STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING _____ B. WING _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation (Event ID #HEJP11) was conducted on 11/13/18 through 11/16/18. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. Tags F600 and F684 constituted substandard quality of care. Immediate jeopardy began on 10/30/18 and was removed on 11/16/18. An extended survey was completed. There were no deficiencies cited as a result of the complaint investigation.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		12/7/18

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

Electronically Signed | 12/10/2018

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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner, Physician, and staff interviews, the facility neglected to assess and maintain a clean covered wound and neglected to implement effective interventions to prevent a resident from picking at a wound to prevent maggot infestation for 1 of 1 resident reviewed with having maggots in a wound (Resident #5). In addition the facility neglected to provide ordered assistive equipment for 1 of 1 resident reviewed for assistive devices (Resident #2). Immediate Jeopardy began on 10/30/18 when maggots were found in Resident #5's wound above his ear. Immediate Jeopardy was removed on 11/16/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) for example #2. The findings included: 1. Resident #5 was admitted to the facility on 01/29/18 with diagnoses of hypertension, unspecified dementia without behavioral disturbance, hyperlipidemia, muscle weakness, and depression. There was no diagnosis of a wound for Resident #5. There were no documented wound assessments completed for Resident #5 from his admission of 01/29/18 until his discharge of 10/30/18. Review of the skin assessment dated 02/16/18 revealed Resident #5 had an open area/blister to	F 600	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By the Deficient Practice: Immediately after learning of the incident the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse: 1. Resident #5 was sent to the hospital for evaluation and treatment of the open cancerous lesion On October 30, 2018. The facility nursing staff had noted that resident #5 had maggots in the wound. Per the resident□s family□s request, he did not return to this facility 2. On October 30, 2018 the Quality Assurance nurse completed a thorough skin assessments on all residents with wounds and noted that no other residents□ wounds showed any evidence of foreign bodies, infection, or neglect by nursing staff. 3. The Director of nursing and Quality Assurance nurse began interviewing nursing staff concerning these residents□ wounds to determine when the last wound treatment was done and when it was first noted that the resident #5 had removed	

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F 600	Continued From page 2 left side of head. Review of the physician order dated 02/20/18 revealed Resident #5 should have a non-adhesive dressing applied to the wound over his left ear every three days. Review of the nurse's notes for Resident #5 revealed the following: 02/28/18 - 11:48 AM Resident observed picking at area above left ear. Blood noted dripping down side of head. Area cleansed, and dry dressing applied. Resident continues to pick at area. 03/01/18 - Dressing to left ear is not present and new one applied. Review of the Nurse Practitioner (NP) progress notes dated 03/13/18 revealed Resident #5 had a skin cancer of the scalp removed with a wound and continued to remove dressing from the wound over his left ear. He refused to leave the dressing over suspected area of skin cancer above his left ear. He was having some minimal drainage. Will continue to monitor, as potentially this is a risk to other residents if his drainage ends up in places that another patient will touch. There were no signs and symptoms of infection at this time, but he is certainly high risk related to this. He and his family have opted for no further workup or treatment related to this at this time. Review of the NP Progress Note dated 05/31/18 revealed Resident #5 was seen due to nursing report that he had some green drainage from the wound on the left side of his head this AM. He	F 600	the dressing from the wound. Staff had noted that the dressing was intact during all round made on the resident up until the 5am round on October 30th when the dressing was noted to be missing. The facility had an order to change the dressing daily and to use dry dressings on the open cancerous lesion. There were no orders for ointments or other treatments due to resident #5□s propensity to pick at the wound and to eat the scabs and other material from the wound. Other than staff intervening and re-directing this resident when he was noted to be picking at the wound, no other interventions were in place as the resident□s cognitive status prevented him from being able to understand the need for leaving the wound alone. An in-house investigation began immediately on October 31, 2018 and neglect was not suspected. A 24 -hour initial report was not sent in due to neglect not being suspected. Statements from staff collected during the October 30th interviews that were done by the Director of nursing, show that staff were aware of the resident removing the dressing and that they would intervene when he was observed doing so. 4. 4. Resident #2 was provided with a nosey cup at all meals as ordered. The appropriate dietary aides, licensed nurses and nursing assitants were immediately re-trained on following tray card orders. Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To be Affected By The Same Deficient Practice: Immediately after learning of the incident	

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F 600	Continued From page 3 has had this wound for several months after an excision related to a cancer. He continues to pick at the wound and it has not healed because of this. Nursing continues to try to cover it several times a day, but he continues to remove and pick at it. Plan - He continues to pick at this lesion. Will likely continue to be open. Nursing will continue to try to dress this, but he will continue to remove. No signs and symptoms of infection noted today. Continue to monitor, high risk for infection given his hands always being in it. Review of the nurse's note dated 08/13/18 11:35 AM revealed Resident #5's dressing to left ear completed this am. Noted odorous greenish/tan drainage on soiled dressing. Acute sheet completed for the physician for further instruction. Review of the NP's Progress Note dated 08/14/18 revealed Resident #5 was seen today for nursing concern about the wound above his left ear. She reports that he has had some greenish/tan odorous drainage. This is a persistent wound removal of skin cancer. Since he has had this done, he has not kept his dressing on this and has been frequently picking at it which has worsened it. Nursing has devised a way it seems at this point to keep the dressing on so that he is not able to touch it, which will certainly help with healing. I do not see any signs or symptoms of infection that would warrant antibiotics at this point. Change the dressing to a dry dressing that is to be changed daily as this may help with the odor since it was only changed every 3 days before. Continue to monitor as he has high risk for infection.	F 600	on October 30,2018 the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse: 1. The facility already has developed and implemented written policies and procedures that prohibit and prevent abuse, neglect and exploitations of residents and misappropriation of resident property. Annually and as needed, in-services are completed, and an acknowledgement is signed by all staff in the facility. 2. All staff, including PRN staff were in-serviced by the Social worker and Vice President on abuse and neglect of residents on November 9, 2018 to ensure that all staff have an understanding of what constitutes neglect and what to do when neglect is suspected. On November 1, 2018 all nurses and aides were in-serviced by the Director of Nursing on what a change in condition is and who should be notified in the event of a change in condition. Aides were in-serviced on November 15, 2018 by the Director of Nursing that they should notify the nurse of any change in a resident□s condition including dressings that are not intact or are in need of changing. The nurses were in-serviced on November 15, 2018 by the Director of Nursing that they should notify the physicians, Director of nursing and the family in any change in condition of a resident. Any nurse or aide not present on November 15, 2018 will receive an in-service by the Director of Nursing as they report to work before beginning their shift. All new hires will receive training on	

