STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN NORTH CAROLINA BAPTIST HOME	213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=G	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 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	F 157	The plan correcting the deficiency: A) The deficient practice occurred when the licensed nurse failed to notify the attending physician of an increase in size of a sacral pressure ulcer, which potentially was a missed opportunity for change in treatment. B) The licensed nurse was re-educated by the Director of Nursing on 09/12/2017 regarding the facilities policy on notification of Medical Director (MD) with changes in residents and that changes in wound measurements that show an increase in size would require notification of MD. C) Resident #48 wounds were assessed by the MD on 09/19/2017 and showed no signs of deterioration. The procedure for implementation: A) The MD was notified of resident #48 increase in size of stage IV pressure ulcer on 09/08/2017. B) The Director of Nursing (DON) and the MDS Coordinator and or other designated Registered Nurses (RNs) will review current residents with pressure ulcers to determine if any changes to pressure ulcer have been documented and to ensure the MD has been notified of any changes by 10/1/2017. C) Licensed nursing staff will be re-educated on the facility policy of notification of MD regarding a change in a resident's pressure. The monitoring procedure: A) Effective 09/27/2017 the DON and the MDS Coordinator will begin weekly rounds for 12 weeks on residents with pressure ulcers. B) The DON and the MDS Coordinator or other designated RNs will validate wound description and measurements weekly for 12 weeks.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher A. Elmer	Administrator	10/02/2017

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 157	Continued From page 1 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 observations, record review, staff and physician interviews the facility failed to notify the physician of an increase in the size of a sacral pressure ulcer for 1 of 3 residents, which resulted in a missed opportunity for a change in treatment (Resident #48). Findings included: Resident #48 was admitted to the facility on 05/01/17 with the diagnoses of Alzheimer's disease, pressure ulcer of the sacral region stage IV, and unspecified dementia with behavioral disturbances. The most recent quarterly Minimum Data Set (MDS) dated 08/03/17 indicated Resident #48 had moderately impaired cognition and needed total assistance with transfers, eating, toileting, and personal hygiene and extensive assistance for bed mobility. The MDS also indicated an unhealed stage IV pressure ulcer was present upon admission. The MDS measurements revealed the length was 0.6cm (centimeters), the width was 0.6cm, and the depth was 1.0cm. Review of the revised care plan for Resident #48 dated 08/09/17 revealed a problem of impaired skin relate to a stage IV Pressure Ulcer (PU) to	F 157	C) The DON and MDS Coordinator or other designated RNs will validate notification of MD weekly for 12 weeks of any changes in size or appearance of pressure ulcers that would require a possible change of treatment. D) The DON will report the findings of the weekly rounds and validations to the QAPI meetings for 3 months. The QAPI committee will review and and revise plan to maintain compliance. The QAPI committee consists of the Medical Director, DON, MDS Coordinator, Administrator, Pharmacy Consultant, Dietary Manager,and the Activity Director. The title of the person responsible for implementation: A) The DON will be responsible for the implementation of the acceptable plan of correction for MD notification with changes in pressure ulcers. Dates when corrective action will be completed: 10/13/2017	

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F 157	Continued From page 2	F 157		

the sacrum. The interventions were for the nurse to measure and monitor the wound status and the progression or deterioration every week. The nurse was to notify the physician of worsening despite the treatment and wound care consults as indicated. The goal was for the pressure ulcer to show evidence of healing by a reduction in size or stage through the next review date.

A review of the skin evaluation form dated 08/04/17 revealed the sacral PU had no drainage and the length was 0.6cm and the width was 0.6cm and depth was 1.0cm with no odor. The next skin evaluation dated 08/11/17 revealed the wound had serosanguineous (a thin, watery, pink or red in color) drainage with a mild odor and measured 1.0cm x 0.5cm x 1.5cm. The next documented evaluation dated 08/14/17 revealed a mild odor with serosanguineous drainage and measured 1.0cm x 0.5cm x 1.5cm. There were no skin evaluations forms documented for the week of 08/21/17 and week 08/28/17. The next documented skin evaluation dated 09/01/17 revealed a foul odor with sanguineous drainage and measured 1.6cm x 0.6cm x 1.8cm.

