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	345096	A. BUILDING _____ B. WING _____	C 11/02/2017

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HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (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 observations, record review, staff, private duty sitter, Hospice Nurse and Nurse Practitioner interviews, the facility failed to implement care plan interventions by not applying a palm guard as ordered for 1 of 3 residents sampled (Resident #2). The findings included: Resident #2 was admitted to the facility on 08/24/16 with diagnoses that included coronary artery disease, dementia, history of right hip fracture, depression, anemia, hypertension, and hyperlipidemia. Review of a Medical Doctor (MD) order dated 09/02/16 read "patient to wear bilateral palmar guard to bilateral hands for skin protection daily and can be removed for skin checks." Review of a care plan initiated 11/28/16 and most recently updated on 10/04/17 read in part that Resident #2 was totally dependent for all activities of daily living (ADLs) secondary to advanced Alzheimer's Dementia. The goal of the stated care plan was that Resident #2 would have all of	F 282	F282 The plan correcting the specific deficiency. The plan should address the processes that led to the deficiency cited During a complaint survey ending 11/2/17, it was identified that Resident #2's plan of care was not being followed. The plan of care for Resident #2 indicated that he should have a palm guard applied as ordered. The CNAs and nurses failed to apply the palm guard as ordered due to not checking the Resident Profile. When this was brought to the facility's attention, the DON immediately reviewed the orders, educated the staff members who worked with Resident #2, made sure the Resident Profile was reviewed, and the palm guard applied as ordered. The DON audited the palm guard application on Resident #2 for 5 consecutive days to ensure compliance. The procedure for implementing the acceptable POC for the specific deficiency cited All residents with palm guards will be	11/30/17

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

Electronically Signed | 11/27/2017

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F 282	Continued From page 1 his ADLs provided and have no complications. The interventions included palm guards as ordered, hand hygiene daily and check skin for signs of irritation/breakdown daily. Review of the most recent quarterly minimum data set (MDS) dated 09/27/17 revealed that Resident #2 was severely cognitively impaired for daily decision making and required total assistance of 1 to 2 staff members for ADL. No restorative nursing or splinting assistance was noted during the assessment period. Observations of Resident #2 made on 11/01/17 at 10:00 AM, 11/01/17 at 11:00 AM and 11/01/17 at 4:30 PM revealed Resident #2 was resting in bed with his eyes closed. Geri sleeves (protective sleeves) were in place to his bilateral hands/arms and no palm guards were in place or were visible in his room. An interview was conducted with the private duty sitter on 11/01/17 at 4:30 PM. The private duty sitter stated she was hired by Resident #2's family and routinely provided care to him for the last 2 ½ years. The sitter stated that Resident #2 wore the geri sleeves to both of his arms/hands everyday but she has never seen him wear any palm guards on the days that she worked with him and had never seen them in his room. The sitter was observed to begin to look for the palm guards and eventually opened a drawer under the window seat and pulled out 2 palm guards and stated that she had never seen Resident #2 with them in place. An observation of Resident #2 was made on 11/02/17 at 10:29 AM. Resident #2 was resting in bed with eyes closed. Geri sleeves were in place	F 282	identified and a visual inspection will be performed to ensure order compliance. Resident refusal or non-compliance will be documented. Date Certain: 11/30/17. Responsible Party: DON and MDS Coordinator All nurses and nursing assistants will receive in-service education related to the process for updating and reviewing the resident profile and care plan. Date Certain: 11/30/17. Responsible Party: RN service line educator and RN facility educator. The facility will establish a weekly interdisciplinary team risk meeting which will include discussion of all residents with palm guards. Date Certain: 11/21/17. Responsible Party: DON The Informatics and Analytics Services (IAS) team has formatted a report that can be run for the previous 24 hours to capture new orders. This report will be available and reviewed Monday – Friday, during the scheduled interdisciplinary team stand-up meeting, The care plan will then be updated with appropriate interventions to reflect the current resident status. Date Certain: 11/24/17. Responsible Party: DON The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements DON will conduct weekly 100% audit of residents with palm guards for appropriate orders, care plan, up-to-date resident profile, and use. Any identified issues will be corrected at that time. Results of	

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F 282	Continued From page 2 to his bilateral hands/arms and no palm guards were in place or were visible in the room. An interview was conducted with the Nursing Assistant (NA) #1 on 11/02/17 at 9:29 AM. NA #1 indicated she routinely provided care to Resident #2. She stated that Resident #2 wore his geri sleeves all during the day but she had never seen any other devices including palm guards in his room or been instructed to apply any other device to Resident #2. NA #1 added that if she needed to review information on her residents she could refer to the electronic medical record and that information was located in the resident's profile. An interview was conducted with NA #2 on 11/02/17 at 9:58 AM. NA #2 stated that she routinely cared for Resident #2. NA #2 stated that Resident #2 wore geri sleeves to his arms/hands each day and if he was in bed he wore puffy boots but to her knowledge he had no other devices. She stated she had not ever seen or applied palm guards to Resident #2 and had not been instructed to apply them. She added that if she needed to know information on her residents she would generally ask the other NAs and could if needed refer to the residents profile located in the electronic medical record. An interview was conducted with the Nurse Practitioner (NP) on 11/02/17 at 10:21 AM. The NP stated she was asked by the Wound Nurse to assess a wound to Resident #2's hand which was a little contracted and required a nurse to open his hand up for visualization. She stated no one including family knew how long the wound was present which was deep and not very granulated. She stated she collaborated with the Medical Doctor and decided secondary healing would be	F 282	the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The DON has overall responsibility for monitoring that all palm guards are applied per the care plan and provider orders.	

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the treatment choice. She stated the wound looked like a laceration but as to the cause she could not make any assumptions or presumptions. She stated she was not aware of any orders for palm guards but thought they would be a good idea, stating Therapy could evaluate the resident for appropriateness of this intervention.

An interview was conducted with the Hospice Nurse (HN) on 11/02/17 at 10:31 AM. The HN stated that she visited Resident #2 two times a week. She stated that Resident #2 routinely wore geri sleeves on both of his arms/hands, would wear mediplex boots on his feet and had a wedge to elevate his heels. The HN stated that there were no other devices that were ordered and had never seen him where any other devices, including palm guards, were on Resident #2 or in his room.

An interview was conducted with Nurse #2 on 11/02/17 at 10:57 AM. Nurse #2 stated that she routinely cared for Resident #2 and the NAs had access to the electronic medical record where there was a brief synopsis of the care that each resident required. Nurse #2 stated that the NAs routinely applied the palm guards and geri sleeves and that the nurses must check and make sure they were applied correctly and to check the integrity of the skin. Nurse #2 stated that when she went in to assess Resident #2 this morning the geri sleeves were in place and the staff was providing care but the palm guards were not in place, yet but she would make sure they were in place as ordered.