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F 600	Continued From page 4 Review of the physician orders dated 08/14/18 for Resident #5's revealed a new order for the dressing to left ear to be changed every day with a dry dressing. Review of the quarterly Minimum Data Set (MDS) dated 10/23/18 revealed Resident #5 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, and personal hygiene. The MDS further revealed Resident #5 had behavioral symptoms toward others 1 to 3 days during the assessment period and was receiving dressing changes with no wound type checked on the MDS. Review of the care plan dated 10/23/18 revealed Resident #5 was care planned for removing the dressing from his left ear and picking at the area. The goal was for the staff to reapply the dressing as needed. The interventions were as follows: weekly skin assessments per facility protocol. Assist resident to reposition/shift weight frequently when up in wheelchair to reduce risk for redness or impairment at pressure points. Keep skin clean and dry. Keep nails clean and trimmed, rough edges filed. Review of the facility Treatment Record for 10/2018 revealed all treatments were checked as being completed as ordered. Review of the nurse's note dated 10/30/18 at 12:29 PM revealed it was reported by night shift nurse that resident had maggots noted in left ear wound. The NP was in and looked at wound. Order to send to emergency room for evaluation	F 600	abuse and neglect, change in condition, and reporting change in condition during initial classroom orientation that is conducted prior to new staff being assigned to work the floor. 3. All residents were interviewed by the social worker on November 9, 2018 to ensure they feel safe in the facility, if they feel anyone has harmed them, and if they feel they are receiving good care. All residents reported feeling safe and they feel the care provided to them is good. No resident reported any harm. 4. On October 30th the Quality assurance nurse completed a thorough skin assessment on all residents with wounds that included visually looking at the wounds to ensure that basic care and cleanliness had been provided and dressing changes and treatments were completed as ordered. 5. All residents with orders for assistive devices were reviewed by the Director of Nursing on 12/7/18 to ensure they are receiving the appropriate assistive device as ordered. On 12/12/18 the Director of Nursing in-serviced the appropriate nurses and nursing assistants on reading tray cards to ensure residents were receiving the ordered assistive device that is documented on the tray card. The Certified Dietary Manager observed the dietary aids completing the tray line to ensure they are reading tray cards and adding the appropriate devices as ordered. Any Nurse or nurse aide not present on 12/12/18, will receive an in-service by the Director of Nursing on tray cards and assistive devices before	

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F 600	Continued From page 5	F 600		

and treatment possible surgical debridement. RP notified, and resident transported via non-emergent transport.

Review of the nurse's note dated 11/02/18 at 2:26 PM as an Addendum with no late entry date documented revealed the following: Late entry: At about 5:00 AM the NA told this writer that resident took dressing off his wound. During application of new dressing, foreign bodies were noted in the wound. Wound was cleaned, and 2 foreign bodies removed. Note left in physician's book for NP who is due in facility this AM.

Review of the hospital records dated 10/30/18 through 11/02/18 revealed Resident #5 was seen in the emergency room (ER) for evaluation of a wound infection. The Plan of Care revealed the following statement from the ER physician, "I am concerned for this patient's well-being as I do not believe that all of his maggots appeared just today. They were likely there before today. I believe that he warrants hospitalization today for aggressive wound care and intravenous antibiotics." Medical Decision Making and Plan of Care revealed there was an infestation by maggots and wound infection. The patient had numerous, very large maggots in his wound which runs very deep. It does still appear to be superficial to the skull however. Did not believe imagining was indicated but certainly extensive blood work was warranted including blood cultures.

Review of the hospital discharge summary dated 11/02/18 revealed this 80-year-old male who

the beginning of their shift. All new hires will receive training on tray cards and assistive devices during the initial classroom orientation that is conducted prior to new staff being assigned to work.

Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur:
1. All neglect policies, practices, procedures and protocols were reviewed with all staff including any PRN staff on November 9, 2018. This was done through in-servicing that was conducted by the facility social worker and the facility Vice President. All new hires will receive in-servicing and training on neglect policies, practices, procedures and protocols during their initial classroom orientation prior to being assigned to work the floor.
2. All wounds will be assessed by the Director of Nursing on November 15, 2018. All wounds will be assessed by the Director of Nursing and the new wound physician on a weekly basis to ensure neglect and infections are not present.
3. On November 15, 2018, The Director of Nursing will review the behavior communication form and audit all charts of residents documented to have non-compliant behaviors to ensure nurses notes include the behaviors documented on the communication form and that interventions have been put in place. For resident□s with severely impaired cognition, interventions will be developed based upon the individual resident□s

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F 600	Continued From page 6 presented from skilled assisted living facility with a wound infection was noted to have a wound over his left ear that had been chronic and biopsied in the past and was noted to be cancer. He was noted to have maggots around his left ear wound. He was given intravenous antibiotics and admitted to the hospital. He was transitioned to by mouth antibiotics prior to discharge. A wound consult was placed, and it was recommended that the patient be placed on twice a day/as needed wound care with Dakins solution, a strong antiseptic that kills most forms of bacteria and viruses then cover with a moist gauze dressing. An interview conducted on 11/14/18 at 10:42 AM with Nurse #1 revealed she cared for Resident #5 from the time he was admitted to the day he was discharged to the hospital. She stated Resident #5 was admitted with a wound above his left upper ear and they were changing his dressing every three days. She stated Resident #5 would pick at his wound under his dressing and take his dressing off. She stated when she observed the greenish/tan odorous drainage on 08/14/18 she notified the NP and who wrote an order to change the dressing every day. Nurse #1 stated they would clean the wound with wound cleanser and cover with a dry dressing once a day. She further stated Resident #5 didn't remove his dressing every day, it was more when he was anxious. She stated she wasn't aware of any interventions in place to keep him from picking at his wound or removing the dressing. Nurse #1 further stated she had never observed maggots in Resident #1's wound until the morning he was sent out to the hospital to have them removed.	F 600	behavior to ensure that severely impaired cognitive residents do not suffer from neglect due to non-compliant behaviors. 4. All dietary aides and cooks will be in-serviced by the Certified Dietary Manager on 12/7/18 on how to read tray cards and ensure the required device is put on the resident tray as documented on the tray card. The Certified Dietary Manager will audit two meals a day daily for two weeks, weekly for two weeks and monthly time three months to ensure all residents needing assistive devices with meals have their ordered assistive device. The Certified Dietary Manager will document all observations and report them to the Quality Assurance Committee. Indicate How The Facility Plans To Monitor It□s Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained: 1. The Quality Assurance Committee, QAPI Committee and the Medical Director and Wound Physician have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on November 11, 2018. 2. The Director of Nursing□s weekly wound assessment rounds and audit of charts to ensure documentation, notification of physician due to change in resident wound conditions will be presented at monthly QA meetings and quarterly to the QAPI Committee for evaluation to determine if the system is	

