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	345236	A. BUILDING _____ B. WING _____	C 07/06/2017

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F 000	INITIAL COMMENTS The exit date for event ID #8SI811 was extended to 07/06/17 due to the need to interview the DON about repeat tags which the facility experienced in the last survey year. This interview was included in the body of the F520 citation. DB 7/25/17: The nh requested IDR for the G tags, F 309, F 325, F 520. IDR coordinator glanced at the tags in question and questioned why they were at G instead of D based on the arterial/vascular problems. IDR coordinator discussed with the author who stated he submitted them to quality review as D based on the diagnoses and the MD interview and quality review said to increase them to G's. IDR coordinator contacted CMS and requested the enforcement be rescinded, and the tags lowered to D's in lieu of an IDR meeting. CMS in agreement to lower the tags to D's. The original 2567 is under attachments. BW	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 157		8/6/17

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

Electronically Signed | 07/17/2017

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F 157	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to notify the Responsible Party (RP) and the Physician of a wound for 1 of 4 Residents (Resident #85) whose bath was observed. Findings included:	F 157	1. Resident # 85 A skin assessment was completed on 6/22/17 by nurse # 1 and Director of Nursing and skin was intact. Nurse #4 was counseled and re-educated on the proper procedure for: notification of physician and responsible party upon	

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F 157	Continued From page 2 Review of the Quarterly Minimum Data Set dated 06/08/17 revealed Resident #85 was admitted to the facility on 11/13/13 with diagnoses of non-Alzheimer's dementia, chronic kidney disease, and atrial fibrillation. Resident #85 was cognitively aware and was dependent on one person for dressing, toilet use and hygiene. There was no application of non-surgical dressings noted. In an observation of care on 06/22/17 at 9:41 AM Nursing Assistant (NA) #1 provided a bed bath to Resident #85. During the bath, a wound dressing with an adhesive border was seen on the side of Resident #85's lower left leg. The dressing was dated 04/26 and had a set of initials above the date. In an interview with Resident #85 directly following the bath, she indicated she did not know why she had a wound dressing on her leg and could not remember if she had received an injury there. In an interview and observation on 06/22/17 at 10:32 AM Nurse #1 stated he was unaware Resident #85 had a wound dressing on her left lower leg. He proceeded to uncover Resident #85's left lower leg and confirmed the date on the initialed wound dressing was 04/26. Nurse #1 removed the wound dressing from Resident #85's leg. The dressing contained a quarter sized, dark brown dried area, with raised edges. Nurse #1 acknowledged the drainage on the dressing but stated the wound had healed. Review of the Nursing Notes on 6/22/17 at 11:37 AM for 04/19/17-06/22/17 revealed no note that	F 157	changes in a resident□s skin integrity and obtaining and transcribing physician orders for new skin impairment. 2. Other residents are at risk for the same alleged deficient practice. Nurse #1 was counseled and re-educated regarding the procedure for conducting weekly skin assessments. Licensed staff will be re-educated by the Director of Nursing or designee regarding procedure for notification of physician and responsible party upon changes in a resident□s skin integrity, obtaining and transcribing physician orders for new skin impairment and the proper procedure for conducting a skin assessment. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur are: The Director of Nursing or designee will audit residents with skin impairments to ensure the responsible party and physician have been notified and appropriate orders have been received and transcribed. The Director of Nursing or designee will observe 3 weekly skin assessments to ensure accuracy and the proper procedure is followed should new impairments be noted. The audits will be conducted times 4 weeks then monthly for 2 months and the results of the weekly audits will be reviewed during the Interdisciplinary meeting on Friday. Negative findings will be addressed at the time noted. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement	

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F 157	Continued From page 3 Resident #85's RP or Physician had been notified of the leg wound. In an interview on 06/22/17 at 3:22 PM Nurse #4, whose initials were on the dressing, stated he could not remember anything about the wound to Resident #85's leg. He indicated he should have written a progress note, notified Resident #85's RP, notified Resident #85's Physician for a treatment order, and filled out an Incident Report. He acknowledged none of these things had been done. In an interview on 06/22/17 at 3:51 PM the Staff Development Coordinator (SDC) stated any change in a resident's condition needed to be reported to the RP and the Physician. She indicated that this included any injuries a resident received. In an interview on 06/22/17 at 4:40 PM Unit Manager #1 stated if anything out of the ordinary happened the nurse was supposed to notify the Unit Manager, the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) so interventions could be started. He indicated the nurse should also write up an Incident Report, write a progress note, write a post incident note, and notify the resident's RP and Physician. In an interview on 06/22/17 at 4:53 PM the DON stated it was her expectation that the Nurse immediately notify the Supervisor if an injury occurred to a resident. She indicated she expected the Nurse to notify the RP and the Physician of the injury.	F 157	meeting monthly for 3 months. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial compliance.	
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		8/6/17

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F 224	Continued From page 4 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident, and physician interviews, the facility neglected to provide pressure wound care as ordered by the physician for 1 of 1 residents (Resident # 1) reviewed for pressure wounds. Findings included: Record review revealed that Resident #1 re-entered the facility on 02/20/14 and had a diagnosis of Quadriplegia. Review of the resident's care plan dated 04/03/17 included the following areas: Limited physical mobility related to neurological deficits-quadriplegia; At risk for further skin	F 224	1. Resident # 1□s dressing was changed at 10:15 a.m. on 6/21/17 and there was no negative outcome noted. The wound care physician noted the wound was actually improving and had a decreased amount of exudate. Nurse #7 was counseled and re-educated regarding following physician orders and the procedure for notifying the direct supervisor if unable to complete the duties of the assignment in a timely manner. 2. Other residents with skin impairments are at risk for the same alleged deficient practice and will be reviewed to ensure the treatments and documentation are	

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F 224	Continued From page 5 breakdown related to impaired mobility and incontinence; Failed surgical wound/pressure ulcer to his right buttock/hip; and Actual impairment to skin integrity of the right ischial tuberosity related to failed surgical flap and right heel wound. Included in the interventions for pressure ulcer care was to administer treatments as ordered and observe for effectiveness. Review of the Annual Minimum Data Set (MDS) dated 04/04/17 revealed that the resident had intact cognition, was totally dependent for all care except for the locomotion of his electric wheelchair, and had (2) stage 4 pressure ulcers (one was present on admission). Review of the physician's orders on 06/21/17 revealed the treatment order for the Stage 4 pressure wound of the right Ischium (hip) was: Cleanse the wound with Dakin's 0.25% solution, apply Silver Alginate and cover with a dry protective dressing every day and evening shift. Observation of wound care on 06/21/17 at 10:15 AM was performed by the Infection Control Nurse and Nurse #6. The wound care physician was present to do wound care and measure the wounds. The dressing on the right hip wound was dated "6/20" with initials "TA". The wound was measured by the physician. He stated the wound on the right hip was improving with a decreased amount of exudate. In an interview with Resident #1 on 6/21/17 at 10:45 AM he stated that the dressing on his right hip was only changed by nursing once a day. In an interview with Nurse #6 on 6/21/17 at 10:50 AM she confirmed that the initials on the	F 224	being completed timely and as ordered by the physician. 3. Systemic measures being implemented to ensure the same alleged deficient practice does not recur are: Licensed staff will be re-educated by the Director of Nursing or designee regarding signing off on the treatment administration record (TAR) after the treatment is completed and not before. Licensed staff will also be re-educated regarding time management, notification of supervisor if unable to complete duties timely and teamwork between the shifts. The Director of Nursing or designee will audit the TARs for completion and monitor the nurses signing the TAR after the treatment has been completed 3 times a week for 4 weeks and then 3 times monthly for 2 months. Negative findings will be addressed at the time noted. Results of the weekly audits will be reviewed on Fridays during the Interdisciplinary Team meeting. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial compliance.	