An observation of Resident #2 was made on 11/02/17 at 2:32 PM. Resident #2 was up in geri

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F 282	Continued From page 4 chair with bilateral geri sleeves in place. No palm guards were in place or were visible in his room. There was a wedge between his knees and boots to his feet. An interview was conducted with the Director of Nursing (DON) on 11/02/17 at 3:13 PM. The DON stated that she had only been at the facility for a few days and that the facility utilized a weekly "Adult System Review" and she would expect the staff to apply the ordered devices and then document those on the "Adult System Review" that could be accessed at any time by the nurses. She added that she expected the staff to follow and implement the care plan for each residents as ordered by MD.	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility 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	F 309		11/30/17

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F 309	Continued From page 5 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 observations, record review, staff, private duty sitter, Hospice Nurse, and Nurse Practitioner interviews the facility failed to identify the cause of a wound to the left hand and once identified failed to apply the correct treatment to the wound for 1 of 3 residents sampled for well-being (Resident #2). The findings included: Resident #2 was admitted to the facility on 08/24/16 with diagnoses that included coronary artery disease, dementia, history of right hip fracture, depression, anemia, hypertension, and hyperlipidemia. Review of the most recent quarterly minimum data set (MDS) dated 09/27/17 revealed that Resident #2 was severely cognitively impaired for daily decision making and required total assistance of 1 to 2 staff members for activities of	F 309	F309 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The plan correcting the specific deficiency. The plan should address the processes that led to the deficiency cited During the survey ending 11/2/17, a surveyor and wound treatment nurse were conducting treatment observations for Resident #2. When they arrived at the patient□s room, the nurse responsible for the patient had already completed Resident #2□s dressing changes. The	

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daily living. The MDS also indicated that Resident #2 had no speech and had impairments to bilateral upper and lower extremities.

Review of a Nurse Practitioner (NP) visit note dated 10/27/17 read in part that Resident #2 was seen at the request of nursing staff who noted a new wound to his left hand of unknown duration that was first observed on the day of this visit. The wound was noted in the crease of his thumb on his left hand. Nursing staff reported no obvious recent trauma to the hand. Family at his bedside during the visit reported they were unsure of its onset or indication as well. The impression and plan read in part that Resident #2 was noted with a significant laceration of skin at his left thumb with wound depth as quite significant. The note documented there was no indication or obvious local or systemic infection, the majority of the tissue involved appeared to be granulated, there was no obvious drainage and it appeared as neurovascularly intact. The note documented a discussion with the Medical Doctor (MD) and care would be to attempt secondary healing of the wound, holding off on surgical/suturing at that point. The note documented the cause of the wound as unclear as to the cause and the note was signed by the NP.

Review of an MD order dated 10/27/17 read to clean the resident's left finger wound with antiseptic and apply wet gauze packing daily.

An observation of Resident #2 was made on 11/01/17 at 11:00 AM with concurrent interview of the facility Wound Nurse (WN). Nurse #1 was observed to report to the WN upon entering Resident #2's room that she had already completed Resident #2's dressing change to his

nurse failed to verify the treatment orders for Resident #2 before applying wound treatments. Correct treatments were immediately applied by the wound treatment nurse. The Registered Nurse who applied the wrong treatment during the survey was immediately provided with re-education from the DON and received written counseling. Re-education included wound evaluation, reporting and documentation expectations, and importance of following provider orders related to wound treatments. Education provided to all nurses on verifying treatment orders prior to applying wound treatments.

The procedure for implementing the acceptable POC for the specific deficiency cited
All nurses will receive wound in-service education that includes: Prevention, identification, reporting, documentation, and treatments options. CNAs will receive in-service education related to the identification of wounds found during routine care. Date Certain: 11/27/17. Responsible Party: RN Service line educator and RN facility educator
Head-to-toe skin assessments completed by a Registered Nurse for all residents to ensure all wounds identified and wound orders are appropriate. Date Certain: 11/30/17. Responsible Party: DON
The facility will establish a weekly risk meeting to be conducted by the interdisciplinary team, and any other members that the Administrator or Director of Nursing include as consultative

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F 309	Continued From page 7 left hand because he had gone to the shower and it had gotten wet, so she just went ahead and completed the dressing change. When the WN entered Resident #2's room he was resting in bed on his right side and had a geri sleeve (protective glove) to each lower arm. The geri sleeve was noted to loop over the thumb and rest between the first finger and thumb and then extended up to the elbow. The WN removed the geri sleeve on Resident #2's left hand to visualize the dressing that Nurse #1 had completed after his shower. As the WN removed the sleeve, the dressing that was between the thumb and first finger came off. The dressing was dated for 11/01/17 and was a dry dressing with the WN stating she would redo the dressing using the correct treatment of saline soaked gauze as ordered. The WN completed the treatment as ordered, applied a new dressing that was again dated 11/01/17 and replaced the geri sleeve to his left hand. After the correct treatment was applied the WN was observed to step out into the hallway and inform Nurse #1 what the correct treatment to the area was and that she had performed the treatment. The WN indicated that she believed that the geri sleeve had caused the area to Resident #2's left hand and she had reported that to the MD. The right geri sleeve was also removed and the hand was visualized with the area between the first finger and thumb appearing red and moist but the skin was intact. An interview was conducted with the WN on 11/01/17 at 1:50 PM. The WN stated initially the area to Resident #2's left hand was discovered by the private duty sitter and reported to the staff. The WN stated that when she went to assess the wound the NP was already in the room. She stated the family actually wanted the area stitched	F 309	experts. Date Certain: 11/21/17. Responsible Party: DON The Informatics and Analytics Services (IAS) team has formatted a report that can be run for the previous 24 hours to capture new wound treatment orders. This will be run daily and brought to the morning stand-up and PPS meetings to ensure appropriate documentation and follow up is completed. Date Certain: 11/24/17. Responsible Party: DON The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements DON will assess all wounds and treatments weekly to validate nursing competencies around wound care and understanding of the in-services and education provided. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The DON has the responsibility for implementation, monitoring, and oversight of this care area.	

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up but because there was no determination as to how long the wound had been present, family agreed to allow the facility to treat the area. The WN confirmed that she had informed Nurse #1 what the correct treatment to Resident #2's left hand was then proceeded to apply the correct treatment to the wound. The WN added that the private duty sitter had told her that when she bathed him on 10/20/17 the wound was not present. She added that Resident #2 had worn the geri sleeves ever since she had worked at the facility since May 2017.