A review of the communication book used to inform the MD confirmed there had been no documentation from 08/11/17 thru 09/08/17 that identified any changes to the sacrum wound for Resident #48.

During an interview conducted on 09/08/17 at 8:06 AM Nurse #1 confirmed the last measurements she had documented were on the skin evaluation form dated 09/01/17. Nurse #1 also confirmed she had not notified the MD of any changes to Resident #48 wound.

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F 157	Continued From page 3 During an interview conducted on 09/08/17 at 2:54 PM the Director of Nursing (DON) revealed it was her expectation the nurses report any wound changes directly to her. The DON also revealed it was her responsibility to review the weekly wound measurements for a change. The DON could not explain why the increase to the sacral PU had not been reported to the MD. During an interview conducted on 09/08/17 at 3:56 PM the MD stated he had not been notified of the increased size of the sacral PU. He relied on the nurses to do weekly wound assessments and expected to be kept informed and notified of any wound changes. The MD also indicated he would have ordered a wound care consult for Resident #48 if he had been notified of the increased size of the sacral PU.	F 157		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	The plan correcting the deficiency: A) The deficient practice occurred when the MDS Coordinator failed to accurately code section I5800 and N0410C. B) the MDS Coordinator was re-educated on coding accuracy for section I and N of the MDS by the facilities nurse consultant on 9/25/2017. C) Resident #45 MDS section I5800 and N0410C was modified to reflect the accurate information on 9/8/2017. The procedure for implementation: A) Resident #45 MDS section I5800 and N0410C was modified to reflect the accurate information on 9/8/2017. B)The facility nurse consultant and MDS Coordinator will review section I and N of the	

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F 278	Continued From page 4 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to accurately code the Minimum Data Set related to active diagnoses and medications received for 1 of 16 sampled residents reviewed. (Resident # 45). Findings included: Resident # 45 was admitted to the facility on 7/2/16 with diagnoses that included aphasia, osteomyelitis, protein-calorie malnutrition and hemiplegia. A significant change Minimum Data Set (MDS) dated 12/25/16 indicated Resident # 45 received 7 days of an antidepressant medication. The MDS did not have depression coded as an active diagnosis in the last 7 days. Record review revealed a medication administration record (MAR) dated December 2016, indicated Resident # 45 received Zoloft 100 mg from 12/1/16 to 12/20/16 and 12/24/16 to	F 278	most recent MDS for current residents to ensure coding accuracy. If discrepancies are noted in coding a modification will be completed by the MDS Coordinator and transmitted by 9/29/2017. The Monitoring procedure: A) Effective 10/1/2017 the facility nurse consultant will review 10 percent of the MDS's completed in a week for accuracy in sections I and N for 12 weeks. B) Any discrepancies will be addressed by re-education with the MDS Coordinator by the facility nurse consultant and a modification will be completed by the MDS coordinator and transmitted. C) the MDS Coordinator will report the findings. of the weekly rounds and validations to the QAPI Committee at their monthly meeting for 3 months. The QAPI Committee will review and revise the plan to maintain compliance. The title of the person responsible for implementation: A) The MDS Coordinator will be responsible for the implementation for the acceptable plan of correction for accuracy of the MDS in sections I and N. Dates when the corrective action will be completed: 10/13/2017	

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F 278	Continued From page 5 12/31/16. The MAR indicated resident # 45 did not receive Zoloft 100 mg on 12/21/16, 12/22/16 and 12/23/16. Record review for Resident # 45 revealed a doctor order dated December 2016 indicated Zoloft 100 mg for depression. Record review also revealed a doctor's progress note dated 10/23/16 indicated Resident # 45 had a diagnosis of depression and was on Zoloft for inappropriate behaviors. During an interview on 9/8/17 at 2:06 PM with the MDS nurse stated information for the MDS was supposed to be gathered from the doctor's history and physical, progress notes and hospital notes. The MDS nurse verified the significant change MDS dated 12/25/16 for Resident # 45 was coded as received 7 days of an antidepressant medication and was not coded for diagnosis of depression. The MDS nurse also verified the December 2016 MAR indicated Resident # 45 did not receive Zoloft on 12/21/16, 12/22/16, and 12/23/16 and the doctor's progress note dated 10/23/16 indicated Resident # 45 had a diagnosis of depression. The MDS nurse went on to say the significant change MDS for Resident # 45 was coded incorrectly and was supposed to have depression coded as an active diagnosis and received 4 days of an antidepressant. On 9/8/17at 2:21 PM, the Director of Nursing indicated her expectations were for the MDS to be coded correctly for Resident # 45. On 9/8/17 at 2:28 PM, the Administrator indicated his expectations were for the MDS to be coded correctly for Resident # 45.	F 278		