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F 600	Continued From page 7 Interview conducted on 11/14/18 at 2:24 PM with Nurse #2 revealed he was working the 11:00 PM to 7:00 AM shift on 10/30/18 when the NA told him Resident #5 had taken off his dressing over his left ear. Nurse #2 stated he went in to replace the dressing and as he was cleaning it with wound cleanser he saw 2 maggots, which he removed from the wound. He stated he covered the wound with the dressing and put a note in the physician's book for the NP to see him later that morning. Nurse #2 further stated he never had to replace Resident #5's wound dressing during the night and that was the first time he had observed Resident #1's wound. Interview conducted on 11/14/18 2:54 PM with the facility Nurse Practitioner stated Resident #5 had a chronic wound over his left ear from a cancer being removed. She stated the family didn't want to pursue any radiation or chemotherapy for the cancer but did want treatment for the wound. She stated she never thought the wound looked infected and she had never cultured or measured the wound. She stated she never considered a wound consult for Resident #5 because he picked at the wound all the time and she didn't think a wound consult would benefit him. The NP stated she did not expect staff to do weekly measurements or weekly documentation of Resident #5's wound. The NP stated she had not assessed Resident #5's wound in about 2 months when she was asked to look at it on 10/30/18. She stated the wound had maggots in it that morning and she wrote an order for him to be sent to the hospital for evaluation. The NP stated the maggots were from Resident #5 picking at his wound and removing his dressing.	F 600	adequate and if determined it is not, they will devise and re-implement a system to ensure the alleged deficient practice does not occur again. 3. The review done by the interdisciplinary team on all residents with non-compliant behavior will be presented to the QA committee monthly and the QAPI committee quarterly. 4. All policies, procedures and protocols pertaining to neglect will be reviewed quarterly by the QAPI Committee for the next 3 quarters and annually thereafter for appropriateness in preventing neglect. 5. The Quality Assurance Committee will be responsible for reviewing all audits completed by the Certified Dietary Manager. They audits will be presented to the Quality Assurance Committee for evaluation monthly for 12 months. The Quality Assurance Committee will be charged with ensuring that correction are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction.	

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An interview conducted with Nurse Aide #1 on 11/14/18 at 3:11 PM revealed if she was working with Resident #5 and his dressing wasn't on she would let the nurse know and they would replace it. She stated Resident #5 constantly picked at the wound and removed his dressing often.

An interview conducted on 11/15/18 at 3:11 PM with the facility Physician revealed maggots in wounds came from flies laying eggs on the wound. He stated they started growing within 8 to 12 hours and the bigger they were the longer they had been present in the wound.

An interview conducted on 11/16/18 at 9:40 AM with Nurse #3 revealed she had changed Resident #5's dressing on 10/27/18, 10/28/18, and 10/29/18 and had not observed maggots or any signs or symptoms of infection in his wound. Nurse #3 further revealed she didn't do weekly measurements or skin assessments for Resident #5's wound above his ear since it wasn't being treated as a pressure area.

An interview conducted on 11/16/18 at 10:30 AM with the Director of Nursing revealed it was her expectation that there should have been documentation of weekly skin assessments completed for Resident #5's wound over his left ear.

On 11/14/18 at 5:12 PM the Administrator and

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F 600	Continued From page 9	F 600		

Corporate Vice President were notified of Immediate Jeopardy.

On 11/16/18 the facility provided a credible allegation of Immediate Jeopardy removal that included:

Immediately after learning of the incident the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse:

1. Resident #5 was sent to the hospital for evaluation and treatment of the open cancerous lesion On October 30, 2018. The facility nursing staff had noted that resident #5 had maggots in the wound. Per the resident's family's request, he did not return to this facility

2. On October 30, 2018 the Quality Assurance nurse completed a thorough skin assessments on all residents with wounds and noted that no other residents' wounds showed any evidence of foreign bodies, infection, or neglect by nursing staff.

3. The Director of nursing and Quality Assurance nurse began interviewing nursing staff concerning these residents' wounds to determine when the last wound treatment was done and when it was first noted that the resident #5 had removed the dressing from the wound. Staff had noted that the dressing was intact during all round made on the resident up until the 5am round on October 30th when the dressing was noted to be missing. The facility had an order to change the dressing daily and to use dry dressings on the open cancerous lesion. There were no orders for ointments or other treatments due to resident #5's propensity to pick at the wound and to eat the

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F 600	Continued From page 10	F 600		

scabs and other material from the wound. Other than staff intervening and re-directing this resident when he was noted to be picking at the wound, no other interventions were in place as the resident's cognitive status prevented him from being able to understand the need for leaving the wound alone. An in-house investigation began immediately on October 31, 2018 and neglect was not suspected. A 24 -hour initial report was not sent in due to neglect not being suspected. Statements from staff collected during the October 30th interviews that were done by the Director of nursing, show that staff were aware of the resident removing the dressing and that they would intervene when he was observed doing so.

Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To be Affected By The Same Deficient Practice:

Immediately after learning of the incident on October 30, 2018 the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse:

1. The facility already has developed and implemented written policies and procedures that prohibit and prevent abuse, neglect and exploitations of residents and misappropriation of resident property. Annually and as needed, in-services are completed, and an acknowledgement is signed by all staff in the facility.

2. All staff, including PRN staff were in-serviced by the Social worker and Vice President on abuse and neglect of residents on November 9, 2018 to ensure that all staff have an understanding of what constitutes neglect and what to do when neglect is suspected. On November 1, 2018 all nurses and aides were in-serviced by the Director of Nursing on what a change in condition is and

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who should be notified in the event of a change in condition. Aides were in-serviced on November 15, 2018 by the Director of Nursing that they should notify the nurse of any change in a resident's condition including dressings that are not intact or are in need of changing. The nurses were in-serviced on November 15, 2018 by the Director of Nursing that they should notify the physicians, Director of nursing and the family in any change in condition of a resident. Any nurse or aide not present on November 15, 2018 will receive an in-service by the Director of Nursing as they report to work before beginning their shift. All new hires will receive training on abuse and neglect, change in condition, and reporting change in condition during initial classroom orientation that is conducted prior to new staff being assigned to work the floor.

3. All residents were interviewed by the social worker on November 9, 2018 to ensure they feel safe in the facility, if they feel anyone has harmed them, and if they feel they are receiving good care. All residents reported feeling safe and they feel the care provided to them is good. No resident reported any harm.

4. On October 30th the Quality assurance nurse completed a thorough skin assessment on all residents with wounds that included visually looking at the wounds to ensure that basic care and cleanliness had been provided and dressing changes and treatments were completed as ordered.

Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur:

1. All neglect policies, practices, procedures and protocols were reviewed with all staff including any PRN staff on November 9, 2018.

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This was done through in-servicing that was conducted by the facility social worker and the facility Vice President. All new hires will receive in-servicing and training on neglect policies, practices, procedures and protocols during their initial classroom orientation prior to being assigned to work the floor.

2. All wounds will be assessed by the Director of Nursing on November 15, 2018. All wounds will be assessed by the Director of Nursing and the new wound physician on a weekly basis to ensure neglect and infections are not present.

3. On November 15, 2018, The Director of Nursing will review the behavior communication form and audit all charts of residents documented to have non-compliant behaviors to ensure nurses notes include the behaviors documented on the communication form and that interventions have been put in place. For residents with severely impaired cognition, interventions will be developed based upon the individual resident's behavior to ensure that severely impaired cognitive residents do not suffer from neglect due to non-compliant behaviors.

Indicate How The Facility Plans To Monitor It's Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained:

1. The Quality Assurance Committee, QAPI Committee and the Medical Director and Wound Physician have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on November 11, 2018.