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F 224	Continued From page 6	F 224		

dressings that were removed were hers from day shift on 6/20/17. She said that she did the dressing change at 1:00 PM the day before. Nurse #6 stated that she had informed the oncoming second shift nurse that the dressing needed to be changed, Nurse #7.

In an interview with the physician on 6/21/17 at 2:40 PM he stated that the reason he ordered the dressing change twice a day to the right hip was because of a high amount of exudate from the wound and if left might cause an infection or could increase the risk for sepsis. He said he was suspicious that the resident may have developed Osteomyelitis at the same time the resident recently had pneumonia. He stated that he had given the resident a course of antibiotics which may have compensated for the lack of wound care and prevented an infection.

In an interview with the Director of Nursing (DON) on 06/21/17 at 4:05 PM she stated that she expected all treatments to be done by nursing as ordered by the physician. She reported that Nurse #7 had a history of time management problems. She said that the facility had offered several time to help her with her time management but that she had declined. She stated that Nurse #7, who worked second shift, often stayed to complete her work until two or three in the morning which was an overtime problem for administration.

In an interview with Nurse #7 on 6/21/17 at 4:45 PM she stated that on the evening shift of 06/20/17 she was very busy with two admissions; 1:1 care needed for a different resident and trouble with the computer. She stated that she had 4 or 5 tube feedings to attend to and some of

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F 224	Continued From page 7 them were bolus. She said she had to care for the whole unit with two nursing assistants and third shift had two nurses coming on. She stated that she expected them to help her (Nurse #8 and Nurse #9). She said she signed the Treatment Administration Record indicating that she had performed the dressing change because she intended to do it but ran out of time. She revealed that she did not do the dressing changes as documented. In an interview on 06/22/17 at 7:30 AM with Nurse #8, who relieved Nurse #7 on 06/20/17, she stated that she was not made aware that a dressing change had not been done and was not asked to do it by Nurse #7. In an interview on 06/22/17 at 10:28 AM with Nurse #9, who was the second nurse that relieved Nurse #7 on 06/20/17, she stated that she was not asked by Nurse #7 to change the resident's dressings. In an interview on 06/22/17 at 11:20 AM with Medication Aide #3, who worked the 500 hall, she stated that Resident #1 is alert and oriented and that he is reliable. In an interview on 06/22/17 at 11:25 AM with Nursing Assistant #3, who worked on the hall with Resident #1, she stated that he is reliable but on occasion his days run together from being inside.	F 224		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility	F 309		8/6/17

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F 309	Continued From page 8 residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to put nutrition interventions in place to promote arterial/venous wound healing for 1 of 3 residents (Resident # 79) reviewed for non-pressure wounds. The	F 309	1. Resident # 79 was ordered house supplement 60ccs by mouth four times daily on 6/22/17 and Decubivite 1 by mouth daily times 60 days on 6/23/17. Resident # 79 care plan was updated accordingly. Resident # 85 skin was	

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F 309	Continued From page 9 facility also failed to assess and treat a lower extremity non-pressure wound for 1 of 3 residents (Resident # 85) reviewed for non-pressure wounds. Findings included: 1. Resident #79 was admitted to the facility on 03/02/11. The resident's documented diagnoses included chronic non-pressure ulcers of the feet, peripheral vascular disease (PVD), diabetes, and cerebrovascular accident (CVA) with hemiplegia. Review of Weekly Ulcer Records revealed on 02/02/17 a blister was identified on Resident #79's right heel. Lab results, obtained from specimens collected on 02/06/17, documented Resident #79's albumin level was low at 2.3 grams per deciliter (g/dL), and the resident's total protein was low at 6.1 g/dL. No reference ranges were provided. Review of Weekly Ulcer Records revealed on 02/20/17 peeling skin was identified on Resident #79's left heel. By 03/01/17 deterioration of the resident's wounds was identified through facility assessments as documented in their Weekly Ulcer Records. The 03/01/17 Wound Care Specialist Initial Evaluation documented Resident #79 had a stage III ulcer to his left heel measuring 2.4 x 2.5 centimeters (cm) with 10% black necrotic tissue, 10% granulation tissue, and 80% other tissue in the wound bed. The assessment also documented the resident had an unstageable deep tissue injury to his right heel measuring 3.8 x 3.9 cm. The facility's wound physician measured and assessed the resident's wounds/ulcers weekly thereafter.	F 309	assessed on 6/22/17 by nurse #1 and there were no skin impairments noted. 2. Residents with skin impairments are at risk for the same alleged deficient practice. Resident□s with skin impairments will be reviewed by the Director of Nursing or designee to ensure there are nutritional interventions implemented as needed, the residents have physician orders to treat the skin impairment and the orders have been transcribed and implemented. Residents will also be reviewed to ensure weekly skin assessments have been implemented. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur are: The District Director of Clinical Services will re-educate the Director of Nursing or designee regarding timeliness of reviewing the Registered Dietician recommendations, notifying the Physician or Physician□s Assistant regarding recommendations and obtaining and transcribing the orders as written. Registered Dietician was educated to check her recommendations weekly to ensure there was follow through by the Director of Nursing or designee. The Registered Dietician (RD) is to notify the Director of Nursing of any negative findings during the visit in which they are noted. Licensed staff will be re-educated by the Director of Nursing or designee regarding procedure for notification of physician and responsible party upon	

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F 309	Continued From page 10 A 03/08/17 physician order documented, "Decubi-vite one capsule QD (daily) for wound healing per RD (registered dietitian) recommendation. Please provide large protein portion with meals." Review of Resident #79's medication administration record (MAR) documented he received Decubi-vite from 03/09/17 through 05/07/17. At 11:52 AM on 06/22/17 the RD stated there was no electronic record of the dietary department receiving a diet order communication documenting that Resident #79 was supposed to receive large protein portions with meals. Resident #79's 04/08/17 quarterly minimum data set (MDS) documented his cognition was intact, he exhibited no behaviors including resistance of care, he required extensive assistance from a staff member for most of his activities of daily living (ADLs), and he had one stage II and one unstageable ulcer with eschar being the most severe tissue. The assessment also documented the resident had pressure relief devices for the bed and chair, nutrition interventions, the application of ointments, and medications were in place to promote wound healing. Review of Weekly Ulcer Records revealed on 04/19/17 another wound/ulcer was found on Resident #79's left proximal medial foot. Review of weekly Wound Care Specialist Evaluations revealed the facility was notifying the wound physician of changes in Resident #79's wounds, and the wound physician was	F 309	changes in a resident□s skin integrity, obtaining and transcribing physician orders for new skin impairment and the proper procedure for conducting a skin assessment. The Registered Dietician will meet with the Director of Nursing or designee and review the current week□s RD recommendations to promote wound healing and weight stabilization for appropriateness. The previous week□s recommendations related to wound healing or weight stabilization will be audited by the Director of Nursing or designee weekly times 4 weeks and then monthly times 2 months to ensure the Physician or Physician Assistant was notified, the orders were received and transcribed and implemented. The Director of Nursing or designee will observe 3 skin assessments weekly to ensure accuracy and the proper procedure is followed should new impairments be noted. The audits will be conducted times 4 weeks then monthly for 2 months and the results of the weekly audits will be reviewed during the Interdisciplinary meeting on Friday. Negative findings will be addressed at the time noted. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial	

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implementing new treatments when the wounds were not healing.

A 04/21/17 ultrasound report documented, "Evidence of PVD bilaterally, right greater than left. Plaque with indirect evidence of a right femoral artery stenosis. Blunted arterial flow distally in both legs, moderate ischemia."