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F 282	Continued From page 6	F 282		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to assess a pressure sore on a weekly basis as indicated in the care plan for 1 of 3 sampled residents reviewed with pressure sores. (Resident #39) The findings included: Resident #39 was admitted to the facility 05/16/17 with diagnoses which included left femur fracture and advanced dementia. The admission Minimum Data Set assessment dated 05/22/17 noted Resident #39 had one unstageable pressure sore on admission and was at risk of developing pressure sores. The Care Area Assessment (dated 05/29/17) associated with the admission MDS included a review of pressure sores which noted, pressure sore triggered due to extensive assistance required with bed mobility; always incontinent of bowel and bladder; at risk for developing pressures ulcers; unstageable area present on admission; requires assistance with bed mobility, transfers and toilet use; status post left hip	F 282	The plan correcting the deficiency: A) The deficient practice occurred when the Licensed nursing staff failed to complete the weekly skin assessments on a resident with a pressure ulcer as per the care plan. B) The licensed nurses will be re-educated on completing skin assessment per a resident care plan by the DON. C) Resident #39 deceased on 6/6/2017 The procedure for implementation: A) Resident #39 deceased on 6/6/2017 B) The DON and MDS Coordinator will review current care plans of residents with pressure ulcers to determine if skin assessments are being completed per their care plan. C) The Licensed nurses were re-educated on completing skin assessment per a resident care plan by the DON on 10/1/2017 The monitoring procedure: A) Effective 9/27/2017 the DON will review residents withe pressure ulcers weekly to ensure skin assessments are completed per their plan of care for 12 weeks. B) Any discrepancies will be addressed by re-education with the Licensed nurse by the DON and a skin assessment will be completed. C) The DON will report the findings of the weekly reviews to the QAPI committee during their monthly meetings for 3 months. The QAPI committee will review and revise the plan to maintain compliance.	

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F 282	Continued From page 7 fracture with repair. The Care Area Assessment (CAA) noted Resident #39 had a diagnosis of advanced dementia with severe cognitive loss and was admitted with unstageable area to left great toe. The CAA noted Resident #39 had a new pressure sore identified on 05/27/17 as a stage 2 to the coccyx, was always incontinent of bowel and bladder, had a surgical incision to the left hip and was started on antibiotic therapy on 05/24/17 for surgical wound infection. A decision was made to proceed to the care plan for interventions. The care plan for pressure sores included a problem area dated 05/17/17 which noted: "Resident has impaired skin integrity related to eschar noted to left great toe on admission." On 05/27/17 the problem area was updated to include "resident noted to have stage II pressure ulcer on coccyx." The goal for this problem area was, "pressure ulcer will show evidence of healing as evidenced by reduction in size or stage by next review." Approaches to this problem area included, "nurse to measure and monitor wound status progression or deterioration every week. Notify physician or authorized assistant of worsening despite treatment." Review of skin assessments in the medical record of Resident #39 from 05/16/19-06/09/17 included: 05/17/17-1 centimeter X 1 centimeter pressure sore with dark scab noted on left toe 05/27/17-stage II pressure ulcer found on coccyx area with a moderate amount of serosanguinous drainage with mild odor and moderate amount of exudate which measured 2 centimeters X 3 centimeters X .1 centimeter with wound edge peeling and surrounding skin red and moist	F 282	The title of the person responsible for implementation: A) The DON will be responsible for the implementation of the acceptable plan of correction for residents with pressure ulcers to have skin assessments per their plan of care. Dates when corrective action will be completed: 10/13/2017	