2. The Director of Nursing's weekly wound assessment rounds and audit of charts to ensure documentation, notification of physician due to

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F 600	Continued From page 13 change in resident wound conditions will be presented at monthly QA meetings and quarterly to the QAPI Committee for evaluation to determine if the system is adequate and if determined it is not, they will devise and re-implement a system to ensure the alleged deficient practice does not occur again. 3. The review done by the interdisciplinary team on all residents with non-compliant behavior will be presented to the QA committee monthly and the QAPI committee quarterly. 4. All policies, procedures and protocols pertaining to neglect will be reviewed quarterly by the QAPI Committee for the next 3 quarters and annually thereafter for appropriateness in preventing neglect. Date of compliance November 16, 2018 The Administrator will be responsible for implementing this plan of correction. Immediate Jeopardy was removed on 11/16/18 at 12:26 PM when facility staff were interviewed and demonstrated they had been trained on the topics of abuse and neglect, change in condition, and report of change in condition. 2. Resident #2 was admitted to the facility 08/24/17 with diagnoses including Parkinson's disease, lack of coordination, and muscle weakness.	F 600		

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Review of the annual Minimum Data Set (MDS) dated 08/09/18 revealed Resident #2 was severely impaired for cognition and required supervision with eating.

Resident #2's care plan for nutrition last updated 11/01/18 revealed she was to receive a nosey cup with meals. (A nosey cup is a cup with a u shaped cut out on one side that allows the person using it to drink without bending their neck or tilting their head.)

Review of Resident #2's Physician orders dated 09/01/17 revealed she was to receive a nosey cup with meal trays.

Observation of Resident #2 on 11/13/18 on 12:32 PM revealed she was feeding herself and her nectar thickened beverages were in regular drinking glasses. There was no nosey cup observed on Resident #2's meal tray.

Observation of Resident #2 on 11/15/18 at 8:12 AM revealed she was eating breakfast with her nectar thickened liquid beverages in their original container. There was no nosey cup observed on Resident #2's meal tray.

An interview with the Dietary Manager on 11/15/18 at 8:39 AM revealed the kitchen was responsible for putting nosey cup on residents' trays and she was not sure why Resident #2 did not receive a nosey cup on her tray.

An interview with the Speech Therapist on 11/16/18 at 9:55 AM revealed he did not make the recommendation for Resident #2 to receive a nosey cup because the Speech Therapist that

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F 600	Continued From page 15 worked at the facility before him made the recommendation but he agreed with the recommendation and felt it was helpful for Resident #2 to be able to drink needed fluids. An interview with the Director of Nursing (DON) on 11/16/18 at 9:55 AM revealed she was aware that Resident #2 had not been receiving the nosey cup on her meal tray. The DON did not offer any reason as to why she did follow up to see why Resident #2 did not receive the nosey cup. The DON stated if the Physician ordered the nosey cup Resident #2 should receive the nosey cup. An interview with the Administrator on 11/16/18 at 1:18 AM revealed she expected Physician orders to be followed and if a resident had orders to receive a nosey cup the resident should receive the nosey cup.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		12/14/18

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F 656	Continued From page 16 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow the care plan to implement weekly skin assessments and reapply dressing as needed to prevent maggot infestation for 1 of 1 resident reviewed with having maggots in a wound (Resident #5). The findings included: Resident #5 was admitted to the facility on 02/20/18 with diagnoses of hypertension, unspecified dementia without behavioral	F 656	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice and what led to this deficiency being cited.	

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F 656	Continued From page 17 disturbance, hyperlipidemia, muscle weakness, and depression. There was no diagnosis of a wound for Resident #5. There were no documented wound assessments completed for Resident #5 from his admission of 01/29/18 until his discharge of 10/30/18. Review of the care plan dated 10/23/18 revealed Resident #5 was care planned for removing the dressing from his left ear and picking at the area. The goal was for the staff to reapply the dressing as needed. The interventions were as follows: weekly skin assessments per facility protocol. Assist resident to reposition/shift weight frequently when up in wheelchair to reduce risk for redness or impairment at pressure points. Keep skin clean and dry. Keep nails clean and trimmed, rough edges filed. The previous care plans could not be reviewed due to them being over-ridden in the electronic document when they were updated. Current physician orders dated 08/14/18 for Resident #5's revealed a new order for the dressing to left ear to be changed every day with a dry dressing. Review of the quarterly Minimum Data Set (MDS) dated 10/23/18 revealed Resident #5 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, and personal hygiene. The MDS further revealed Resident #5 had behavioral symptoms toward others 1 to 3 days during the assessment period and was receiving dressing changes with no wound type checked on the MDS. Review of the facility Treatment Record for	F 656	It is the policy of Alexandria Place to ensure care plans are initiated and followed appropriately. The appropriate nursing staff were immediately re-trained on completing weekly skin assessments and documentation. They were also immediately re-trained on following care plans. The records cannot be amended retrospectively due to Resident #5 being discharged from the facility to the hospital for treatment. Resident #5□s responsible party chose not to re-admit Resident #5 to Alexandria Place. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. The Director of Nursing and the MDS Coordinator audited all care plans with wounds for accuracy and completion on 12/7/18. The Director of Nursing audited all weekly skin assessments on 12/7/18 to ensure they are accurate and being completed weekly. All residents with wounds were audited and reviewed on 12/7/18 by the MDS Coordinator to ensure their prospective wound type is documented in the MDS. No other residents were found to be affected. C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. All licensed nurses will be receiving an in-service by the Director of Nursing on 12/10/18 on completing weekly skin	

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F 656	Continued From page 18 10/2018 revealed all treatments were checked as being completed as ordered. Review of the nurse's note dated 10/30/18 at 12:29 PM revealed it was reported by night shift nurse that resident had maggots noted in left ear wound. The NP was in and looked at wound. Order to send to emergency room for evaluation and treatment possible surgical debridement. RP notified, and resident transported via non-emergent transport. Review of the nurse's note dated 11/02/18 at 2:26 PM as an Addendum with no late entry date documented revealed the following: Late entry: At about 5:00 AM the NA told this writer that resident took dressing off his wound. During application of new dressing, foreign bodies were noted in the wound. Wound was cleaned, and 2 foreign bodies removed. Note left in physician's book for NP who is due in facility this AM. An interview conducted on 11/14/18 at 10:42 AM with Nurse #1 revealed she cared for Resident #5 from the time he was admitted to the day he was discharged to the hospital. She stated Resident #5 was admitted with a wound above his left upper ear and they were changing his dressing every three days. She stated Resident #5 would pick at his wound under his dressing and take his dressing off. She stated when she observed the greenish/tan odorous drainage on 08/14/18 she notified the NP and who wrote an order to change the dressing every day. Nurse #1 stated they would clean the wound with wound cleanser and cover with a dry dressing once a day. She further stated Resident #5 didn't remove his dressing	F 656	assessments and the proper documentation as well as re-education for following established care plan initiatives. Any licensed nurse not present on 12/10/18 will be in-serviced by the Director of Nursing before the start of their shift. All new hires will receive training on documentation, skin assessments and care plan initiatives during the initial classroom orientation that is conducted prior to new staff being assigned to work the floor. The Director of Nursing will re-train the MDS Coordinator on 12/10/18 on properly documenting wound types on the MDS. The Director of nursing will audit all residents with wounds to ensure their skin assessments have been completed, the care plans initiated are being followed and the MDS reflects the correct wound type weekly for 2 weeks and monthly times three months. All audits completed by the Director of Nursing and the MDS Coordinator will be documented and presented to the Quality Assurance Committee for review. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. The Quality Assurance Committee will be responsible for reviewing the audits	