An interview was conducted with the Assistant Director of Nursing (ADON) on 11/01/17 at 2:43 PM. The ADON indicated that when she was notified of the wound and went to assess it the NP was already in the room. She stated that when she went to assess the wound it was near the end of first shift and she had only spoken to 1 NA who stated that the wound was not present the previous day. The ADON stated that after the wound was discovered the focus was on getting the treatment ordered and in place, that they had decided to leave the geri sleeves in place because of Resident #2's history of bruises and as he now had the protective treatment between the skin and the geri sleeve she felt like it was ok to leave them in place. The ADON confirmed that they were not sure how the wound developed and that no investigation was completed to determine the cause.

An interview was conducted with private duty sitter on 11/01/17 at 2:50 PM. The sitter stated she was hired by Resident #2's family to make ensure he ate, was changed, and make sure he was comfortable. The sitter stated that she had provided care to Resident #2 on 10/25/17 and

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had visualized the area between his left first finger and thumb and the skin was intact and then on 10/27/17 when she returned she discovered the area was open and reported it to Nurse #1. The sitter stated that when she arrived at the facility to care for Resident #2 he would already have on the geri sleeves and it was very rare to see the staff remove or apply them because they were on all the time. The sitter further stated that Resident #2 was contracted and she had to calm him down by talking to him, at which point he would relax his hand and she was able to see the full wound, but if he was tightly contracted it was very difficult to see the area.

An interview was conducted with Nurse #1 on 11/01/17 at 3:14 PM. Nurse #1 stated that she routinely cared for Resident #2 and on 10/27/17 his sitter reported to her that the resident needed a band aid as he had a cut on his hand. Nurse #1 stated she went to assess the area which looked as if the skin had come apart where the geri sleeve rested between his first finger and thumb. She stated this wound was approximately 0.2 centimeters (cm) deep and had no blood, no odor and no signs of infection. Nurse #1 stated that she completed the head to toe assessments on Resident #2 weekly and she would move clothes around to visualize the skin, including routinely removing the geri gloves during the assessment to visualize the hands. Nurse #1 stated that she had completed Resident #2 dressing to his left hand because he was in the shower and the old dressing was wet. Nurse #1 stated she applied the dry dressing and dated the dressing, but would have gone back after her medication pass to apply the correct treatment to the area.

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Review of an MD order dated 11/02/17 directed that geri sleeves were to be worn at all times and could be removed for daily skin checks during bathing.

An interview was conducted with NA #1 on 11/02/17 at 9:29 AM. NA #1 stated that she routinely cared for Resident #2. She stated that the hospice staff was at the facility on Monday, Wednesday and Friday and they provided his care and that on those days hospice staff were not at the facility she provided the care. NA #1 added that the private duty sitters were also present most of the time to assist with feeding and to provide companionship to Resident #2. NA #1 added that Resident #2 wore his geri sleeves all during the day and she would remove them for his bath and then reapply them. NA #1 stated that she had last visualized the area between Resident #2's left first finger and thumb on 10/24/17 and the skin was intact, then hospice staff would have provided the care to him on 10/25/17 and 10/26/17. She stated on 10/27/17 the sitter noted the open area to his left hand and they started treatment to the wound.

An interview was conducted with the Nurse Practitioner (NP) on 11/02/17 at 10:21 AM. The NP stated she was asked by the WN to assess a wound to Resident #2's hand which was a little contracted and required a nurse to open his hand up for visualization. She stated no one including family knew how long the wound was present which was deep and not very granulated. She stated she collaborated with the Medical Doctor and decided secondary healing would be the treatment choice. She stated the wound looked like a laceration but as to the cause she could not make any assumptions or presumptions.

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HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(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 309	Continued From page 11 An interview was conducted with the Hospice Nurse (HN) on 11/02/17 at 10:31 AM. The HN stated that she visited Resident #2 twice a week and the NAs visited him 3 times a week on Monday, Wednesday and Friday. She added that on Monday and Friday the NAs provide him with a full bed bath and on Wednesdays they took Resident #2 to the shower. The HN stated that the NAs were trained to look at the resident's skin and if they noticed any changes or anything unusual they were to report that directly to her and she would follow up. She added that she had actually applied Resident #2's geri sleeves on Tuesday 10/24/17 and Thursday 10/26/17 and did not see any wound to his left hand, but stated it was difficult to assess his skin due to his contracture. An interview was conducted with the Director of Nursing (DON) on 11/02/17 at 3:13 PM. The DON stated that she had only been at the facility since Monday 10/30/17 and really wanted to build a comprehensive wound program at the facility. The DON stated she would expect for skin checks to be done weekly as ordered, then sometime during the day the geri sleeves to be removed and the skin inspected and any changes reported. The DON further stated she expected the staff to follow wound orders exactly as ordered. The DON stated that she had been completely through Resident #2's medical record and she could not find an order for the geri sleeves and therefore had no idea how long they had been in place. She added that she had written an order for the geri sleeves on 11/02/17 that included daily skin checks.	F 309		

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{F 225} SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	{F 225}		11/30/17

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

Electronically Signed | 11/27/2017

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{F 225}	Continued From page 1 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to notify the State Survey Agency within the required 24 hour initial report time frame for an allegation of misappropriation of resident property and failed to report to the State Survey Agency within the required 5 working day time frame of the investigation of an allegation of misappropriation of resident property for 1 of 1 sampled residents (Resident #4). The findings included: Review of the admission comprehensive	{F 225}	F225 The plan correcting the specific deficiency. The plan should address the processes that led to the deficiency cited On 10/23/17, Resident #4 reported to the facility staff that he had money missing. A grievance report for the missing money was filed, however, the administrator at the time did not think the incident should be reported using the appropriate 24-hour and 5-working day reports to the State Agency. Instead, the administrator made the determination that this was a	