Resident #79's 05/03/17 Wound Care Specialist Evaluation (the last assessment prior to the resident's Decubi-vite being discontinued on 05/07/17) documented Resident #79's unstageable right heel wound measured 6 x 7 x 0.3 cm with 10% necrotic tissue and 90% granulation tissue in the wound bed. The resident's stage III left heel wound measured 1.9 x 2.2 x 0.3 cm with 100% granulation tissue. The resident's left proximal medial foot wound measured 4.5 x 5.5 x 0.3 cm with 30% black necrotic eschar and 70% skin in the wound bed (this wound was not staged).

A 05/18/17 hospital Discharge Summary documented Resident #97 was hospitalized between 05/16/17 and 05/18/17 for foot ulcer arterogram, left anterior tibial angioplasty, debridement of wounds on bilateral feet, and wound vac placement on the right foot.

Resident #79's 05/25/17 significant change MDS documented his cognition was intact, he exhibited no behaviors including resistance of care, he required extensive assistance from a staff member for most of his activities of daily living (ADLs), he had one stage III and one unstageable ulcer and a foot infection.

The RD's 05/27/17 Nutrition Note documented,

compliance.

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"Resident (#79) with 75-100% meal intake...noting wt (weight) decrease and skin impairment suggest 60 cc (cubic centimeters) house med pass QID (four times daily) to provide 480 kcal (kilocalories) and 20 g (grams) of protein, decubi-vite x 60 days..."

A 06/12/17 physician order placed Resident #79 on palliative care (although the assistant director of nursing reported the facility had been trying to get the resident's family to agree to palliative care since April 2017).

The RD's 06/21/2017 Nutrition Note documented, "...suggest use of decubi-vite x 60 days and use of house med pass 60 cc TID (three times daily) to provide additional 360 kcals and 15 g of protein to diet to aid in wound healing and to promote a stable weight..."

Resident #79's care plan, last updated on 06/21/17, documented, "____ (name of resident) has wounds to bilateral heels/left proximal foot." None of the interventions for this problem concerned nutrition support to promote wound healing.

During an observation of wound treatment/assessment and interview with the wound physician on 6/21/17 at 11:50 AM the physician stated he had followed Resident #79 weekly since blisters had opened on the resident's heels. He reported the resident had cellulitis of his left leg, and then developed a wound on the left proximal medial foot on 04/19/17. The physician commented Resident #79 was extremely compromised because he had both arterial and venous problems of a severe nature. According to the physician, he found a

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new area to the resident's right distal medial foot on 06/14/17 with spotty eschar. The physician stated the resident has advanced PVD with no palpable pulses in his feet. The doctor removed gauze/dressings dated 06/20/17. The left lateral foot wound consisted of three separate spots with the total wound area measuring 5.5 x 5.5 cm, and the spot on ankle almost completely healed. The wound bed consisted of 70% skin, 10% granulation tissue, and 20% necrotic tissue. The physician decided to continue treating with silver alginate. The resident's left heel wound measured 0.7 x 0.7 cm, and the physician remarked this area was much improved. The physician commented the wound was 100% scab, and he changed the treatment to skin prep. The resident's right distal medial foot wound measured 6.5 x 2.5 cm, and was 100% dry eschar. The resident's right heel wound measure 6 x 6.5 x 0.3 cm with 50% eschar, 45% necrosis, and 5% granulation tissue. The wound physician stated vascular revitalization attempts of the right heel had been unsuccessful, and the wound was not healing and would likely not heal due to extreme arterial and venous insufficiency.

A 06/22/17 review of the resident's June MAR revealed Resident #79 was still not receiving the Decubi-vite or the house nutritional supplement (which were first recommended by the RD on 05/27/17).

At 8:48 AM on 06/22/17 Resident #79 was observed eating breakfast in his room. He ate the one sausage patty that he received (review of the dietary spreadsheet revealed residents on a regular diet received one sausage patty and those residents on large protein portions were supposed to receive two patties). Review of the

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resident's tray slips revealed no documentation that the resident was to receive large protein portions at meals.

At 10:46 AM on 06/22/17 the RD stated she was in the building twice a week, and tried to provide nutritional assessments for residents with pressure ulcers monthly and as needed for those residents with other types of wounds such as arterial/venous and surgical. She reported extra protein and Decubi-vite (which contained vitamin C and zinc) were her primary interventions for wound healing. She commented after each of her visits she provided a list of her recommendations to the director of nursing (DON), assistant director of nursing (ADON), and unit managers. According to the RD, it was not until her next monthly assessment that she checked to make sure her recommendations were implemented. The RD explained that was the reason she repeated her nutrition recommendations for Resident #79 on 06/21/17 because she realized these same recommendations which she made on 05/27/17 were not implemented.

At 11:02 AM on 06/22/17 the ADON/acting unit manager stated between two physician assistants (PAs) a member of the physician's care team was in the facility daily. She reported these PAs were very agreeable to the RD's nutrition recommendations. She explained if the recommendations were shown to them, they would immediately write orders to make sure they were implemented. However, the ADON commented she did not realize RD recommendations were included in her big stack of inter-facility mail which had accumulated. She stated she had just not had time to go completely

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through this backlog of mail.

At 12:08 PM on 06/22/17, during a follow-up interview with the wound physician via phone, he stated he believed in an interdisciplinary approach to wound healing. He reported his recommended nutritional approach to healing all wounds was to provide protein and vitamins/minerals such as vitamin C and zinc. However, he commented residents differed in how their bodies utilized these nutrients. The physician stated he was not sure good nutrition could really promote the healing of Resident #79's right heel, but the facility needed to implement nutrition interventions to make sure the resident's other wounds did not follow the same course of deterioration as the right heel.

At 1:42 PM on 06/22/17 Resident #79 stated he could not remember staff asking him about the foods he liked and would be willing to eat. He reported smoked sausage, "chops", and milk were some of his favorite foods. He commented he had not drunk liquid nutrition supplements before, but he would be willing to try them. According to the resident, he received enough food, and he never felt hungry between meals.

At 2:28 PM on 06/22/17 PA #1 stated she was agreeable to the RD's recommendations. However, she reported she did not remember getting nutrition recommendations for Resident #79 in the last couple of months. She commented the resident's arterial and venous circulation was extremely compromised, and he was on palliative care (a physician order placed him on palliative care on 06/12/17). According to the PA, Resident #79's creatinine was stable so he should be able to handle protein and nutrition

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supplementation products. The PA stated the facility usually wanted residents with wounds to receive extra protein and a product with vitamin C and zinc in it. She reported she was not sure nutrition interventions could promote healing of the resident's right heel wound, but the facility needed to try everything possible to prevent possible amputations.

At 2:36 PM on 06/22/17 certified medication aide (CMA) #2 stated Resident #79 ate about 50 - 75% of his meals. She reported he never complained about the food or asked for any specific foods. She commented the resident was very agreeable, and would try whatever food or nutritional supplements were put in front of him.

At 3:02 PM on 06/22/17 the DON stated the RD provided a list of nutrition recommendations after each of her visits, but if interventions were urgent she could go straight to one of the PAs who were in the building daily to get an order. She commented she expected the RD to follow-up and make sure her recommendations were implemented.

2. Review of the Quarterly Minimum Data Set dated 06/08/17 revealed Resident #85 was admitted to the facility on 11/13/13 with diagnoses of non-Alzheimer's dementia, chronic kidney disease, and atrial fibrillation. Resident #85 was cognitively aware and was dependent on one person for dressing, toilet use and hygiene. There was no application of non-surgical dressings noted.

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Review of the April, May and June 2017 Treatment Administration Records (TAR) revealed no wound care orders for Resident #85.