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F 656	Continued From page 19 every day, it was more when he was anxious. She stated she wasn't aware of any interventions in place to keep him from picking at his wound or removing the dressing and she did not document weekly skin assessments of the wound. An interview conducted with Nurse Aide (NA) #1 on 11/14/18 at 3:11 PM revealed if she was working with Resident #5 and his dressing wasn't on she would let the nurse know and they would replace it. She stated Resident #5 constantly picked at the wound and removed his dressing often. An interview conducted on 11/15/18 at 11:54 PM with NA #2 revealed she worked with Resident #5 often and he would pick at his wound above his left ear and take the dressing off most days. She stated he didn't refuse showers or nail care often. An interview conducted on 11/16/18 at 9:40 AM with Nurse #3 revealed she had changed Resident #5's dressing on 10/27/18, 10/28/18, and 10/29/18 and had not observed maggots or any signs or symptoms of infection in his wound. Nurse #3 further stated she did not document weekly skin assessments of Resident #5's wound above his left ear. An interview conducted on 11/16/18 at 10:30 AM with the Director of Nursing revealed it was her expectation that the care plan be followed. She stated there should have been weekly skin assessments completed for Resident #5's wound over his left ear.	F 656	completed by the Director of Nursing and the MDS Coordinator. The audits will be presented to the Quality Assurance Committee for evaluation monthly for 12 months. The Quality Assurance Committee and DON will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction.	

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F 684 SS=J	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Physician interviews, the facility failed to provide care and treatment to a wound in accordance with accepted professional standards of practice, resulting in one resident's wound becoming infected and infested with maggots and requiring hospitalization. This was evidenced in 1 of 1 sampled resident reviewed for maggots (Resident #5). Immediate Jeopardy began on 10/30/18 when Resident #5 was found with maggots in the uncovered wound over his left ear. Immediate Jeopardy was removed on 11/16/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service. The findings included: Resident #5 was admitted to the facility on 02/20/18 with diagnoses of hypertension,	F 684	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. Address How Corrective Action (S) Will Be Accomplished For Those Residents Found To Have Been Affected By the Deficient Practice: Immediately after learning of the incident the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse: 1. Resident #5 was sent to the hospital for evaluation and treatment of the open cancerous lesion on October 30, 2018. The facility nursing staff had noted that the resident #5 had maggots in the wound. Per the resident□s family□s request, he did not return to the facility. 2. On October 30, 2018 the Quality Assurance nurse completed a thorough skin assessments on all residents with	11/17/18

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F 684	Continued From page 21 unspecified dementia without behavioral disturbance, hyperlipidemia, muscle weakness, and depression. There were no documented wound assessments completed for Resident #5 from his admission of 01/29/18 until his discharge of 10/30/18. Review of the physician order dated 02/20/18 revealed Resident #5 should have a non-adhesive dressing applied to the wound over his left ear every three days. Review of the nurse's notes for Resident #5 revealed the following: 02/28/18 - 11:48 AM Resident observed picking at area above left ear. Blood noted dripping down side of head. Area cleansed, and dry dressing applied. Resident continues to pick at area. 03/01/18 - Dressing to left ear is not present and new one applied. Review of the Nurse Practitioner (NP) progress notes dated 03/13/18 revealed Resident #5 had a skin cancer of the scalp removed with a wound and continued to remove dressing from the wound over his left ear. He refused to leave the dressing over suspected area of skin cancer above his left ear. He was having some minimal drainage. Will continue to monitor, as potentially this is a risk to other residents if his drainage ends up in places that another patient will touch. There were no signs and symptoms of infection at this time, but he is certainly high risk related to this. He and his family have opted for no further workup or treatment related to this at this time.	F 684	wounds and noted that no other residents wounds showed any evidence of foreign bodies, infection, or neglect by nursing staff. 3. The Director of nursing and Quality Assurance nurse interviewed nursing staff between October 31st and November 1, 2018 concerning this resident's wound to determine when the last wound treatment was done and when it was first noted that resident #5 had removed the dressing at some point between the late evening of October 29th and early morning October 30, 2018. Staff interviews showed that the dressing was noted to be intact through the day on October 29, 2018 and into the evening/night on October 29, 2018. Staff had noted that the dressing was intact during all rounds made on the resident up until the 5am round when the dressing was noted to be removed. Statements from staff also spoke to the week prior to October 30th 2018 and resident #5 was noted not to have maggots in the wound prior to 5am on October 30th 2018. The facility had an order to change the dressing daily and to use dry dressings on the open cancerous lesion. There were no orders for any ointments due to resident's propensity to pick at the wound and eat scabbed material from the wound. Other than staff intervening and redirecting resident #5 when he was noted to be picking and eating at the dressing/wound, no other interventions were in place Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To be Affected By The	

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F 684	Continued From page 22 Review of the NP Progress Note dated 05/31/18 revealed Resident #5 was seen due to nursing report that he had some green drainage from the wound on the left side of his head this AM. He has had this wound for several months after an excision related to a cancer. He continues to pick at the wound and it has not healed because of this. Nursing continues to try to cover it several times a day, but he continues to remove and pick at it. Plan - He continues to pick at this lesion. Will likely continue to be open. Nursing will continue to try to dress this, but he will continue to remove. No signs and symptoms of infection noted today. Continue to monitor, high risk for infection given his hands always being in it. Review of the nurse's note dated 08/13/18 11:35 AM revealed Resident #5's dressing to left ear completed this am. Noted odorous greenish/tan drainage on soiled dressing. Acute sheet completed for PEC for further instruction. Review of the NP's Progress Note dated 08/14/18 revealed Resident #5 was seen today for nursing concern about the wound above his left ear. She reports that he has had some greenish/tan odorous drainage. This is a persistent wound removal of skin cancer. Since he has had this done, he has not kept his dressing on this and has been frequently picking at it which has worsened it. Nursing has devised a way it seems at this point to keep the dressing on so that he is not able to touch it, which will certainly help with healing. I do not see any signs or symptoms of infection that would warrant antibiotics at this	F 684	Same Deficient Practice: Immediately after learning of the incident the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse: 1. On October 31, 2018 the Quality Assurance nurse completed a thorough skin assessments on all residents with wounds and noted that no other residents wounds showed any evidence of foreign bodies, infection, or neglect by nursing staff. 2. On November 2, 2018 the facility signed a contract with a wound services physician in order to get a designated wound care physician contracted to take over the treatment and prescribing of wounds in the facility. The wound physician had been contacted on October 31, 2018. 3. All nurses and aides were in-serviced by the Director of Nursing on what a change in condition is and who should be notified in the event of a change in condition on November 1, 2018. Aides were in-serviced by the Director of Nursing on November 1, 2018 that they should notify the nurse on the unit of any change in a resident s condition including dressings that are not intact or in need of being changed. The nurses will be in-serviced on November 15, 2018 by the Director of Nursing that they should notify the physician, the director of nursing and the family of any change in condition of residents and non-compliance with wound care or removing dressing. For the nurses and aids not present on November 15, 2018 they will be in-serviced by the	