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{F 225}	Continued From page 2 minimum data set (MDS) dated 10/17/17 revealed that Resident #4 was cognitively intact and required set up assistance with activities of daily living. Review of a grievance filed by Resident #4 on 10/23/17 read in part that Resident #4 reported he was missing $389.00 out of his wallet that was located in his night stand drawer. The steps taken to investigate read in part that facility staff looked all over resident's room including the bed sheets, under the bed and in drawers and could not locate the money. Staff called the hospital that Resident #4 was discharged from and verified that he was given $445.00 upon transfer to the facility. Summary of pertinent findings read in part that on 10/23/17 Resident #4 was given a lock box to keep the remaining $56.00 in and a maintenance request was made to get the key to the night stand drawer so Resident #4 could keep it locked. The form was signed by Social Worker (SW) #1. Review of an incident report dated 10/26/17 read in part that Resident #4 reported that when he came into the facility he had $446.00 in cash in his wallet and as of 10/23/17 he only had $56.00 left. The resident further reported that he did not have the night stand drawer locked at bedside because he did not have a key. A brief interview was conducted with the Administrator on 11/01/17 at 10:00 AM who stated that the facility had not submitted any 24 hour/5 working day reports since 10/23/17. An interview was conducted with Resident #4 on 11/01/17 at 3:54 PM. Resident #4 stated that he resided in an apartment complex when he	{F 225}	grievance and did not constitute a reportable event. The administrator at the time of this incident is no longer employed at the facility. The interim administrator instructed the DON to complete the 24-hour and 5-working day reports and to attach the investigative materials to the appropriate State Agency. Determining what constitutes as a concern, grievance, or a reportable event has been included in education for all staff. The facility□s department heads have been instructed to bring all concerns to the morning stand-up meeting and the IDT can make recommendations as to whether an incident needs to be reported to the State Agency, however, the Administrator and DON will be responsible for reporting all allegations of abuse, neglect, misappropriation, and exploitation on the 24-hour and 5-working day reports. The procedure for implementing the acceptable POC for the specific deficiency cited All active grievances within the previous 90 days as of 11/15/17 will be reviewed, action will be taken to close all grievances to the satisfaction of the resident. Grievances opened after date certain will follow new grievance process flow. Date Certain: 11/15/17. Responsible Person: Consulting Administrator A Resident Council Meeting was held to educate the residents on the facility□s grievance process. Date Certain 11/15/17. Responsible Person: Consulting	

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{F 225}	Continued From page 3 became very ill and could not walk to the bus station so the leasing agent at his complex had called him a taxi cab to take him to the hospital. Resident #4 stated that when the taxi came to pick him up he asked the driver to take him to an Automatic Teller Machine (ATM) to withdraw some money because he had no idea when or if he would be returning to his apartment. Resident #4 stated he withdrew $500.00 which was enough to pay the taxi driver and to have some extra cash. He stated that when he arrived at the hospital he paid the driver $55.00, the hospital locked up the remaining $445.00 and before he was discharged to the facility the money was returned. He added that when he arrived at the facility he counted the money and had $445.00. After counting the money Resident #4 stated he wrote the amount on a small piece of paper, folded it with the money which was mostly $20.00 bills and placed the bill fold in the night stand drawer that had a lock on it but no key was in the room. He stated that on 10/22/17 he wanted to go the facility store to get a few items so he took his wallet out and counted his money and there was $389.00 missing mostly the $20.00 bills but whoever took it left the piece of paper folded in the money to make it look like it had not been touched. Resident #4 stated he reported it to the SW who stated all she could do was report it and make sure it was not the room. He added that he told the SW that he assumed this place was safe and put it in his night stand. Resident #4 stated he explained to the SW that there was no key to lock the night stand drawer. The SW provided a lock box to Resident #4 and maintenance placed a new lock with a key to the night stand. Resident #4 stated that when he admitted to the facility no one offered to lock his belongings up and he added that he came late in the day and really did	{F 225}	Administrator All current interviewable residents as of 11/16/17 were interviewed to identify any additional outstanding grievance issues that need further investigation. Date Certain: 11/16/17. Responsible Person: Consulting Administrator All-staff will participate in education/training to include policies, procedures, and appropriate handling of grievances, concerns, questions, or service opportunities to include definitions and access locations for resources. This education will also include training on policies, procedures, and appropriate reporting of abuse-neglect-misappropriation allegations with a concentration on misappropriation of funds. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to completed training prior to working a scheduled shift. Date Certain: 11/30/17. Responsible Person: RN Facility Educator and RN Service Line Educator The new DON and interim administrator have reviewed the facility policies on the expectations of reporting allegations of misappropriation. Date Certain: 11/17/17. Responsible Person: Administrator and DON The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Consulting Administrator is responsible for the overall implementation of this plan of	

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{F 225}	Continued From page 4 not see anyone until the next day. An interview was conducted with the Administrator on 11/01/17 at 4:28 PM. The Administrator stated that he was responsible for reporting allegations of misappropriation of resident property to the State Agency and he did not report Resident #4's allegation to the State Agency. He stated that they had a facility policy that stated they were not responsible for missing items. He added that he was not confident that Resident #4 even had that money coming into the facility. He further stated that SW #1 had interviewed him and reminded him of the missing item policy. The Administrator stated that every room had a drawer at bedside that locked and the key was provided to them on admission. He added that if the facility was aware that the resident had valuables they would offer to lock them up, but it was not routinely offered to all residents to lock up their belongings. The Administrator stated that in this case they were not sure if he had the money to begin with and "he did not believe this was misappropriation of resident property because Resident #4 had been out of the facility for appointments and other things in the community." He again confirmed that he had not reported this to the State Agency. An interview was conducted with SW #2 on 11/02/17 at 10:19 AM. She stated she was off for a day and returned to work on 10/25/17 and she had a message from Nursing Assistant (NA) #3 that Resident #4 had reported to her that he had some money missing and she had reported it the nurse, but she could not recall which nurse. She stated she went and talked to her supervisor, SW #1 and was told that she had initiated a grievance because he had reported it to her as well. SW #2	{F 225}	correction. Consulting Administrator will monitor 100% of grievances for compliance daily. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations.	

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{F 225}	Continued From page 5	{F 225}		

stated that Resident #4 had stopped by her office later that day and stated he had $389.00 missing. He also stated that he had not told anyone that he had the money when he came to the facility. SW #2 stated that Resident #4 had gotten the money out of the ATM on the way to the hospital and she had called the hospital and confirmed that he had locked up $446.00 and was given the money upon discharge to the facility. She added that she had given him a lock box to use and then when maintenance had replaced the lock and given him a key to the night stand,he returned the lock box. SW #2 stated that the police were not notified that the money was missing.

An interview was conducted with SW #1 on 11/02/17 at 11:59 AM. SW #1 stated that Resident #4 had come to her office on 10/23/17 and stated he was missing money. He stated when he left the hospital he had $446.00 and now he did not have that much money now. SW #1 stated she asked "are you sure you did not drop it?" and he replied that he had been to the vending machine a couple of time but would not have spent over $300 which was what was missing. SW #1 stated that Resident #4 had been out to doctor appointments and she did not know if he had taken it with him and lost it or what had happened to the money. She added that she had the staff do an incident report and she initiated a grievance. SW # 1 stated that when she went to Resident #4's room she noticed that there was no key to the top drawer of the night stand so she had maintenance get him a key so he could lock the remaining #56.00 up in it. SW #1 stated that when the incident report was filed it would go to the Administrator and Director of Nursing (DON) and it would be up to them to report the issue to the police and/or State Agency.