Review of the April, May and June 2017 Weekly Non-pressure Condition records revealed no wound care assessments for Resident #85.

In an observation of care on 06/22/17 at 9:41 AM Nursing Assistant (NA) #1 provided a bed bath to Resident #85. During the bath, a wound dressing with an adhesive border was seen on the side of Resident #85's lower left leg. The dressing was dated 04/26 and had a set of initials above the date.

In an interview with Resident #85 directly following the bath, she indicated she did not know why she had a wound dressing on her leg and could not remember if she had received an injury there.

In an interview and observation on 06/22/17 at 10:32 AM Nurse #1 stated he was unaware Resident #85 had a wound dressing on her left lower leg. He proceeded to uncover Resident #85's left lower leg and confirmed the date on the initialed wound dressing was 04/26. Nurse #1 removed the wound dressing from Resident #85's leg. The dressing contained a quarter sized, dark brown dried area, with raised edges. Nurse #1 acknowledged the drainage on the dressing but stated the wound had healed.

In a telephone interview on 06/22/17 at 3:18 PM Nurse #3 stated she had never been informed that Resident #85 had a wound.

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F 309	Continued From page 18 In an interview on 06/22/17 at 3:22 PM Nurse #4, whose initials were on the dressing, stated he could not remember anything about the wound to Resident #85's leg. He indicated he should have notified Resident #85's Physician for a treatment order and transcribed it onto the Treatment Administration Record (TAR). He acknowledged he had not done this. In an interview on 06/22/17 at 4:40 PM Unit Manager #1 stated if a resident received an injury the nurse should notify the Physician and get an order for treatment. UM #1 stated the wound should be assessed weekly. In an interview on 06/22/17 at 4:53 PM the Director of Nursing (DON) stated it was her expectation that the Nurse notify the Physician of any injury, get an order for treatment, put it on the TAR and pass the information on in report. She indicated she expected weekly assessments of wounds to be performed.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 314		8/6/17

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F 314	Continued From page 19 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident, and physician interviews, the facility failed to provide pressure wound care as ordered by the physician for 1 of 1 residents (Resident # 1) reviewed for pressure wounds. Findings included: Record review revealed that Resident #1 re-entered the facility on 02/20/14 and had a diagnosis of Quadriplegia. Review of the resident's care plan dated 04/03/17 included the following areas: Limited physical mobility related to neurological deficits-quadriplegia; At risk for further skin breakdown related to impaired mobility and incontinence; Failed surgical wound/pressure ulcer to his right buttock/hip; and Actual impairment to skin integrity of the right ischial tuberosity related to failed surgical flap and right heel wound. Included in the interventions for pressure ulcer care was to administer treatments as ordered and observe for effectiveness. Review of the Annual Minimum Data Set (MDS) dated 04/04/17 revealed that the resident had intact cognition, was totally dependent for all care except for the locomotion of his electric wheelchair, and had (2) stage 4 pressure ulcers (one was present on admission). Review of the physician ' s orders on 06/21/17	F 314	1. Resident # 1□s dressing was changed at 10:15 a.m. on 6/21/17 and there was no negative outcome noted. The wound care physician noted the wound was actually improving and had a decreased amount of exudate. Nurse #7 was counseled and re-educated regarding following physician orders and the procedure for notifying the direct supervisor if unable to complete the duties of the assignment in a timely manner. 2. Other residents with skin impairments are at risk for the same alleged deficient practice and will be reviewed by the Director of Nursing to ensure the treatments and documentation are being completed timely and as ordered by the physician. 3. Systemic measures being implemented to ensure the same alleged deficient practice does not recur are: Licensed staff will be re-educated by the Director of Nursing or designee regarding signing off on the treatment administration record (TAR) after the treatment is completed and not before. Licensed staff will also be re-educated regarding time management, notification of supervisor if unable to complete duties timely and teamwork between the shifts. The Director of Nursing or designee will audit the TARs	

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F 314	Continued From page 20 revealed the treatment order for the Stage 4 pressure wound of the right Ischium (hip) was: Cleanse the wound with Dakin ' s 0.25% solution, apply Silver Alginate and cover with a dry protective dressing every day and evening shift. Observation of wound care on 06/21/17 at 10:15 AM was performed by the Infection Control Nurse and Nurse #6. The wound care physician was present to do wound care and measure the wound. The dressing on the right hip wound was dated "6/20" with initials "TA". The wound was measured by the physician. He stated the wound on the right hip was improving with a decreased amount of exudate. In an interview with Resident #1 on 6/21/17 at 10:45 AM he stated that the dressing on his right hip was only changed by nursing once a day. In an interview with Nurse #6 on 6/21/17 at 10:50 AM she confirmed that the initials on the dressings that were removed were hers from day shift on 6/20/17. She said that she did the dressing change at 1:00 PM the day before. Nurse #6 stated that she had informed the oncoming second shift nurse that the dressing needed to be changed, Nurse #7. In an interview with the physician on 6/21/17 at 2:40 PM he stated that the reason he ordered the dressing change twice a day to the right hip was because of a high amount of exudate from the wound and if left might cause an infection or could increase the risk for sepsis. He said he was suspicious that the resident may have developed Osteomyelitis at the same time the resident recently had pneumonia. He stated that he had given the resident a course of antibiotics	F 314	for completion and monitor the nurses signing the TAR after the treatment has been completed 3 times a week for 4 weeks and then 3 times monthly for 2 months. Negative findings will be addressed at the time noted. Results of the weekly audits will be reviewed on Fridays during the Interdisciplinary Team meeting. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial compliance.	

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which may have compensated for the lack of wound care and prevented an infection.

In an interview with the Director of Nursing (DON) on 06/21/17 at 4:05 PM she stated that she expected all treatments to be done by nursing as ordered by the physician. She reported that Nurse #7 had a history of time management problems. She said that the facility had offered several time to help her with her time managment but that she had declined. She stated that Nurse #7, who worked second shift, often stayed to complete her work until two or three in the morning which was an overtime problem for administration.

In an interview with Nurse #7 on 6/21/17 at 4:45 PM she stated that on the evening shift of 06/20/17 she was very busy with two admissions; 1:1 care needed for a different resident and trouble with the computer. She stated that she had 4 or 5 tube feedings to attend to and some of them were bolus. She said she had to care for the whole unit with two nursing assistants and third shift had two nurses coming on. She stated that she expected them to help her (Nurse #8 and Nurse #9). She said she signed the Treatment Administration Record indicating that she had performed the dressing changes because she intended to do it but ran out of time. She revealed that she did not do the dressing changes as documented.

In an interview on 06/22/17 at 7:30 AM with Nurse #8, who relieved Nurse #7 on 06/20/17, she stated that she was not made aware that a dressing change had not been done and was not asked to do it by Nurse #7.