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F 684	Continued From page 23 point. Change the dressing to a dry dressing that is to be changed daily as this may help with the odor since it was only changed every 3 days before. Continue to monitor as he has high risk for infection. Review of the physician orders dated 08/14/18 for Resident #5's revealed a new order for the dressing to left ear to be changed every day with a dry dressing. Review of the quarterly Minimum Data Set (MDS) dated 10/23/18 revealed Resident #5 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, and personal hygiene. The MDS further revealed Resident #5 was receiving dressing changes with no wound type checked on the MDS. Review of the care plan dated 10/23/18 revealed Resident #5 was care planned for removing the dressing from his left ear and picking at the area. The goal was for the staff to reapply the dressing as needed. The interventions were as follows: weekly skin assessments per facility protocol. Assist resident to reposition/shift weight frequently when up in wheelchair to reduce risk for redness or impairment at pressure points. Keep skin clean and dry. Keep nails clean and trimmed, rough edges filed. Review of the facility Treatment Record for 10/2018 revealed all treatments were checked as being completed as ordered. Review of the nurse's note dated 10/30/18 at	F 684	Director of Nursing as they report to work to ensure they are re-educated before they begin their shift. 4. All wound orders were audited and reviewed by the Director of Nursing and the Corporate Quality Assurance nurse on November 14, 2018 to ensure treatments are being done as ordered and that all dressings were intact. This audit will be reviewed with the wound physician on November 21, 2018. 5. All residents who are known to exhibit the behavior of non-compliance with wound care will be re-assessed by the Interdisciplinary Team to ensure that appropriate interventions are in place and appropriate interventions will be put in place by November 16, 2018. For any intervention that is found to be out of place it will be re-initiated immediately, and staff will be re-trained on the importance of maintaining intervention. For resident□s with severely impaired cognition, interventions will be developed based upon the individual resident□s behavior to ensure that a severely impaired cognitive resident□s wound dressing remains intact at all times. All alert and oriented residents will receive education by November 16, 2018 regarding possible negative outcomes of non-compliance with dressing changes and leaving dressings intact. All nurses will be in-serviced on November 15, 2018 on the procedure for the behavior communication form. This form will allow staff to write in the date, residents name, behaviors noted and what interventions they initiated at that time and whether	

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F 684	Continued From page 24 12:29 PM revealed it was reported by night shift RN that resident had maggots noted in left ear wound. The Nurse Practitioner (NP) was in and looked at wound. Order to send to the emergency room for evaluation and treatment possible surgical debridement. The responsible party was notified, and resident was transported via non-emergent transport. Review of the nurse's note dated 11/02/18 at 2:26 PM as an Addendum with no late entry date documented revealed the following: Late entry: At about 5:00 AM the Nurse Aide (NA) told this writer that resident took dressing off his wound. During application of new dressing, foreign bodies were noted in the wound. Wound was cleaned, and 2 foreign bodies removed. Note left in physician's book for NP who is due in facility this AM. Review of the hospital records dated 10/30/18 through 11/02/18 revealed Resident #5 was seen in the emergency room (ER) for evaluation of a wound infection. The Plan of Care revealed the following statement from the ER physician, "I am concerned for this patient's well-being as I do not believe that all of his maggots appeared just today. They were likely there before today. I believe that he warrants hospitalization today for aggressive wound care and intravenous antibiotics." Medical Decision Making and Plan of Care revealed there was an infestation by maggots and wound infection. The patient had numerous, very large maggots in his wound which runs very deep. It does still appear to be superficial to the skull however. Did not believe imagining was indicated but certainly extensive blood work was warranted including blood	F 684	those interventions were effective. For the nurses and aids not present on November 15, 2018 they will be in-serviced by the Director of Nursing as they report to work to ensure they are re-educated before they begin their shift. Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur: 1. All nursing staff will be in-serviced by the Director of Nursing before the start of their shift on November 15, 2018 on how to complete and document on a behavior communication form all noted behaviors including non-compliant behavior. For any nurse or aide that is not present on November 15, 2018, they will receive an in-service as they report to work before the start of their shift by the Director of Nursing. Staff will turn in the behavior communication forms to the Director of Nursing once they have completed them. All housekeeping, laundry, dietary, maintenance and administrative staff will be educated on the importance of reporting behaviors to the unit nurse by November 15, 2018.All new hires will be educated during their initial orientation on the communication of behaviors including non-compliant behavior before they are released to work on the floor. 2. For any resident with non-compliant behaviors noted on the behavior communication form, the Interdisciplinary team will review interventions weekly that are in place to ensure that these interventions are effective in ensuring the	

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F 684	Continued From page 25 cultures. Review of the hospital discharge summary dated 11/02/18 revealed this 80-year-old male who presented from skilled assisted living facility with a wound infection was noted to have a wound over his left ear that had been chronic and biopsied in the past and was noted to be cancer. He was noted to have maggots around his left ear wound. He was given intravenous antibiotics and admitted to the hospital. He was transitioned to by mouth antibiotics prior to discharge. A wound consult was placed, and it was recommended that the patient be placed on twice a day/as needed wound care with Dakins solution, a strong antiseptic that kills most forms of bacteria and viruses then cover with a moist gauze dressing. Resident #5 was discharged from the hospital to a different skilled nursing facility on 11/02/18. An interview conducted with Nurse Aide #1 on 11/14/18 at 3:11 PM revealed if she was working with Resident #5 and his dressing wasn't on she would let the nurse know and they would replace it. She stated Resident #5 constantly picked at the wound and removed his dressing often. An interview conducted on 11/14/18 at 10:42 AM with Nurse #1 revealed she cared for Resident #5 from the time he was admitted to the day he was discharged to the hospital. She stated Resident #5 was admitted with a wound above his left upper ear and they were changing his dressing every three days. She stated they did not do weekly wound assessments or measurements on	F 684	resident remains free from non-compliance to as the high of a degree as possible. For resident□s with severely impaired cognition, interventions will be developed based upon the individual resident□s behavior to ensure that a severely impaired cognitive resident□s wound dressings remain intact at all times. 3. The Director of Nursing will inspect each wound in the facility to ensure that the wound is free of foreign bodies, signs of infection, and neglect. These rounds will begin November 15, 2018. For any wound that shows a negative change in condition the Director of Nursing will also review residents□ medical records to ensure that the physician was notified of the change in condition. 4. The Director of Nursing□s observations will be recorded on a Quality Assurance form and will be presented to the interdisciplinary team each week for review and discussion to ensure that wounds remain free of signs of neglect on November 15, 2018. Indicate How The Facility Plans To Monitor It□s Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained: 1. The Quality Assurance Committee, QAPI Committee and the Medical Director and Wound Physician have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on November 11, 2018.	