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{F 225}	Continued From page 6 Attempt to speak to NA #3 on 11/02/17 at 3:57 PM was unsuccessful.	{F 225}		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention.	F 226		11/30/17

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F 226	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to follow its "Abuse, Neglect, Exploitation, or Mistreatment, including Injuries of unknown source, and Misappropriation of Resident Property" policy by failing to notify the appropriate agencies of an allegation of misappropriation of resident property for 1 of 1 residents sampled (Resident #4). The Findings Included: Review of a facility policy titled Prohibit and Prevent Violations of Resident Abuse, Neglect, Exploitation, or Mistreatment, including Injuries of Unknown Source, and Misappropriation of Resident Property, dated as issued on 02/09 and most recently updated 11/16, read in part "the Administrator will provide to the person in charge of the investigation a completed copy of the 24 Hour Initial Report from and any supporting documents relative to the alleged incident." The policy further stated "the investigator will give a copy of the completed 5 Working Day Report form to the administrator with 5 working days of the reported incident." The policy also directed that should the investigation reveal that suspected or actual theft/misappropriation of resident property occurred, the Administrator or designee would report such findings to the resident's representative and appropriate agencies. Review of the admission comprehensive minimum data set (MDS) dated 10/17/17 revealed that Resident #4 was cognitively intact and required set up assistance with activities of daily living.	F 226	F226 The plan correcting the specific deficiency. The plan should address the processes that led to the deficiency cited On 10/23/17, Resident #4 reported to the facility staff that he had money missing. A grievance report for the missing money was filed, however, the administrator at the time did not think the incident should be reported using the appropriate 24-hour and 5-working day reports to the State Agency. Instead, the administrator made the determination that this was a grievance and did not constitute a reportable event. The administrator at the time of this incident is no longer employed at the facility. The interim administrator instructed the DON to complete the 24-hour and 5-working day reports and to attach the investigative materials to the appropriate State Agency. Determining what constitutes as a concern, grievance, or a reportable event has been included in education for all staff. The facility□s department heads have been instructed to bring all concerns to the morning stand-up meeting and the IDT can make recommendations as to whether an incident needs to be reported to the State Agency, however, the Administrator and DON will be responsible for reporting all allegations of abuse, neglect, misappropriation, and exploitation on the 24-hour and 5-working day reports.	

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F 226	Continued From page 8 Review of a grievance filed by Resident #4 on 10/23/17 read in part that Resident #4 reported missing $389.00 out of his wallet that was in his night stand drawer. The steps taken to investigate read in part that facility staff looked all over resident's room including the bed sheets, under the bed and in drawers and could they not locate the money. Staff called the hospital that Resident #4 was discharged from and verified that he was given $445.00 upon transfer to the facility. Summary of pertinent findings read in part that on 10/23/17 Resident #4 was given a lock box to keep the remaining $56.00 in and a maintenance request was made to get the key to the night stand drawer so Resident #4 could keep it locked. The form was signed by Social Worker (SW) #1. Review of an incident report dated 10/26/17 read in part that Resident #4 reported that when he came into the facility he had $446.00 in cash in his wallet and as of 10/23/17 he only had $56.00 left. This report documented that he did not have the night stand drawer locked at bedside because he did not have a key. A brief interview was conducted with the Administrator on 11/01/17 at 10:00 AM who stated that the facility had not submitted any 24 hour/5 working day reports since 10/23/17. An interview was conducted with Resident #4 on 11/01/17 at 3:54 PM. Resident #4 stated that on the way to the prior to his admission to the facility he withdrew $500.00 which was enough to pay the taxi driver and to have some extra cash. He stated that when he arrived at the hospital he paid the driver, the hospital locked up the remaining	F 226	The procedure for implementing the acceptable POC for the specific deficiency cited A new process flow to help staff members determine what constitutes as a concern, grievance, or reportable issue to the State Survey Agency will be included in education for all staff members. Date Certain: 11/30/17. Responsible Person: RN Facility Educator and RN Service Line Educator All active grievances within the previous 90 days as of 11/15/17 will be reviewed, action will be taken to close all grievances to the satisfaction of the resident. This will ensure that the facility□s policy has been followed. Grievances opened after date certain will follow new grievance process flow. Date Certain: 11/15/17. Responsible Person: Consulting Administrator A Resident Council Meeting was held to educate the residents on the facility□s grievance process. Date Certain 11/15/17. Responsible Person: Consulting Administrator All-staff will participate in education/training to include policies, procedures, and appropriate handling of grievances, concerns, questions, or service opportunities to include definitions and access locations for resources. This education will also include training on policies, procedures, and appropriate reporting of abuse-neglect-misappropriation allegations with a concentration on misappropriation of funds. Any staff members who do not receive the training by the specified date (due to FMLA, leave,	

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F 226	Continued From page 9 $445.00 and before he was discharged to the facility the money was returned. He added when he arrived at the facility he counted his money and he had $445.00. After counting the money Resident #4 stated he wrote the amount on a small piece of paper, folded it with the money which was mostly $20.00 bills and placed the bill fold in the night stand drawer that had a lock on it but no key was in the room. He stated that on 10/22/17 he recounted his money and there was $389.00 missing, mostly the $20.00 bills, but whoever took it left the piece of paper folded in the money to make it look like it had not been touched. Resident #4 stated he reported it to the SW on 10/23/17 who stated all she could do was report it and make sure it was not in the room. Resident #4 stated he explained to the SW that there was no key to lock the night stand drawer. The SW provided a lock box to Resident #4 and maintenance placed a new lock with a key to the night stand. Resident #4 stated that when he admitted to the facility no one offered to lock his belongings up. An interview was conducted with the Administrator on 11/01/17 at 4:28 PM. The Administrator stated that he was responsible for reporting allegations of misappropriation of resident property to the State Agency/law enforcement and he did not report Resident #4's allegation to the State Agency/law enforcement. He stated that they had a facility policy that stated they were not responsible for missing items. He added that he was not confident that Resident #4 even had that money coming into the facility. He further stated that SW #1 had interviewed him and reminded him of the missing item policy. The Administrator stated that every room had a drawer at bedside that locked and the key was	F 226	etc.) will be required to completed training prior to working a scheduled shift. Date Certain: 11/30/17. Responsible Person: RN Facility Educator and RN Service Line Educator The new DON and interim administrator have reviewed the facility policies on the expectations of reporting allegations of misappropriation. Date Certain: 11/17/17. Responsible Person: Administrator and DON The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Consulting Administrator is responsible for the overall implementation of this plan of correction. Consulting Administrator will monitor 100% of grievances for compliance daily. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations.	