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F 314	Continued From page 22 In an interview on 06/22/17 at 10:28 AM with Nurse #9, who was the second nurse that relieved Nurse #7 on 06/20/17, she stated that she was not asked by Nurse #7 to change the resident's dressings. In an interview on 06/22/17 at 11:20 AM with Medication Aide #3, who worked the 500 hall, she stated that Resident #1 is alert and oriented and that he is reliable. In an interview on 06/22/17 at 11:25 AM with Nursing Assistant #3, who worked on the hall with Resident #1, she stated that he is reliable but on occasion his days run together from being inside.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 325		8/6/17

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F 325	Continued From page 23 Based on physician assistant interview, resident interview, staff interview, and record review the facility failed to put nutrition interventions in place to prevent or halt significant weight loss for 1 of 5 residents (Resident # 79) reviewed for nutrition. Findings included: Resident #79 was admitted to the facility on 03/02/11. The resident's documented diagnoses included diabetes, hypertension, esophageal reflux, chronic non-pressure ulcers of the feet, and cerebrovascular accident (CVA) with hemiplegia. The resident's weight summary documented he weighed 196.4 pounds on 01/23/17. A 03/08/17 physician order documented, "Decubi-vite one capsule QD (daily) for wound healing per RD (registered dietitian) recommendation. Please provide large protein portion with meals." (A 06/22/17 11:52 AM review of the computer system by the facility's registered dietitian revealed the dietary department had never received a diet order communication form to implement the large protein portions). The resident's weight summary documented he weighed 184.6 pounds on 03/27/17. (The resident lost 11.8 pounds, and experienced a 6% weight loss between 01/23/17 and 03/27/17). The registered dietitian's 03/27/2017 Nutrition Note documented Resident #79 was on a consistent carbohydrate, no-added salt diet with large protein portions (which he was not receiving). She also documented the resident was receiving Decubi-vite daily, and his "current diet and supplement encourage wt	F 325	1. Resident # 79 was ordered house supplement 60ccs by mouth four times daily on 6/22/17 and Decubivite 1 by mouth daily times 60 days on 6/23/17. Resident # 79 care plan was updated accordingly. Resident # 85 skin was assessed on 6/22/17 by nurse #1 and there were no skin impairments noted. 2. Residents with skin impairments are at risk for the same alleged deficient practice. Registered Dietician was educated by the Director of nursing to check her recommendations weekly to ensure there was follow through. The Registered Dietician (RD) is to notify the Director of Nursing of any negative findings during the visit in which they are noted. Licensed staff will be re-educated by the Director of Nursing or designee regarding procedure for notification of physician and responsible party upon changes in a resident□s skin integrity, obtaining and transcribing physician orders for new skin impairment and the proper procedure for conducting a skin assessment. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur are: The Registered Dietician will meet with the Director of Nursing or designee and review the current week□s RD recommendations to promote wound healing and weight stabilization for appropriateness. The previous week□s recommendations related to wound healing or weight stabilization will be audited by the Director of Nursing or designee weekly for 4	

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F 325	Continued From page 24 (weight) maintenance and improvement in skin integrity." Resident #79's 04/08/17 quarterly minimum data set (MDS) documented his cognition was intact, he exhibited no behaviors including resistance of care, he required supervision (oversight, encouragement, or cueing) with set-up help only from a staff member with eating, he was 5' 11" tall and weighed 185 pounds, he experienced significant weight loss, he was on a therapeutic diet, and he had one stage II and one unstageable ulcer. The resident's weight summary documented he weighed 184.6 pounds on 04/10/17 and 170.4 pounds on 05/15/17. (The resident lost 14.2 pounds, and experienced a 7.7% weight loss in one month between 04/10/17 and 05/15/17). Resident #79's 05/25/17 significant change MDS documented his cognition was intact, he exhibited no behaviors including resistance of care, he required supervision (oversight, encouragement, or cueing) with assistance from a staff member with eating, he was 5' 11" tall and weighed 170 pounds, he experienced significant weight loss, and he had one stage III and one unstageable ulcer and a foot infection. The RD's 05/27/17 Nutrition Note documented, "Resident (#79) with 75-100% meal intake...noting wt (weight) decrease and skin impairment suggest 60 cc (cubic centimeters) house med pass QID (four times daily) to provide 480 kcal (kilocalories) and 20 g (grams) of protein, decubi-vite x 60 days..." The resident's weight summary documented he	F 325	weeks and then monthly times 2 months to ensure the Physician or Physician Assistant was notified, the orders were received, transcribed and implemented. The results of all audits will be reviewed during the Interdisciplinary Team meeting on Fridays. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial compliance.	

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weighed 172.3 pounds on 06/14/17.

The RD's 06/21/2017 Nutrition Note documented, "...suggest use of decubi-vite x 60 days and use of house med pass 60 cc TID (three times daily) to provide additional 360 kcals and 15 g of protein to diet to aid in wound healing and to promote a stable weight..."

The resident's care plan, last updated on 06/22/17, identified, "____ (name of resident) is at risk for weight changes" as a problem. Interventions to this problem included, "Determine individual likes and dislikes", "Provide, serve diet as ordered", "RD to evaluate and make diet change recommendations PRN (as needed)", and "Will provide supplements as ordered."

A 06/22/17 review of the resident's June MAR revealed Resident #79 was still not receiving the Decubi-vite or the house nutritional supplement (which were first recommended by the RD on 05/27/17).

At 10:46 AM on 06/22/17 the RD stated she was in the building twice a week. She reported she first recommended med pass supplement for Resident #79 on 05/27/17 because she hoped it would promote weight gain as well as provide some extra protein for wound healing. She commented after each of her visits she provided a list of her recommendations to the director of nursing (DON), assistant director of nursing (ADON), and unit managers. According to the RD, it was not until her next monthly follow-up assessment for residents that experienced significant weight loss that she checked to make sure her recommendations from the initial

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assessment were implemented. The RD explained that was the reason she repeated her nutrition recommendations for Resident #79 on 06/21/17 because she realized these same recommendations which she made on 05/27/17 were not implemented.

At 11:02 AM on 06/22/17 the ADON/acting unit manager stated between two physician assistants (PAs) a member of the physician's care team was in the facility daily. She reported these PAs were very agreeable to the RD's nutrition recommendations. She explained if the recommendations were shown to them, they would immediately write orders to make sure they were implemented. However, the ADON commented she did not realize RD recommendations were included in her big stack of inter-facility mail which had accumulated. She stated she had just not had time to go completely through this backlog of mail.

At 1:42 PM on 06/22/17 Resident #79 stated he could not remember staff asking him about the foods he liked and would be willing to eat. He reported smoked sausage, "chops", and milk were some of his favorite foods. He commented he had not drunk liquid nutrition supplements before, but he would be willing to try them. According to the resident, he received enough food, and he never felt hungry between meals.

At 2:28 PM on 06/22/17 PA #1 stated she was agreeable to the RD's recommendations. However, she reported she did not remember getting nutrition recommendations for Resident #79 in the last couple of months. She commented providing the resident with good nutrition, promoting a healthy weight, and

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preventing weight loss for the resident would be important since he had multiple wounds which needed healing. However, she stated the resident was very compromised with severe circulation problems, and was placed on palliative care (per physician order on 06/12/17) so the resident might experience some weight loss due to his declining condition.

At 2:32 PM on 06/22/17 nursing assistant (NA) #2 stated Resident #79 ate between 50% and 75% of his breakfast and lunch. She reported the resident just did not seem that enthused about the food he was served in general, but she commented she was not sure if the resident had any cravings for specific foods or if there were food items which the kitchen stocked that the resident might be more enthusiastic about rather than what was served on his plate. She explained the resident ate what he wanted off his meal trays, and did not ask for alternates or anything special.

At 2:36 PM on 06/22/17 certified medication aide (CMA) #2 stated Resident #79 ate about 50 - 75% of his meals. She reported he never complained about the food or asked for any specific foods. She commented the resident was very agreeable, and would try whatever food or nutritional supplements were put in front of him. The CMA stated since she had cared for Resident #79 she had never administered med pass to the resident.