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F 684	Continued From page 26 Resident #5's wound because it wasn't a pressure wound. She stated Resident #5 would pick at his wound under his dressing and take his dressing off. She stated when she observed the greenish/tan odorous drainage on 08/14/18 she notified the NP and who wrote an order to change the dressing every day. Nurse #1 stated they would clean the wound with wound cleanser and cover with a dry dressing once a day. She stated Resident #5 didn't remove his dressing every day, it was more when he was anxious and she wasn't aware of any interventions in place to keep him from picking at his wound or removing the dressing. Nurse #1 further stated she had never observed maggots in Resident #1's wound until the morning he was sent out to the hospital to have them removed. An interview conducted on 11/16/18 at 9:40 AM with Nurse #3 revealed she had changed Resident #5's dressing on 10/27/18, 10/28/18, and 10/29/18 and had not observed maggots or any signs or symptoms of infection in his wound. Nurse #3 stated his wound always had an odor and she didn't notice any difference in the odor or observe any flies in the building the three days she changed his dressing before he was sent to the hospital. She further she they did not do weekly wound assessments on his wound because it wasn't a pressure ulcer. Interview conducted on 11/14/18 at 2:24 PM with Nurse #2 revealed he was working the 11:00 PM to 7:00 AM shift on 10/30/18 when the NA told him Resident #5 had taken off his dressing over his left ear. Nurse #2 stated he went in to replace the dressing and as he was cleaning it with	F 684	2. The Director of Nursing□s weekly wound assessment rounds and audit of charts to ensure notification of physician due to change in resident wound condition will be presented at monthly QA meetings and quarterly for 12 months to the QAPI Committee for evaluation to determine if the system is adequate and if determined it is not, they will devise and re-implement a system to ensure the alleged deficient practice does not occur again. 3. The review done by the interdisciplinary team on all residents with non-compliant behavior will be presented to the QA committee monthly and the QAPI committee quarterly for 12 months. The Administrator is responsible for implementing this plan of correction.	

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wound cleanser he saw 2 maggots, which he removed from the wound. He stated he covered the wound with the dressing and put a note in the physician's book for the NP to see him later that morning. Nurse #2 further stated he never had to replace Resident #5's wound dressing during the night and that was the first time he had observed Resident #1's wound.

Interview conducted on 11/14/18 2:54 PM with the facility Nurse Practitioner stated Resident #5 had a chronic wound over his left ear from a cancer being removed. She stated the family didn't want to pursue any radiation or chemotherapy for the cancer but did want treatment for the wound. She stated she never thought the wound looked infected and she had never cultured or measured the wound. She stated she never considered a wound consult for Resident #5 because he picked at the wound all the time and she didn't think a wound consult would benefit him. The NP stated she had not assessed Resident #5's wound in about 2 months when she was asked to look at it on 10/30/18. She stated the wound had maggots in it that morning and she wrote an order for him to be sent to the hospital for evaluation. The NP stated the maggots were from Resident #5 picking at his wound and removing his dressing.

An interview conducted on 11/15/18 at 3:11 PM with the facility Physician revealed maggots in wounds came from flies laying eggs on the wound. He stated they started growing within 8 to 12 hours and the bigger they were the longer they had been present in the wound.

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F 684	Continued From page 28 An interview conducted on 11/16/18 at 10:30 AM with the Director of Nursing revealed it was her expectation that there should have been documentation of weekly wound assessments by the treatment nurse and floor nurse completed for Resident #5's wound over his left ear. She stated any odor or change in the wound should have been documented on the wound assessments. On 11/14/18 at 5:12 PM the Administrator and Corporate Vice President were notified of Immediate Jeopardy. On 11/16/18 the facility provided a credible allegation of Immediate Jeopardy removal that included: Immediately after learning of the incident the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse: 1. Resident #5 was sent to the hospital for evaluation and treatment of the open cancerous lesion on October 30, 2018. The facility nursing staff had noted that the resident #5 had maggots in the wound. Per the resident's family's request, he did not return to the facility. 2. On October 30, 2018 the Quality Assurance nurse completed a thorough skin assessments on all residents with wounds and noted that no other residents' wounds showed any evidence of foreign bodies, infection, or neglect by nursing staff. 3. The Director of nursing and Quality Assurance nurse interviewed nursing staff	F 684		

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between October 31st and November 1, 2018 concerning this resident's wound to determine when the last wound treatment was done and when it was first noted that resident #5 had removed the dressing at some point between the late evening of October 29th and early morning October 30, 2018. Staff interviews showed that the dressing was noted to be intact through the day on October 29, 2018 and into the evening/night on October 29, 2018. Staff had noted that the dressing was intact during all rounds made on the resident up until the 5am round when the dressing was noted to be removed. Statements from staff also spoke to the week prior to October 30th 2018 and resident #5 was noted not to have maggots in the wound prior to 5am on October 30th 2018. The facility had an order to change the dressing daily and to use dry dressings on the open cancerous lesion. There were no orders for any ointments due to resident's propensity to pick at the wound and eat scabbed material from the wound. Other than staff intervening and redirecting resident #5 when he was noted to be picking and eating at the dressing/wound, no other interventions were in place

Address How Corrective Action Will Be Accomplished For Those Residents Having Potential To be Affected By The Same Deficient Practice:

Immediately after learning of the incident the following interventions were put into place by the Director of Nursing and the Corporate Quality Assurance Nurse:

1. On October 31, 2018 the Quality Assurance nurse completed a thorough skin assessments on all residents with wounds and noted that no other residents' wounds showed any evidence of foreign bodies, infection, or neglect by nursing

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staff.
2. On November 2, 2018 the facility signed a contract with a wound services physician in order to get a designated wound care physician contracted to take over the treatment and prescribing of wounds in the facility. The wound physician had been contacted on October 31, 2018.
3. All nurses and aides were in-serviced by the Director of Nursing on what a change in condition is and who should be notified in the event of a change in condition on November 1, 2018. Aides were in-serviced by the Director of Nursing on November 1, 2018 that they should notify the nurse on the unit of any change in a resident's condition including dressings that are not intact or in need of being changed. The nurses will be in-serviced on November 15, 2018 by the Director of Nursing that they should notify the physician, the director of nursing and the family of any change in condition of residents and non-compliance with wound care or removing dressing. For the nurses and aids not present on November 15, 2018 they will be in-serviced by the Director of Nursing as they report to work to ensure they are re-educated before they begin their shift.
4. All wound orders were audited and reviewed by the Director of Nursing and the Corporate Quality Assurance nurse on November 14, 2018 to ensure treatments are being done as ordered and that all dressings were intact. This audit will be reviewed with the wound physician on November 21, 2018.
5. All residents who are known to exhibit the behavior of non-compliance with wound care will be re-assessed by the Interdisciplinary Team to ensure that appropriate interventions are in place and appropriate interventions will be put in place

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by November 16, 2018. For any intervention that is found to be out of place it will be re-initiated immediately, and staff will be re-trained on the importance of maintaining intervention. For resident's with severely impaired cognition, interventions will be developed based upon the individual resident's behavior to ensure that a severely impaired cognitive resident's wound dressing remains intact at all times. All alert and oriented residents will receive education by November 16, 2018 regarding possible negative outcomes of non-compliance with dressing changes and leaving dressings intact. All nurses will be in-serviced on November 15, 2018 on the procedure for the behavior communication form. This form will allow staff to write in the date, residents name, behaviors noted and what interventions they initiated at that time and whether those interventions were effective. For the nurses and aids not present on November 15, 2018 they will be in-serviced by the Director of Nursing as they report to work to ensure they are re-educated before they begin their shift.