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F 226	Continued From page 10	F 226		

provided to them on admission. The Administrator stated that in this case they were not sure if he had the money to begin with and "he did not believe this was misappropriation of resident property because Resident #4 had been out of the facility for appointments and other things in the community." He again confirmed that he had not reported this to the State Agency/law enforcement.

An interview was conducted with SW #2 on 11/02/17 at 10:19 AM. She stated she was off for a day and returned to work on 10/25/17 and was notified that Resident #4 had some money missing. She stated she went and talked to her supervisor, SW #1, and was told that she had initiated a grievance because he had reported it to her as well. SW #2 stated that Resident #4 had stopped by her office later that day and stated he had $389.00 missing. SW #2 stated that Resident #4 had gotten the money out of the ATM on the way to the hospital and she had called the hospital and confirmed that he had locked up $446.00 and was given the money upon discharge to the facility. She added that she had given him a lock box to use and then when maintenance had replaced the lock and given him a key to the night stand he returned the lock box. SW #2 stated that the police were not notified that the money was missing.

An interview was conducted with SW #1 on 11/02/17 at 11:59 AM. SW #1 stated that Resident #4 had come to her office on 10/23/17 and stated he was missing money. He stated when he left the hospital he had $446.00 and now he did not have that much money now. SW #1 stated she asked "are you sure you did not drop it?" and he replied that he had been to the

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F 226	Continued From page 11 vending machine a couple of time but would not have spent over $300 which was what was missing. SW #1 stated that Resident #4 had been out to doctor appointments and she did not know if he had taken it with him and lost it or what had happened to the money. She added that she had the staff do an incident report and she initiated a grievance. SW #1 stated that when the incident report was filed it would go to the Administrator and Director of Nursing (DON) and it would be up to them to report the issue to the police and/or State Agency.	F 226		
{F 309} SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility 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.	{F 309}		11/30/17

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{F 309}	Continued From page 12 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 observations, record review, staff, private duty sitter, Hospice Nurse, and Nurse Practitioner interviews the facility failed to identify the cause of a wound to the left hand and once identified failed to apply the correct treatment to the wound for 1 of 3 residents sampled for well-being (Resident #2). The findings included: Resident #2 was admitted to the facility on 08/24/16 with diagnoses that included coronary artery disease, dementia, history of right hip fracture, depression, anemia, hypertension, and hyperlipidemia. Review of the most recent quarterly minimum data set (MDS) dated 09/27/17 revealed that Resident #2 was severely cognitively impaired for daily decision making and required total assistance of 1 to 2 staff members for activities of daily living. The MDS also indicated that Resident #2 had no speech and had impairments to bilateral upper and lower extremities.	{F 309}	F309 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The plan correcting the specific deficiency. The plan should address the processes that led to the deficiency cited During the survey ending 11/2/17, a surveyor and wound treatment nurse were conducting treatment observations for Resident #2. When they arrived at the patient□s room, the nurse responsible for the patient had already completed Resident #2□s dressing changes. The nurse failed to verify the treatment orders for Resident #2 before applying wound treatments. Correct treatments were immediately applied by the wound treatment nurse. The Registered Nurse	

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{F 309}	Continued From page 13 Review of a Nurse Practitioner (NP) visit note dated 10/27/17 read in part that Resident #2 was seen at the request of nursing staff who noted a new wound to his left hand of unknown duration that was first observed on the day of this visit. The wound was noted in the crease of his thumb on his left hand. Nursing staff reported no obvious recent trauma to the hand. Family at his bedside during the visit reported they were unsure of its onset or indication as well. The impression and plan read in part that Resident #2 was noted with a significant laceration of skin at his left thumb with wound depth as quite significant. The note documented there was no indication or obvious local or systemic infection, the majority of the tissue involved appeared to be granulated, there was no obvious drainage and it appeared as neurovascularly intact. The note documented a discussion with the Medical Doctor (MD) and care would be to attempt secondary healing of the wound, holding off on surgical/suturing at that point. The note documented the cause of the wound as unclear as to the cause and the note was signed by the NP. Review of an MD order dated 10/27/17 read to clean the resident's left finger wound with antiseptic and apply wet gauze packing daily. An observation of Resident #2 was made on 11/01/17 at 11:00 AM with concurrent interview of the facility Wound Nurse (WN). Nurse #1 was observed to report to the WN upon entering Resident #2's room that she had already completed Resident #2's dressing change to his left hand because he had gone to the shower and it had gotten wet, so she just went ahead and completed the dressing change. When the WN entered Resident #2's room he was resting in bed	{F 309}	who applied the wrong treatment during the survey was immediately provided with re-education from the DON and received written counseling. Re-education included wound evaluation, reporting and documentation expectations, and importance of following provider orders related to wound treatments. Education provided to all nurses on verifying treatment orders prior to applying wound treatments. The procedure for implementing the acceptable POC for the specific deficiency cited All nurses will receive wound in-service education that includes: Prevention, identification, reporting, documentation, and treatments options. CNAs will receive in-service education related to the identification of wounds found during routine care. Date Certain: 11/27/17. Responsible Party: RN Service line educator and RN facility educator Head-to-toe skin assessments completed by a Registered Nurse for all residents to ensure all wounds identified and wound orders are appropriate. Date Certain: 11/30/17. Responsible Party: DON The facility will establish a weekly risk meeting to be conducted by the interdisciplinary team, and any other members that the Administrator or Director of Nursing include as consultative experts. Date Certain: 11/21/17. Responsible Party: DON The Informatics and Analytics Services (IAS) team has formatted a report that can be run for the previous 24 hours to	

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{F 309}	Continued From page 14 on his right side and had a geri sleeve (protective glove) to each lower arm. The geri sleeve was noted to loop over the thumb and rest between the first finger and thumb and then extended up to the elbow. The WN removed the geri sleeve on Resident #2's left hand to visualize the dressing that Nurse #1 had completed after his shower. As the WN removed the sleeve, the dressing that was between the thumb and first finger came off. The dressing was dated for 11/01/17 and was a dry dressing with the WN stating she would redo the dressing using the correct treatment of saline soaked gauze as ordered. The WN completed the treatment as ordered, applied a new dressing that was again dated 11/01/17 and replaced the geri sleeve to his left hand. After the correct treatment was applied the WN was observed to step out into the hallway and inform Nurse #1 what the correct treatment to the area was and that she had performed the treatment. The WN indicated that she believed that the geri sleeve had caused the area to Resident #2's left hand and she had reported that to the MD. The right geri sleeve was also removed and the hand was visualized with the area between the first finger and thumb appearing red and moist but the skin was intact. An interview was conducted with the WN on 11/01/17 at 1:50 PM. The WN stated initially the area to Resident #2's left hand was discovered by the private duty sitter and reported to the staff. The WN stated that when she went to assess the wound the NP was already in the room. She stated the family actually wanted the area stitched up but because there was no determination as to how long the wound had been present, family agreed to allow the facility to treat the area. The WN confirmed that she had informed Nurse #1	{F 309}	capture new wound treatment orders. This will be run daily and brought to the morning stand-up and PPS meetings to ensure appropriate documentation and follow up is completed. Date Certain: 11/24/17. Responsible Party: DON The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements DON will assess all wounds and treatments weekly to validate nursing competencies around wound care and understanding of the in-services and education provided. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The DON has the responsibility for implementation, monitoring, and oversight of this care area.	