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F 282	Continued From page 8 Review of physician orders and the treatment record for Resident #39 from 05/16/19-06/09/17 noted treatments were done as ordered and up through the time of discharge on 06/09/17. These included: 05/17/17-Betadine twice daily for intact black left great toe 05/29/17-Apply a hydrocolloid dressing-change every 3 days and as needed Review of all nurse's notes, assessments and skin assessments for Resident #39 from 05/16/19-06/09/17 noted no further skin assessments of the area on the left toe and coccyx after the initial assessment. Weekly assessments of the left toe were not present 05/24/17, 05/31/17 and 06/07/17. Weekly assessment of the coccyx was not present on 06/03/17. On 09/08/17 at 2:50 PM the Director of Nursing (DON) and Minimum Data Set assessment nurse were interviewed about the weekly skin assessments for Resident #39. The DON explained there was not a wound nurse at the facility and nurses on duty were responsible for weekly assessments and treatments. The DON explained there was a weekly schedule for staff to review and the expectation was for the nurse on duty to do a skin assessment based on this schedule. The DON stated they realized weekly skin assessments were not being done consistent with the care plan and the facility was in the process of addressing the concern. The DON stated management staff would discuss all wounds on a weekly basis with discussion including the condition of the wound. The DON stated because of the lack of assessments she	F 282		

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F 282	Continued From page 9 could not tell if the left great toe and coccyx improved or worsened for Resident #39.	F 282		
F 314 SS=G	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 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 observations, record review, staff, and physician interviews the facility failed to assess and document the condition of a resident's stage 4 sacral pressure ulcer (PU) weekly per the plan of care and failed to report the pressure ulcer was worsening despite treatment to the resident's physician (Resident #48) and the facility failed to assess an additional pressure ulcer weekly as indicated in the care plan (Resident #39) for 2 of 3 sampled residents reviewed for pressure ulcers. Findings included:	F 314	The plan correcting the deficiency: A) The deficient practice occured when the Licensed nursing staff failed to assess and document the condition of two residents pressure ulcers per their care plan and report any worsening changes to the MD. B) the Licensed nurses will be re-educated on completing skin assessments per a resident care plan by the DON. C) Resident #39 deceased on 6/6 2017. D) Resident #48 a skin assessment was completed on 9/26/2017 and then weekly per their care plan MD notified of any changes. The procedure for implementation: A) Resident #39 deceased on /6/2017 B) Resident #48 skin assessment was completed on 9/19/2017 and then weekly per their care plan. MD notified of any worsening of pressure ulcer and if needed orders received. C) The DON and MDS Coordinator or other designated RNs will will review current care plans of residents with pressure ulcers to determine if skin assessments are being completed per their care plan 9/29/2017. The Licensed nurses were re-educated on completing skin assessments per a residents care plan by the DON on 10/1/2017	

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F 314	Continued From page 10 1.Resident #48 was admitted to the facility on 05/01/17 with the diagnoses of Alzheimer's disease, pressure ulcer (PU) of the sacral region stage 4 and unspecified dementia with behavioral disturbances. The most recent quarterly Minimum Data Set (MDS) dated 08/03/17 indicated Resident #48 had moderately impaired cognition and needed total assistance with transfers, eating, toileting, and personal hygiene and extensive assistance for bed mobility, and was incontinent of bladder and bowel. The MDS also indicated an unhealed stage 4 PU was present upon admission and measured as follows: length was 0.6cm (centimeter), the width was 0.6cm, and the depth was 1.0cm. Review of the revised care plan for Resident #48 dated 08/09/17 revealed a problem related to impaired skin related to a stage 4 PU to the sacrum. The goal was for the PU to show evidence of healing by a reduction in size or stage through the next review date. The interventions were for the nurse to measure and monitor the wound status and the progression or deterioration every week. The nurse was to notify the physician of worsening despite the treatment and wound care consults as indicated. A review of the skin evaluation form dated 08/04/17 revealed the sacral PU had no drainage and the length was 0.6cm and the width was 0.6cm and depth was 1.0cm with no odor. The next skin evaluation dated 08/11/17 revealed the wound had serosanguineous (a thin, watery, pink or red in color drainage) with a mild odor and measured 1.0cm x 0.5cm x 1.5cm. The next documented evaluation dated 08/14/17 revealed a mild odor with serosanguineous drainage and	F 314	The monitoring procedure: A) Effective 9/27/2017 the DON and the MDS Coordinator will review residents with pressure ulcers weekly to ensure skin assessments are completed per their care plan and validate would description and measurements for 12 weeks. B) Any discrepancies will be addressed by re-education with the Licensed nurse by the DON and a skin assessment will be completed. C) The DON and the MDS Coordinator will validate notification of MD weekly for 12 weeks of any changes in size or appearance of pressure ulcers that would require a possible change of treatment. D) The DON will report the findings of the weekly reviews to the QAPI Committee at their monthly meeting for 3 months. The QAPI Committee will review and revise the plan to maintain compliance. The title of the person implementing the plan: A) The DON will be responsible for the implementation of the acceptable plan of correction for residents with pressure ulcers to have skin assessments completed per their plan of care and any worsening in description or measurements are reported to the MD. Dates when corrective action will be completed: 10/13/2017	