At 3:02 PM on 06/22/17 the DON stated the RD provided a list of nutrition recommendations after each of her visits, but if interventions were urgent she could go straight to one of the PAs who were in the building daily to get an order. She

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F 325	Continued From page 28 commented she expected the RD to follow-up and make sure her recommendations were implemented.	F 325		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to clean dusty and dirty light fixtures in the kitchen and failed to prevent the risk of cross contamination during food preparation tasks. Findings included:	F 371	The light panels in the kitchen were cleaned on 7/14/17 by the Maintenance Manager. The food preparation table was sanitized on 6/21/17 prior to another work activity by the Cook after the observation was made known to her. On 6/21/17 the	8/6/17

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F 371	Continued From page 29 1. During initial tour of the kitchen on 06/19/17, beginning at 11:45 AM, there was a thick coating of dust and dirt on three fluorescent light panels in the kitchen. Both ends of the fluorescent light panel above food preparation sinks were very dusty and dirty, one side of the fluorescent light panel above hanging utensils was very dusty and dirty, and one side of the fluorescent light panel above a storage shelf of sanitized kitchenware in the dish machine area was very dusty and dirty. During a follow-up tour of the kitchen on 06/21/17, beginning at 9:05 AM, there was a thick coating of dust and dirt on three fluorescent light panels in the kitchen. Both ends of the fluorescent light panel above food preparation sinks were very dusty and dirty, one side of the fluorescent light panel above hanging utensils was very dusty and dirty, and one side of the fluorescent light panel above a storage shelf of sanitized kitchenware in the dish machine area was very dusty and dirty. At 11:24 AM on 06/22/17 a cook/dietary aide stated she thought the maintenance department cleaned the light fixtures in the kitchen because they were so high up in the ceiling. She reported they should be kept free from dust and dirt because these contaminates could fall onto sanitized kitchenware and into the food which could make residents sick. At 11:28 AM on 06/22/17 the dietary manager (DM) stated he had recently arrived in the facility, but he thought the maintenance manager was supposed to clean light fixtures, vents, and ceiling fans every two to three weeks to make sure they were free of dust and dirt which could cross-contaminate food and kitchenware.	F 371	Cook ran the Robot Coupe through the three-compartment sink sanitizing system after the observation was made known to her. Other areas are at risk for the same alleged deficient practice. Dietary staff will be re-educated by the Dietary Manager or his designee on cross contamination prevention by reporting maintenance needs when observed to the Maintenance Manager; sanitizing the food preparation table after each work activity; using the three compartment sink sanitizing system for kitchenware, including the Robot Coupe; and other cross contamination practices/risks . Systemic measures implemented to ensure the same alleged deficient practice does not reoccur are: The fluorescent light panels in the kitchen will be inspected for cleanliness and cleaned monthly as needed by the Maintenance Manager. The Dietary Manager or his designee will do staff observations 3 times a week for 4 weeks, 1 time a week for the next 4 weeks, and then monthly to monitor for cross contamination conditions. The Nursing Home Administrator or her designee will audit the kitchen monthly for maintenance issues and dietary staff practices resulting in possible cross contamination. The results of the weekly and monthly audits will be reviewed during Interdisciplinary meeting on Fridays. Negative findings will be addressed at the time noted.	

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F 371	Continued From page 30 At 1:52 PM on 06/22/17 the maintenance manager (MM) stated he cleaned the vents, lights, and ceiling fans in the kitchen about three times a year. He reported the last time he did such cleaning was about three of four months ago. He commented his kitchen cleaning was not conducted on a set schedule, but he tried to fit it in when he could. 2. During food preparation observation at 9:20 AM on 06/21/17 the cook set three boxes on top of her food preparation table. At 9:29 AM on 06/21/17 2 of 3 of the boxes had been removed from the food preparation table, but in the same area where they had been sitting the cook had placed a knife, spatula, and scoop. The cook had not sanitized this work surface between 9:20 AM and 9:29 AM. At 11:24 AM on 06/22/17 a cook/dietary aide stated she was in-serviced that boxes and cans were to be transported and kept on a cart, and they were not to be set on food preparation tables. She reported these boxes were transported in trucks and had been in storage shelving so they could spread germs. At 11:28 AM on 06/22/17 the dietary manager (DM) stated he had not really thought about the possible outcome of sitting boxes on the food preparation tables, and the scenario had not come up for discussion among dietary employees before. Therefore, he reported the dietary staff had not been in-serviced on this practice which could cause cross-contamination when utensils were placed on the prep tables where boxes had been sitting previously.	F 371	The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The Committee, under the direction of the Nursing Home Administrator, will monitor for negative patterns/trends, and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial compliance.	

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F 371	Continued From page 31 3. During food preparation observation at 10:10 AM on 06/21/17 the cook pureed sweet potatoes in the Robot Coupe (food processor). At 10:20 AM on 06/21/17 the cook washed the Robot Coupe out using running water only at the one-compartment sink built into the food preparation table. At 10:24 AM on 06/21/17 the cook was getting ready to puree hamburger steak. She had not run the Robot Coupe through the three-compartment sink sanitizing system or the dish machine. At this time the dietary manager (DM) stated the Robot Coupe was to be sanitized between food preparation tasks. At 11:24 AM on 06/22/17 a cook/dietary aide stated she was in-serviced to run kitchenware, including the Robot Coupe, through the three-compartment sink sanitizing system between food preparation tasks. She reported this helped to prevent cross-contamination which could potentially make residents sick.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431		8/6/17

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that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the

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F 431	Continued From page 33 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to discard expired medications, remove medications for orders that had been discontinued, and to remove medication for a resident who had been discharged from from 1 of 4 medication carts (200 Hall Cart) reviewed for medication storage. Findings included: An observation of the medication cart on the 200 Hall on 6/22/17 at 2:50 PM revealed: 1. One inhaler of Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/Dose (medication used for treating or preventing breathing problems), which was undated when it was first used and was supposed to be disposed of 1 month after opening, but had a dispense date of 5/2/17. 2. One bottle of Prolensa 0.07% ophthalmic solution (a nonsteroidal anti-inflammatory drug (NSAID))medication eye drop used to reduce and prevent pain and swelling after eye surgery), with an order to discontinue the medication on 5/12/17. 3. One bottle of Procrit (medication used to treat anemia), for a resident who was discharged from the facility on 6/9/17. During an interview with Nurse on 06/22/17 at 3:00 PM, Nurse #1 verified that there was no date on the Advair and that it should have been discarded according to the dispense date of 5/2/17, that the bottle of Prolensa had been	F 431	1. One Advair Diskus, one bottle of Prolensa 0.07% ophthalmic solution and one bottle of Procrit was discarded when noted on 6/22/17 by nurse #1. 2. All medication carts were checked for expired medications or medications of discharged residents on 6/22/17 and these medications were discarded immediately. The Director of Nursing re-educated nurse #1 regarding medication storage, labeling, discarding expired medications and removing medications of discharged resident from the cart and returning them to pharmacy on 6/22/17. 3. Systemic measures implemented to prevent the same alleged deficient practice from recurring are: Licensed staff and Certified Medication Aides will be re-educated on the proper labeling of medications, expired medications and removing discharged resident□s medications from the cart by the Director of Nursing or designee. The Director of Nursing or designee will conduct weekly audits of all medication carts times 4 weeks and then monthly times 2 to ensure proper labeling of medications, expired medications are discarded and discharged residents do not have medications on the cart. The results of the weekly audits will be reviewed on Fridays during the Interdisciplinary Team	

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F 431	Continued From page 34 discontinued, was no longer in use, and should have been taken from the card, and that the Procrit should have been discarded or returned to the pharmacy because the resident had discharged from the facility. Nurse #1 indicated he was not sure why the medications had not been disposed of and removed them from the cart. He reported that he had administered the Advair in the morning of 6/22/17 without any negative outcome for the resident, but the resident had a new diskus in the drawer and he would place the new one in service and throw out the old one. Nurse # 1 expressed understand of the importance of having medications properly labeled and of disposing of expired medications and medications no longer in use. During an interview with the DON (Director of Nursing) on 06/22/17 at 5:40 PM, The DON indicated that it was her expectation that the medications are labeled when opened and disposed of when expired and that medications be discarded or sent back to the pharmacy when they are discontinued or when residents discharge from the facility.	F 431	meeting for 4 weeks. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial compliance.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 514		8/6/17