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what the correct treatment to Resident #2's left hand was then proceeded to apply the correct treatment to the wound. The WN added that the private duty sitter had told her that when she bathed him on 10/20/17 the wound was not present. She added that Resident #2 had worn the geri sleeves ever since she had worked at the facility since May 2017.

An interview was conducted with the Assistant Director of Nursing (ADON) on 11/01/17 at 2:43 PM. The ADON indicated that when she was notified of the wound and went to assess it the NP was already in the room. She stated that when she went to assess the wound it was near the end of first shift and she had only spoken to 1 NA who stated that the wound was not present the previous day. The ADON stated that after the wound was discovered the focus was on getting the treatment ordered and in place, that they had decided to leave the geri sleeves in place because of Resident #2's history of bruises and as he now had the protective treatment between the skin and the geri sleeve she felt like it was ok to leave them in place. The ADON confirmed that they were not sure how the wound developed and that no investigation was completed to determine the cause.

An interview was conducted with private duty sitter on 11/01/17 at 2:50 PM. The sitter stated she was hired by Resident #2's family to make ensure he ate, was changed, and make sure he was comfortable. The sitter stated that she had provided care to Resident #2 on 10/25/17 and had visualized the area between his left first finger and thumb and the skin was intact and then on 10/27/17 when she returned she discovered the area was open and reported it to Nurse #1.

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The sitter stated that when she arrived at the facility to care for Resident #2 he would already have on the geri sleeves and it was very rare to see the staff remove or apply them because they were on all the time. The sitter further stated that Resident #2 was contracted and she had to calm him down by talking to him, at which point he would relax his hand and she was able to see the full wound, but if he was tightly contracted it was very difficult to see the area.

An interview was conducted with Nurse #1 on 11/01/17 at 3:14 PM. Nurse #1 stated that she routinely cared for Resident #2 and on 10/27/17 his sitter reported to her that the resident needed a band aid as he had a cut on his hand. Nurse #1 stated she went to assess the area which looked as if the skin had come apart where the geri sleeve rested between his first finger and thumb. She stated this wound was approximately 0.2 centimeters (cm) deep and had no blood, no odor and no signs of infection. Nurse #1 stated that she completed the head to toe assessments on Resident #2 weekly and she would move clothes around to visualize the skin, including routinely removing the geri gloves during the assessment to visualize the hands. Nurse #1 stated that she had completed Resident #2 dressing to his left hand because he was in the shower and the old dressing was wet. Nurse #1 stated she applied the dry dressing and dated the dressing, but would have gone back after her medication pass to apply the correct treatment to the area.

Review of an MD order dated 11/02/17 directed that geri sleeves were to be worn at all times and could be removed for daily skin checks during bathing.

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An interview was conducted with NA #1 on 11/02/17 at 9:29 AM. NA #1 stated that she routinely cared for Resident #2. She stated that the hospice staff was at the facility on Monday, Wednesday and Friday and they provided his care and that on those days hospice staff were not at the facility she provided the care. NA #1 added that the private duty sitters were also present most of the time to assist with feeding and to provide companionship to Resident #2. NA #1 added that Resident #2 wore his geri sleeves all during the day and she would remove them for his bath and then reapply them. NA #1 stated that she had last visualized the area between Resident #2's left first finger and thumb on 10/24/17 and the skin was intact, then hospice staff would have provided the care to him on 10/25/17 and 10/26/17. She stated on 10/27/17 the sitter noted the open area to his left hand and they started treatment to the wound.

An interview was conducted with the Nurse Practitioner (NP) on 11/02/17 at 10:21 AM. The NP stated she was asked by the WN to assess a wound to Resident #2's hand which was a little contracted and required a nurse to open his hand up for visualization. She stated no one including family knew how long the wound was present which was deep and not very granulated. She stated she collaborated with the Medical Doctor and decided secondary healing would be the treatment choice. She stated the wound looked like a laceration but as to the cause she could not make any assumptions or presumptions.

An interview was conducted with the Hospice Nurse (HN) on 11/02/17 at 10:31 AM. The HN stated that she visited Resident #2 twice a week

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{F 309}	Continued From page 18 and the NAs visited him 3 times a week on Monday, Wednesday and Friday. She added that on Monday and Friday the NAs provide him with a full bed bath and on Wednesdays they took Resident #2 to the shower. The HN stated that the NAs were trained to look at the resident's skin and if they noticed any changes or anything unusual they were to report that directly to her and she would follow up. She added that she had actually applied Resident #2's geri sleeves on Tuesday 10/24/17 and Thursday 10/26/17 and did not see any wound to his left hand, but stated it was difficult to assess his skin due to his contracture. An interview was conducted with the Director of Nursing (DON) on 11/02/17 at 3:13 PM. The DON stated that she had only been at the facility since Monday 10/30/17 and really wanted to build a comprehensive wound program at the facility. The DON stated she would expect for skin checks to be done weekly as ordered, then sometime during the day the geri sleeves to be removed and the skin inspected and any changes reported. The DON further stated she expected the staff to follow wound orders exactly as ordered. The DON stated that she had been completely through Resident #2's medical record and she could not find an order for the geri sleeves and therefore had no idea how long they had been in place. She added that she had written an order for the geri sleeves on 11/02/17 that included daily skin checks.	{F 309}		
{F 520} SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance.	{F 520}		11/30/17

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{F 520}	Continued From page 19 (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 (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:	{F 520}		

