deli ham was found refrigerated in a bag dated 01/12/16.</p> <p>At 10:28 AM on 01/29/16 the dietary manager (DM) stated all dietary employees who entered storage areas were responsible for checking to make sure opened food items were labeled and dated, foods were not kept past their discard or use-by dates, and food items were stored per</p>	F 371			

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F 371	Continued From page 46 manufacturer's recommendations. She also reported the kitchen supervisor checked storage areas in the main kitchen when he was ordering and putting up stock two days a week, and each of the auxiliary kitchens had a supervisor who checked storage areas at least every other day. The DM commented labeling and dating opened food items was important to make sure older foods were used up first, and checking discard dates and use-by dates was important to make sure food was not spoiled and was served as fresh as possible to the residents. At 10:45 AM on 01/29/16 the assistant dietary manager (ADM) stated anyone entering storage areas should make sure opened food items were labeled and dated, leftovers were disposed of timely, and manufacturer guidelines for storage were being followed. She also reported that she, the DM, and the kitchen supervisor did walk-throughs in the main kitchen and auxiliary kitchens each morning to make sure the storage areas were in good shape.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431			2/26/16

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F 431	<p>Continued From page 47</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to label 1 of 28 medications observed during Medication Administration. Findings included: Resident #125's Quarterly Minimum Data Set (MDS) dated 11/11/15 revealed she was admitted to the facility on 09/04/14 with cumulative diagnoses of Parkinson's disease, depression and muscle weakness. Resident #125 was cognitively aware and received scheduled pain medications. Review of the January 2015 Medication Administration Record (MAR) showed an order for Tramadol (a pain medication) 50mg (milligrams) to be given three times each day for</p>	F 431	<p>Preparation and or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.</p> <p>1)Medications observed in unlabeled plastic bags were immediately discarded, and replaced with medication labeled and dispensed by the Pharmacy.</p> <p>2)All medication carts were audited on</p>		

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F 431	Continued From page 48 pain. During an observation of Medication Administration on 01/27/16 at 9:46 AM Nurse #4 removed a re-sealable bag from a locked drawer on the medication cart. The bag contained an empty pill bottle labeled with Resident #125's name, the name and dosage of the medication, directions for administration and the expiration date. The bag also contained small packets of unlabeled tablets. In an interview on 01/27/16 at 9:46 AM Nurse #4 stated Resident #125's family provided medications from a private pharmacy and did not use the facility pharmacy for medications. She indicated that to make it easier for the nurses to count the narcotic medication the bottle was emptied and the pills were packaged in bags of 10. Nurse #4 stated the empty bottle was kept in the bag with the small packages of medications to show what the medication was. In an interview on 01/28/16 at 4:10 PM the Administrator stated he had been unable to discover which nurse started placing Resident #125's Tramadol in the small plastic bags. He indicated he had informed the family when Resident #125 was admitted that medications needed to be provided in bubble packs for administration. The Administrator stated it was unacceptable that unlabeled bags of medications were being used even though the empty bottle was in the bag with the packets. He indicated the medication had been taken off the medication cart and was now being supplied using their automated system. In an interview on 01/29/16 at 11:45 AM Pharmacist #1 stated only the pharmacy could relabel medications. She indicated legally narcotics could not be sent to the facility pharmacy for repackaging/relabeling and placing	F 431	1/27/2016 to assure all medications were properly labeled and packaged. All Licensed Nurses will be educated on or before 2/26/2016 by the DNS and /or designee regarding all medications being maintained in the original packaging labeled by the pharmacy. Residents who desire to provide their own medication will be given a copy of the Pharmacy policy , including packaging guidelines. Medications will be refused by Nursing staff if not in acceptable packaging as determined by the Pharmacy Policy. 3)All medication carts will be audited weekly, for 3 months, by the DNs,ADNS, or Nurse managers to ensure all medications are located in the original packaging labeled by the pharmacy. The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. 4) The results of the monitoring will be brought to the QAPI committee monthly for a minimum of 3 months to insure quality improvement and to track progress. Plan will be adjusted according to the results and success of the plan implemented.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 49 the medication in smaller bags was not an ideal situation. In an interview on 01/29/16 at 5:16 PM the Director of Nursing (DON) stated she expected medications to be kept in their original containers.	F 431			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) committee failed	F 520	Preparation and or execution of this plan of correction do not constitute admission	2/26/16	

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F 520	<p>Continued From page 50</p> <p>to prevent the reoccurrence of deficient practice related to failure to keep the medication error rate at less than 5% during medication pass observation which resulted in a repeat citation at F332. The facility also failed to prevent the reoccurrence of deficient practice related to labeling stored medications which resulted in a repeat deficiency at F431. The re-citing of F332 and F431 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included:</p> <p>This tag is cross-referenced to:</p> <p>F332: Medication Error Rate: Based on observation, record review and staff interviews the facility failed to ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 28 opportunities, resulting in a medication error rate of 7.14% for 2 of 4 residents (Resident #366 and Resident #367) observed during medication pass. These errors included wrong dosages.</p> <p>F431: Medication Storage: Based on observation, record review and staff interviews the facility failed to label 1 of 28 medications observed during Medication Administration.</p> <p>Review of the facility's survey history revealed F332 was cited during a 09/03/15 complaint investigation survey, and was re-cited during the current 01/29/16 annual recertification survey.</p> <p>Review of the facility's survey history revealed F431 was cited during the facility's 03/05/15 annual recertification survey, and was re-cited during the current 01/29/16 annual recertification</p>	F 520	<p>or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and or executed solely because the provision of federal and state laws requires it.</p> <p>1) A QAPI meeting will be held on 2/24/2016 to discuss F332 and F431, and develop a immediate plan for improvement.</p> <p>2)The QAPI Committee will meet more frequently than the required Quarterly meeting, meeting at least monthly. The monthly meeting will focus on the requirements of the tags referenced, and the committee will develop action plans for process improvement, and deficiency correction.</p> <p>3) All results from the action plan steps will be discussed in detail at each QAPI meeting,for 6 months, and existing action steps will be revised, or added to ensure correction.</p> <p>4) The results of the monthly monitoring will be brought to the Quarterly QAPI committee monthly for a minimum of 6 months to insure quality improvement and to track progress. The Medical Director and pharmacy Consultant will attend the quarterly meetings,as required, and will collaborate with the team for improvements. The QAPI Plan will be adjusted according to the results and</p>		

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F 520	Continued From page 51 survey. At 5:50 PM on 01/29/16 the administrator stated in September 2015 the facility was cited for timing issues with the administration of medications which resulted in a medication pass error rate greater than 5%. He reported the facility corrected this problem by having morning medications given at two different times rather than one time for all residents and by having afternoon medications given at two different times rather than one time for all residents. However, he stated the F332 citation this year involved improper doses of medication. Even though he received citations in both 2015 and 2016 at F332, he explained the deficient practice was not really the same, timing of medications in 2015 and improper dosages of medication in 2016. According to the administrator, the same principle applied to the F431 which was cited in 2015 and 2016. He reported in 2015 the issue was failure to discard medications and in 2016 the issue was failure to label stored medications.	F 520	success of the plan implemented.		