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measured 1.0cm x 0.5cm x 1.5cm. There were no skin evaluations forms provided or documented for the week of 08/21/17 and week of 08/28/17. The next documented skin evaluation dated 09/01/17 revealed a foul odor with bloody, sanguineous drainage and measured 1.6cm x 0.6cm x 1.8cm.

A review of the physician order dated 8/13/17 read as to cleanse sacral wound with wound cleanser and place a small amount of gentamicin ointment into wound and apply a small piece of calcium alginate to wound and cover with foam dressing and change every day on 11:00 PM thru 7:00 AM shift.

Review of Resident #48's treatment records revealed no change in treatment to the resident's sacral wound from 8/13/17 to 09/01/17.

During an interview conducted on 09/07/17 at 4:28 PM the Medical Doctor (MD) indicated he had seen Resident #48 approximately twice since admission to the facility. The MD also stated there had been no verbal or written communication related to the increase of the sacral PU.

An observation was made on 09/08/17 at 7:18 AM of Nurse #1 and Nurse #2 providing wound care and measuring the sacral PU for Resident #48. Nurse #1 confirmed the wound care supplies she had were a foam dressing, calcium alginate, gentamicin ointment, a bottle of wound cleanser spray, and 4 x 4 gauze. An intact foam dressing dated 09/08/17 with initials was noted on the sacrum of Resident #48. Nurse #1 removed the soiled dressing and revealed a small amount of

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F 314	Continued From page 12 bowel movement with a small amount of bloody drainage. There was no foul odor noted. Nurse #1 sprayed wound cleanser to the sacrum wound and proceeded to pat the area dry with 4 x 4 gauze. Nurse #1 changed position with Nurse #2. Nurse #2 put on clean gloves and measured the wound. The measurements were confirmed as follows: length 1.6cm and width 1.0 cm and depth 1.8 cm. Nurse #1 proceeded to apply gentamicin ointment to the inside of the wound, insert a small strip of calcium alginate, and covered with a foam dressing. An interview was conducted on 09/08/17 at 7:18 AM with Nurse #2 who revealed she used the sacral PU measurements to reevaluate Resident #48 skin condition by checking the last evaluation and compared measurements to check for healing or increasing. Nurse #2 revealed the skin evaluation generated a 24 hour report and all nurses had access to the report. She also indicated a verbal report would be given to the oncoming nurse supervisor and the MD would be notified using a written communication tool. The tool was used by the nurses to inform the MD of residents who needed to be seen, or had any changes and would be reviewed by the MD when at the facility. A review of the written communication tool the nurses used to inform the MD confirmed there had been no documentation from 08/04/17 thru 09/08/17 of the resident's sacrum wound condition changes worsening for Resident #48. An interview was conducted on 09/08/17 at 8:06 AM with Nurse #1 who confirmed the last measurements she had documented on the computer generated skin evaluation form was on	F 314		