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{F 520}	Continued From page 20 Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October 05, 2017 following a follow-up and complaint survey, subsequently recited in November 02, 2017 on the current follow-up complaint survey. The repeat deficiencies were in the area of resident behaviors and facility practices (F225) and provide care to maintain well-being (F309). These deficiencies were recited during the facility's current follow up complaint survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F225: Based on staff interviews and record reviews the facility failed to notify the State Survey Agency within the required 24 hour initial report time frame for an allegation of misappropriation of resident property and failed to report to the State Survey Agency within the required 5 working day time frame of the investigation of an allegation of misappropriation of resident property for 1 of 1 sampled residents (Resident #4). During the follow up complaint survey of 10/05/17, this regulation was cited for failing to notify the Stage Survey Agency with the required 24 hour initial report time frame for an allegation of abuse for 1 of 7 residents (Resident #5) and failed to notify the State Survey Agency within the	{F 520}	F 520 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F225 was a repeat citation for failing to report an allegation of misappropriation. The allegation was not communicated with the QAPI committee. Instead, the administrator at the time of the allegation made the determination that it did not constitute as a reportable incident. Instead, the administrator investigated the allegation through the facility□s grievance process. On 10/23/17, Resident #4 reported to the facility staff that he had money missing. A grievance report for the missing money was filed, however, the administrator at the time did not think the incident should be reported using the appropriate 24-hour and 5-working day reports to the State Agency. Instead, the administrator made the determination that this was a grievance and did not constitute a reportable event. The administrator at the time of this incident is no longer employed at the facility. The interim administrator instructed the DON to complete the 24-hour and 5-working day reports and to attach the investigative materials to the appropriate State Agency. Determining what constitutes as a concern, grievance, or a	

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	345096	A. BUILDING _____ B. WING _____	R-C 11/02/2017

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{F 520}	Continued From page 21 required 5 working day time frame of allegation of abuse investigation for 2 of 7 residents with abuse allegations (Resident #5 and #2). 1b. F309: Based on observations, record review, staff, private duty sitter, Hospice Nurse, and Nurse Practitioner interviews the facility failed to investigate a wound to the left hand and once identified failed to apply the correct treatment to the wound for 1 of 3 residents sampled for well-being (Resident #2). During the follow up complaint survey of 10/05/17, this regulation was cited for failing to assess a surgical incision on a resident's lower back or provide daily dressing changes according to the physician's orders who had to be readmitted to the hospital for an incision and drainage and revision of the incision due to a wound infection of their lower back (Resident #2) for 1 of 1 resident with a surgical incision. An interview was conducted with the Administrator on 11/02/17 at 3:35 PM. The Administrator stated that the Quality Assurance (QA) team met monthly and consisted of the Administrator, Director of Nursing, Dietitian, Medical Director, Pharmacist, Social Worker, Wound Nurse, Nurse Educator and anyone else as needed. He added that they had not yet had the time to take the previous follow up complaint survey through the QA program. The Administrator stated that he believed the investigation that was conducted with the grievance that Resident #4 filed was sufficient evidence to determine that the allegation was not misappropriation of resident property and that was why he had not filed the required 24/5 working reports to the State Agency. He added	{F 520}	reportable event has been included in education for all staff. The facility□s department heads have been instructed to bring all concerns to the morning stand-up meeting and the IDT can make recommendations as to whether an incident needs to be reported to the State Agency, however, the Administrator and DON will be responsible for reporting all allegations of abuse, neglect, misappropriation, and exploitation on the 24-hour and 5-working day reports. The new interim administrator and new DON understand the requirement to report allegations to the QAPI committee for further guidance. F309 was also a repeat citation. During the survey ending 11/2/17, a surveyor and wound treatment nurse were conducting treatment observations for Resident #2. When they arrived at the patient□s room, the nurse responsible for the patient had already completed Resident #2□s dressing changes. The nurse failed to verify the treatment orders for Resident #2 before applying wound treatments. Correct treatments were immediately applied by the wound treatment nurse. The Registered Nurse who applied the wrong treatment during the survey was immediately provided with re-education from the DON and received written counseling. Re-education included wound evaluation, reporting and documentation expectations, and importance of following provider orders related to wound treatments. Education provided to all nurses on verifying treatment orders prior to applying wound treatments. The QAPI	

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{F 520}	Continued From page 22 that the facility was going to use the associated hospital's resources to gain substantial compliance going forward and he believed that would be very helpful to the facility.	{F 520}	committee□s original recommendations to the DON were not followed. The previous DON was responsible for auditing wound treatments and failed to do so adequately. The new DON has implemented a weekly risk meeting to discuss current residents with wounds, and is also assessing wounds and treatments on a weekly basis. The procedure for implementing the acceptable POC for the specific deficiency cited All active grievances within the previous 90 days as of 11/15/17 will be reviewed, action will be taken to close all grievances to the satisfaction of the resident. Grievances opened after date certain will follow new grievance process flow. Date Certain: 11/15/17. Responsible Person: Consulting Administrator A Resident Council Meeting was held to educate the residents on the facility□s grievance process. Date Certain 11/15/17. Responsible Person: Consulting Administrator All current interviewable residents as of 11/16/17 were interviewed to identify any additional outstanding grievance issues that need further investigation. Date Certain: 11/16/17. Responsible Person: Consulting Administrator All-staff will participate in education/training to include policies, procedures, and appropriate handling of grievances, concerns, questions, or service opportunities to include definitions and access locations for resources. This education will also include training on policies, procedures, and appropriate	

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{F 520}	Continued From page 23	{F 520}	reporting of abuse-neglect-misappropriation allegations with a concentration on misappropriation of funds. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to completed training prior to working a scheduled shift. Date Certain: 11/30/17. Responsible Person: RN Facility Educator and RN Service Line Educator The new DON and interim administrator have reviewed the facility policies on the expectations of reporting allegations of misappropriation. Date Certain: 11/17/17. Responsible Person: Administrator and DON All nurses will receive wound in-service education that includes: Prevention, identification, reporting, documentation, and treatments options. CNAs will receive in-service education related to the identification of wounds found during routine care. Date Certain: 11/27/17. Responsible Party: RN Service line educator and RN facility educator Head-to-toe skin assessments completed by a Registered Nurse for all residents to ensure all wounds identified and wound orders are appropriate. Date Certain: 11/30/17. Responsible Party: DON The facility will establish a weekly risk meeting to be conducted by the interdisciplinary team, and any other members that the Administrator or Director of Nursing include as consultative experts. Date Certain: 11/21/17. Responsible Party: DON The Informatics and Analytics Services	

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{F 520}	Continued From page 24	{F 520}	(IAS) team has formatted a report that can be run for the previous 24 hours to capture new wound treatment orders. This will be run daily and brought to the morning stand-up and PPS meetings to ensure appropriate documentation and follow up is completed. Date Certain: 11/24/17. Responsible Party: DON The monitoring procedure to ensure that the POC is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements F225 - Consulting Administrator is responsible for the overall implementation of this plan of correction. Consulting Administrator will monitor 100% of grievances for compliance daily. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. F309 - DON will assess all wounds and treatments weekly to validate nursing competencies around wound care and understanding of the in-services and education provided. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat	

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{F 520}	Continued From page 25	{F 520}	citations. The DON has the responsibility for implementation, monitoring, and oversight of this care area. The interim Administrator will have responsibility of monitoring and oversight of this citation.	