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F 514	Continued From page 35 (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to accurately document skin assessments for 1 of 5 residents (Resident #85) and failed to accurately document wound care for 2 of 5 residents (Resident #85 and Resident #1). Findings included: 1. Review of the Quarterly Minimum Data Set dated 06/08/17 revealed Resident #85 was admitted to the facility on 11/13/13 with diagnoses of non-Alzheimer's dementia, chronic kidney disease, and atrial fibrillation. Resident #85 was cognitively aware and was dependent on one	F 514	1. A skin assessment was completed by the Director of Nursing and Nurse #1 on resident # 85 and the skin was found to be intact. Resident #85 had no wound therefore no orders were obtained nor treatment provided. Wound care was provided to Resident #1 on 6/21/17 as ordered by the physician. 2. Other resident□s with wounds are at risk for the same alleged deficient practice and will be reviewed by the Director of Nursing or designee to ensure physician orders have been obtained and	

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F 514	Continued From page 36 person for dressing, toilet use and hygiene. There was no application of non-surgical dressings noted. Review of the April 2017 Treatment Administration Record (TAR) revealed no wound care orders for Resident #85. Review of the April 2017 Medication Administration Record (MAR) revealed weekly skin checks were to be done on Saturdays during day shift. The skin check was to be documented in the computer. The 04/29/17 skin check was initialed as completed by Nurse #1. The corresponding Weekly Skin Assessment in the computer showed Resident #85 had intact skin. Review of the May 2017 TAR revealed no wound care orders for Resident #85. Review of the May 2017 MAR revealed weekly skin checks were to be done on Saturdays during day shift. The skin checks were to be documented in the computer. The 05/06/17 skin check was initialed as completed by Certified Medication Aide (CMA) #1 but had no corresponding skin assessment in the computer. The 05/13/17 skin check was initialed as completed by Nurse #5 and the corresponding skin assessment in the computer listed Resident #85 as having intact skin. The 05/20/17 and 05/27/17 skin checks were initialed as completed by Nurse #1 and the corresponding skin assessments showed Resident #85 as having intact skin. Review of the June 2017 TAR revealed no wound care orders for Resident #85.	F 514	transcribed correctly, treatments and skin checks are being completed timely and accurately and the Treatment Administration Record is not being signed until after the treatment has been completed. 3. Systemic measures being implemented to prevent the same alleged deficient practice does not recur are: The Director of Nursing or designee will observe 3 weekly skin assessments to ensure accuracy. Licensed staff will be re-educated by the Director of Nursing or designee regarding signing off on the treatment administration record (TAR) after the treatment is completed and not before. The Director of Nursing or designee will audit the TARs for completion and monitor the nurses signing the TAR after the treatment has been completed 3 times a week for 4 weeks and then 3 times monthly for 2 months. Negative findings will be addressed at the time noted. Results of the weekly audits will be reviewed on Fridays during the Interdisciplinary Team meeting. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial	

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Review of the June 2017 MAR revealed weekly skin checks were to be done on Saturdays during day shift. The skin checks were to be documented in the computer. The 06/03/17 skin check was initialed as being completed by Nurse #2 but had no corresponding skin assessment in the computer. The 06/10/17 skin check was initialed as completed by Nurse #1. The corresponding skin assessment was completed on 06/10/17 by Nurse #1 and listed Resident #85 as having intact skin. The 06/17/17 skin check was not initialed as completed (by Nurse #3) and there was no corresponding skin assessment in the computer.

In an observation of care on 06/22/17 at 9:41 AM Nursing Assistant (NA) #1 provided a bed bath to Resident #85. During the bath, a wound dressing with an adhesive border was seen on the side of Resident #85's lower left leg. The dressing was dated 04/26 and had a set of initials above the date.

In an interview and observation on 06/22/17 at 10:32 AM Nurse #1 stated he was unaware Resident #85 had a wound dressing on her left lower leg. He proceeded to uncover Resident #85's left lower leg and confirmed the date on the initialed wound dressing was 04/26. Nurse #1 removed the wound dressing from Resident #85's leg. The dressing contained a quarter sized, dark brown dried area, with raised edges. Nurse #1 acknowledged the drainage on the dressing but stated the wound had healed.

In an interview on 06/22/17 at 1:52 PM CMA #1 stated she incorrectly documented she performed the 05/06/17 skin check for Resident #85. She indicated she was not a nurse and could not

compliance.

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perform a skin assessment. CMA #1 stated she did not remember the nurse she was working with on 05/06/17 who should have done the skin check and the skin assessment.

In an interview on 06/22/17 at 2:04 PM Nurse #2 stated when a skin check was performed it was from head to toe. The resident was then turned over and the assessment was continued on the back side. Nurse #2 indicated she could not remember if she had completed the skin check or skin assessment for Resident #85 on 06/03/17. Nurse #2 reviewed the computer records and stated that although she had initialed that she had completed the skin check there was no skin assessment so she must not have done it. She indicated if she had done the skin assessment she would have seen the wound dressing on Resident #85's lower left leg that was dated 04/26.

In an interview on 06/22/17 at 2:15 PM Nurse #1 stated when a head to toe skin assessment was performed he looked for bruises and open areas. He indicated if Resident #85 had a dressing he would have seen it and if there was a dressing the skin was not intact. Nurse #1 admitted that he was more focused on Resident #85's buttocks area and did not pull the bed coverings down to look at the legs and feet. He indicated he did not know what kind of wound Resident #85 had under the dressing that he removed earlier as it was not on the Treatment Administration Record (TAR).

In a telephone interview on 06/22/17 at 3:18 PM Nurse #3 stated if the skin check was not initialed and the skin assessment was not in the computer then she did not do them. She indicated if she

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had done the skin check she would have seen the dressing on Resident #85's left lower leg.

In an interview on 06/22/17 at 3:22 PM Nurse #4 (whose initials were on the dressing) stated he did not remember anything about Resident #85's wound. He indicated he did not call the Physician to notify her of the wound and had not received an order for treatment.

In an interview on 06/22/17 at 3:51 PM the Staff Development Coordinator (SDC) stated a dressing should not be placed on a wound without an order from the physician.

In an interview on 06/22/17 at 4:40 PM Unit Manager (UM) #1 stated the skin checks were placed on the MAR to make sure they were completed. He indicated if the skin checks were initialed but the assessment was not done in the computer it was not considered to be complete. He indicated it was not an accurate assessment if the resident had a wound dressing and the skin assessment showed the skin as intact. UM #1 indicated an order for the wound dressing should have been received and transcribed to the TAR so the wound and dressing could have been monitored.

In an interview on 06/22/17 at 4:53 PM the Director of Nursing (DON) stated she expected the nurses to appropriately and accurately document skin checks and wound care in the resident record. She stated she expected Physician orders for wound care to be received and the MARs and TARs to be signed off accurately and correctly.

2. Record review revealed that Resident #1 re-entered the facility on 02/20/14 and had a

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diagnosis of Quadriplegia.

Review of the physician ' s orders on 06/21/17 revealed the treatment order for the Stage 4 pressure wound of the right Ischium (hip) was: Cleanse the wound with Dakin ' s 0.25% solution, apply Silver Alginate and cover with a dry protective dressing every day and evening shift.

Observation of wound care on 06/21/17 at 10:15 AM was performed by the Infection Control Nurse and Nurse #6. The dressing removed from the right hip wound was dated "6/20" with initials "TA".