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F 314	Continued From page 13 09/01/17. Nurse #1 revealed the wound had not changed, but she had not compared the wound measurements to the previous evaluation. It was noted Nurse #1 could not navigate the computer skin evaluation form to show all previous measurements to compare for wound changes. Nurse #1 indicated she would report wound changes to the oncoming nurse. Nurse #1 also confirmed she had not notified the MD of any wound changes. During an interview conducted on 09/08/17 at 2:54 PM the Director of Nursing (DON) revealed it was her expectation the nurses report any wound changes directly to her. The DON also revealed it was her responsibility to review the weekly wound measurements for a change. The DON could not explain why the increase of the sacral PU had not been reported to the MD. During an interview conducted on 09/08/17 at 3:56 PM the MD stated he had not been notified of the increase of the resident's sacral PU until 09/08/17. The MD state he hadn't seen the resident's PU and didn't look at the PU unless the nurses notified him of a change to the PU. The MD specified that he last examined the resident on 5/19/17 and he relied on the nurses to do weekly wound assessments and expected to be kept informed and notified of any wound changes. The MD also indicated he would have ordered a wound care consult for Resident #48 if he had been notified of the increased size of the sacral PU. 2. Resident #39 was admitted to the facility 05/16/17 with diagnoses which included left femur fracture and advanced dementia.	F 314		

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F 314	Continued From page 14 The admission Minimum Data Set assessment dated 05/22/17 noted Resident #39 had one unstageable pressure sore on admission and was at risk of developing pressure sores. The Care Area Assessment (dated 05/29/17) associated with the admission MDS included a review of pressure sores which noted, pressure sore triggered due to extensive assistance required with bed mobility; always incontinent of bowel and bladder; at risk for developing pressures ulcers; unstageable area present on admission; requires assistance with bed mobility, transfers and toilet use; status post left hip fracture with repair. The Care Area Assessment (CAA) noted Resident #39 had a diagnosis of advanced dementia with severe cognitive loss and was admitted with unstageable area to left great toe. The CAA noted Resident #39 had a new pressure sore identified on 05/27/17 as a stage 2 to the coccyx, was always incontinent of bowel and bladder, had a surgical incision to the left hip and was started on antibiotic therapy on 05/24/17 for surgical wound infection. A decision was made to proceed to the care plan for interventions. The care plan for pressure sores included a problem area dated 05/17/17 which noted: "Resident has impaired skin integrity related to eschar noted to left great toe on admission." On 05/27/17 the problem area was updated to include "resident noted to have stage II pressure ulcer on coccyx." The goal for this problem area was, "pressure ulcer will show evidence of healing as evidenced by reduction in size or stage by next review." Approaches to this problem area included, "nurse to measure and monitor wound status progression or deterioration every week.	F 314		

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F 314	Continued From page 15 Notify physician or authorized assistant of worsening despite treatment." Review of skin assessments in the medical record of Resident #39 from 05/16/19-06/09/17 included: 05/17/17-1 centimeter X 1 centimeter pressure sore with dark scab noted on left toe 05/27/17-stage II pressure ulcer found on coccyx area with a moderate amount of serosanguinous drainage with mild odor and moderate amount of exudate which measured 2 centimeters X 3 centimeters X .1 centimeter with wound edge peeling and surrounding skin red and moist Review of physician orders and the treatment record for Resident #39 from 05/16/19-06/09/17 noted treatments were done as ordered and up through the time of discharge on 06/09/17. These included: 05/17/17-Betadine twice daily for intact black left great toe 05/29/17-Apply a hydrocolloid dressing-change every 3 days and as needed Review of all nurse's notes, assessments and skin assessments for Resident #39 from 05/16/19-06/09/17 noted no further skin assessments of the area on the left toe and coccyx after the initial assessment. Weekly assessments of the left toe were not present 05/24/17, 05/31/17 and 06/07/17. Weekly assessment of the coccyx was not present on 06/03/17. There was no documentation present to reflect whether there was an improvement or decline in the size or stage of the pressure ulcers. On 09/08/17 at 2:50 PM the Director of Nursing (DON) and Minimum Data Set assessment nurse	F 314		

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F 314	Continued From page 16 were interviewed about the weekly skin assessments for Resident #39. The DON explained there was not a wound nurse at the facility and nurses on duty were responsible for weekly assessments and treatments. The DON explained there was a weekly schedule for staff to review and the expectation was for the nurse on duty to do a skin assessment based on this schedule. The DON stated they realized weekly skin assessments were not being done and the facility was in the process of addressing the concern. The DON stated management staff would discuss all wounds on a weekly basis with discussion including the condition of the wound. The DON stated because of the lack of assessments she could not tell if the left great toe and coccyx improved or worsened for Resident #39.	F 314		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441	The plan correcting the deficiency: A) The deficient practice occurred when the nurse #1 failed to provide appropriate hand sanitation when changing from incontinent to wound care. B) The Licensed nurse was in-serviced by the DON on 9/25/2107 on the facilities Hand Hygiene policy. C) Resident #48's wounds we assessed on 9/19/2017 by Mission Hospitals Wound Care Department and showed no signs of infection. The procedure for implmentation: A) The DON began re-education of the nursing staff on the facility's policy for Han Hygiene on 9/25/2017.	