In an interview with Resident #1 on 6/21/17 at 10:45 AM he stated that the dressing on his right hip was only changed by nursing once a day.

In an interview with Nurse #6 on 06/21/17 at 10:50 AM she confirmed that the initials on the dressings that were removed were hers from day shift on 6/20/17. She said that she did the dressing change at 1:00 PM the day before. Nurse #6 stated that she had informed the oncoming second shift nurse that the dressing needed to be changed, Nurse #7.

In an interview with the physician on 06/21/17 at 2:40 PM he stated that the reason he ordered the dressing change twice a day to the right hip was because of a high amount of exudate from the wound and if left might cause an infection or could increase the risk for sepsis.

In an interview with the Director of Nursing on 06/21/17 at 4:05 PM she stated that she expected all treatments to be done by nursing as ordered by the physician. She revealed that if a treatment was signed off by a nurse she expected that it

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F 514	Continued From page 41 was completed. In an interview with Nurse #7 on 06/21/17 at 4:45 PM she stated that on the evening shift of 06/20/17 she was very busy. She said she signed the Treatment Administration Record indicating that she had performed the dressing changes because she intended to do it. She revealed that she did not do the dressing changes as documented.	F 514		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and	F 520		8/6/17

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F 520	Continued From page 42 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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) program failed to prevent the reoccurrence of deficient practice related to maintaining the well being of residents which resulted in a repeat deficiency at F309. The facility's quality assurance program also failed to prevent the reoccurrence of deficient practice related to medication storage which resulted in a repeat deficiency at F431. The re-citing of F309 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: This tag is cross-referenced to: 1. F309: Well Being: Based on observation, physician interview, resident interview, staff interview, and record review the facility failed to put nutrition interventions in place to promote arterial/venous wound healing for 1 of 3 residents (Resident # 79) reviewed for non-pressure wounds. The facility also failed to assess and	F 520	1. Resident # 79 was ordered house supplement 60ccs by mouth four times daily on 6/22/17 and Decubivite 1 by mouth daily times 60 days on 6/23/17. Resident # 79 care plan was updated accordingly. Resident # 85 skin was assessed on 6/22/17 by nurse #1 and there were no skin impairments noted. One Advair Diskus, one bottle of Prolensa 0.07% ophthalmic solution and one bottle of Procrit was discarded when noted on 6/22/17 by nurse #1. 2. Residents with skin impairments are at risk for the same alleged deficient practice. Resident□s with skin impairments will be reviewed to ensure there are nutritional interventions implemented as needed, the residents have physician orders to treat the skin impairment and the orders have been transcribed and implemented. Residents will also be reviewed to ensure weekly skin assessments have been	

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F 520	Continued From page 43 treat a lower extremity non-pressure wound for 1 of 3 residents (Resident # 85) reviewed for non-pressure wounds. Record review revealed the facility was cited at F309 for not providing post-dialysis assessment during the facility's 08/16/16 recertification and complaint investigation survey. The facility was cited at F309 again during a 09/16/16 complaint investigation for not providing post-dialysis assessment and failure to administer medications as ordered by the physician. The facility was cited at F309 during the current 07/06/17 recertification and complaint investigation survey for failure to put nutrition interventions in place to help heal arterial/venous ulcers and failure to assess and treat a lower extremity non-pressure wound. In a phone interview with the director of nursing (DON) on 07/06/17 at 11:12 AM she stated she was not present in the facility for the facility's 2016 recertification survey. She reported even though the facility was cited at F309 multiple times over the past survey year, the areas of deficient practice were very different. She explained in 2016 the deficient practice revolved around lack of post-dialysis assessment and failure to administer medications as ordered. However, in 2017 she commented the deficient practice was very different because it concerned non-pressure wounds. According to the DON, the facility was attempting to improve on communication in its interdisciplinary processes. 2. F431: Medication Storage: Based on observations, record reviews and staff interviews, the facility failed to discard expired medications, remove medications for orders that had been	F 520	implemented. All medication carts were checked for expired medications or medications of discharged residents on 6/22/17 and these medications were discarded immediately. The Director of Nursing re-educated nurse #1 regarding medication storage, labeling and discarding expired medications and removing medications of discharged resident from the cart and returning them to pharmacy on 6/22/17. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur: Will schedule the Quality Improvement Organization (QIO) to educate the facility Quality Assurance Performance Committee on the QAPI process. The District Director of Clinical Services will re-educate the Director of Nursing or designee regarding timeliness of reviewing the Registered Dietician recommendations, notifying the Physician or Physician□s Assistant regarding recommendations and obtaining and transcribing the orders as written. Registered Dietician was educated to check her recommendations weekly to ensure there was follow through by the Director of Nursing or designee. The Registered Dietician (RD) is to notify the Director of Nursing of any negative findings during the visit in which they are noted. The Registered Dietician will meet with the Director of Nursing or designee and review the current week□s RD recommendations to promote wound healing and weight stabilization for appropriateness. The previous week□s	

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F 520	Continued From page 44 discontinued, and to remove medication for a resident who had been discharged from from 1 of 4 medication carts (200 Hall Cart) reviewed for medication storage. Record review revealed the facility was cited at F431 for failure to discard expired medications during the facility's 08/16/16 recertification and complaint investigation survey. The facility was cited at F431 again during a 03/15/17 complaint investigation for failure to store medications out of the reach of residents. The facility was cited at F431 during the current 07/06/17 recertification and complaint investigation survey for failure to discard expired medications and failure to remove medications for orders that had been discontinued and for residents who had been discharged. In a phone interview with the director of nursing (DON) on 07/06/17 at 11:12 AM she stated she was not present in the facility for the facility's 2016 recertification survey. She reported even though the facility was cited at F431 multiple times over the past survey year, the areas of deficient practice were varied and different. She explained in 2016 the issue was expired medications, but in 2017 the problem was with a nurse leaving medications unattended on a cart and medications not being removed from the cart when the order was discontinued or the resident was discharged. The DON commented she was surprised that medication storage was still an issue in 2017 because the facility did weekly cart audits, and there had been extensive in-servicing about removing from the medication carts expired medications and medications that were discontinued or belonged to residents who were discharged . She also reported the consultant	F 520	recommendations related to wound healing or weight stabilization will be audited by the Director of Nursing or designee to ensure the Physician or Physician Assistant was notified; the orders were received, transcribed and implemented. The audits will be conducted times 4 weeks then monthly for 2 months and the results of the weekly audits will be reviewed during the Interdisciplinary meeting on Friday. Negative findings will be addressed at the time noted. Licensed staff and Certified Medication Aides will be re-educated on the proper labeling of medications, expired medications and removing discharged resident□s medications from the cart by the Director of Nursing or designee. The Director of Nursing or designee will conduct weekly audits times 4 weeks and then monthly times 2 of all medication carts to ensure proper labeling of medications, expired medications are discarded and discharged residents do not have medications on the cart. The results of the weekly audits will be reviewed on Fridays during the Interdisciplinary Team meeting for 4 weeks. 4. The Quality Assessment Performance Improvement Committee shall review the results of all audits during the Quality Assessment Performance Improvement meeting monthly for 3 months. The District Director of Clinical Services (DDCS) will attend in person or via telephone the facilities Quality Assessment Performance Improvement	

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F 520	Continued From page 45 pharmacist completed cart audits at each visit, and this pharmacist had not reported any problems to her (the DON).	F 520	meeting for 3 months and minutes will be reviewed during facility visits for an additional 3 months to ensure the Committee is utilizing company tools to identify concerns in care areas. The Committee will monitor for negative patterns/trends and additional interventions will be developed and implemented as deemed necessary by the Committee to maintain substantial compliance.	