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F 441	Continued From page 17 for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441	The monitoring procedure: A) The DON or MDS Coordinator or designated RN's will complete random observations of the nurses completing wound care to ensure Hand Hygiene compliance is maintained weekly for 12 weeks. The DON will provide additional training to nurses when area are identitied during their observations. B) The DON will report the findings of the random observations to the monthly QAPI meeting for 3 months. The QAPI Committee will review and revise the plan to maintain compliance. The title of the person responsible for implementation of the acceptable plan of correction: A) The DON will be responsible for the implementation of the acceptable plan of correction for hand washing hygiene. Dates when corrective action will be completed: 10/13/2017	

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F 441	Continued From page 18 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to wash hands and remove gloves after providing incontinence care and cleaning a sacrum stage IV wound and after working from a contaminated body site and moving to a clean body site for 1 of 2 residents reviewed for wound care (Resident #48). Findings included: The facility policy for standard precautions reference #4007 read in part standard precautions include the following: Hand hygiene- Adherence to hand hygiene techniques including washing hands with soap and water or use of an alcohol-based hand rub, reduces transmission of antimicrobial resistant organisms and overall infection rates. If hands are visibly dirty or contaminated with protein material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Gloves- Gloves are to be worn when touching blood, body fluids, secretions, excretions and other contaminated items. Gloves shall be changed between tasks and procedures on the same resident after contact with material that may contain a high concentration of	F 441		

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F 441	Continued From page 19 microorganisms. The facility policy for hand hygiene reference #4008 read in part all personnel will use the hand hygiene techniques as set forth in the following procedure. Before each resident encounter, after working on a contaminated body site and then moving to a clean body site on the same resident, after coming in contact with bodily fluids, dressings, mucous membranes, etc., and hands are not visibly soiled, and always after removing gloves. Always follow standard precautions. An observation was made on 09/08/17 at 7:18 AM of Nurse #1 and Nurse #2 providing wound care to a sacrum pressure ulcer for Resident #48. Nurse #1 and Nurse #2 and this surveyor entered the room of Resident #48. Nurse #2 washed her hands with soap and water and dried them with disposable paper towels and donned on clean gloves then assisted Resident #48 to be positioned on her side. Nurse #1 donned on clean gloves, but did not use an alcohol based rub or soap and water to wash her hands. Resident #48 was having a bowel movement and Nurse #1 proceeded to provide incontinence care. Nurse #1 removed a sacrum wound dressing that revealed bowel movement and bloody drainage on the back of the dressing. Nurse #1 picked up a spray bottle of wound cleanser and sprayed the wound and used 4 x 4 gauze to pat the area dry. Nurse #1 moved to the opposite side of the bed and continued to position Resident #48 on her side while Nurse #2 measured the wound. Nurse #1 removed her gloves and without washing her hands donned on cleaned gloves and started to provide wound care. During an interview conducted on 09/08/17 at 8:06 AM Nurse #1 confirmed it was appropriate to	F 441		

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F 441	Continued From page 20 change gloves after cleaning a bowel movement and before starting to clean a wound. Nurse #1 revealed she did not have any visible bowel movement or debris on her hands or gloves after cleaning the bowel movement. Nurse #1 also revealed her hands were not visibly dirty and that was why she did not wash her hands and thought she had promoted hand hygiene. During an interview conducted on 09/08/17 at 4:18 PM the Director of Nursing (DON) confirmed her expectations were for the nurse to wash their hands when entering a Residents room and put on clean gloves. The DON also confirmed it was her expectation for the nurse to remove the gloves used to provide incontinence care and wash their hands and put on clean gloves before proceeding to clean a wound. The DON confirmed if the same gloves were used to clean a bowel movement and spray the wound cleanser and pat the wound area dry there was a break in infection control.	F 441		