Address What Measures Will Be Put Into Place Or Systemic Changes Made To Ensure That The Deficient Practice Will Not Recur:
1. All nursing staff will be in-serviced by the Director of Nursing before the start of their shift on November 15, 2018 on how to complete and document on a behavior communication form all noted behaviors including non-compliant behavior. For any nurse or aide that is not present on November 15, 2018, they will receive an in-service as they report to work before the start of their shift by the Director of Nursing. Staff will turn in the behavior communication forms to the Director of Nursing once they have completed them. All housekeeping, laundry, dietary,

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maintenance and administrative staff will be educated on the importance of reporting behaviors to the unit nurse by November 15, 2018.All new hires will be educated during their initial orientation on the communication of behaviors including non-compliant behavior before they are released to work on the floor.
2. For any resident with non-compliant behaviors noted on the behavior communication form, the Interdisciplinary team will review interventions weekly that are in place to ensure that these interventions are effective in ensuring the resident remains free from non-compliance to as the high of a degree as possible. For resident's with severely impaired cognition, interventions will be developed based upon the individual resident's behavior to ensure that a severely impaired cognitive resident's wound dressings remain intact at all times.
3. The Director of Nursing will inspect each wound in the facility to ensure that the wound is free of foreign bodies, signs of infection, and neglect. These rounds will begin November 15, 2018. For any wound that shows a negative change in condition the Director of Nursing will also review residents' medical records to ensure that the physician was notified of the change in condition.
4. The Director of Nursing's observations will be recorded on a Quality Assurance form and will be presented to the interdisciplinary team each week for review and discussion to ensure that wounds remain free of signs of neglect on November 15, 2018.
Indicate How The Facility Plans To Monitor It's Performance To Make Sure That Solutions Are Sustained. The Facility Must Develop A Plan For Ensuring That Correction Is Achieved And Sustained:

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F 684	Continued From page 33 1. The Quality Assurance Committee, QAPI Committee and the Medical Director and Wound Physician have been apprised of this plan and commit their support to assisting the facility with achieving and sustaining compliance with this alleged citation. The QAPI Committee was notified on November 11, 2018. 2. The Director of Nursing's weekly wound assessment rounds and audit of charts to ensure notification of physician due to change in resident wound condition will be presented at monthly QA meetings and quarterly to the QAPI Committee for evaluation to determine if the system is adequate and if determined it is not, they will devise and re-implement a system to ensure the alleged deficient practice does not occur again. 3. The review done by the interdisciplinary team on all residents with non-compliant behavior will be presented to the QA committee monthly and the QAPI committee quarterly. Date of Compliance is November 16, 2018. The Administrator will be responsible for implementing this plan of correction. Immediate Jeopardy was removed on 11/16/18 at 12:26 PM when facility staff were interviewed and demonstrated they had been trained on the topics of abuse and neglect, change in condition, and report of change in condition.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		12/14/18

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F 690	Continued From page 34 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to prevent an indwelling urinary catheter bag and tubing from resting on the floor for 1 of 1 residents reviewed with urinary catheter (Resident #27). The findings included: Resident #27 was admitted to the facility on	F 690	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law.	

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F 690	Continued From page 35 10/19/13 with current diagnoses of heart failure and neurogenic bladder. Review of the annual Minimum Data Set dated 09/12/18 revealed Resident #27 was cognitively intact and had an indwelling urinary catheter. Review of the care plan dated 09/12/18 revealed Resident #27 had an indwelling suprapubic urinary catheter due to urine retention and a neurogenic bladder, the lack of bladder control. The goal was for Resident #27 not to have discomfort noted from the catheter or any signs or symptoms of infection through the next review. The interventions included: give good catheter care every shift. Maintain closed drainage system. Be careful with movement and do not pull on suprapubic catheter. Observations made throughout the survey revealed the following: 11/14/18 at 11:30 AM observed Resident #27 up in her wheelchair in the hallway with her catheter bag hanging on the bottom of the wheelchair with the catheter bag and catheter tubing resting on the floor. 11/15/18 8:50 AM observed Resident #27 in her wheelchair in the main dining room with her catheter bag hanging on the bottom of her wheelchair with the catheter bag and tubing resting on the floor. 11/16/18 8:42 AM observed Resident #27 propelling herself from the dining room to the hallway with her catheter bag hanging on the bottom of her wheelchair and the catheter bag and tubing dragging the floor as she propelled	F 690	A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice and what led to this deficiency being cited. It is the policy of Alexandria Place to ensure catheter bags and tubing be kept off the floor. The catheter bag and tubing for resident #27 was immediately secured so it would not hang under the wheelchair. The appropriate nursing staff were immediately re-trained on proper catheter care. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. All residents with indwelling urinary catheter bags have the potential to be affected by the deficient practice. The Director of Nursing completed visual audits on 12/7/18 to ensure all residents with indwelling catheters, identified by the Minimum Data Set, have their bags and tubing off the floor. Nurse Aide #2 received appropriate disciplinary action and was re-trained on the handling, positioning and securement of urinary catheter bags and tubing. B. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. Audits on all urinary catheter bags and tubing will be completed daily for one week and weekly for 4 weeks to ensure all bags and tubing remain off the floor and are properly secured. Any bags or tubing to be noted on the floor will be	

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F 690	Continued From page 36 down the hallway. An interview conducted on 11/16/18 at 10:12 AM with Nurse #1, who cared for Resident #27, revealed all catheter bags should have a privacy cover and the catheter bag or tubing should not ever touch the floor. She stated she had not observed Resident #27's urinary catheter bag and tubing being on the floor. An interview conducted on 11/16/18 at 10:14 AM with Nurse Aide (NA) #2, who cared for Resident #27, revealed she had observed Resident #27's catheter bag and tubing resting on the floor the day before but didn't try to get it off the floor and didn't report it to the nurse because she got busy and forgot about it. NA #2 stated the catheter bag and tubing should not touch the floor. An interview conducted on 11/16/18 at 11:30 AM with the Director of Nursing revealed she expected all urinary catheter bags and tubing to be kept off the floor to prevent possible urinary infections and if staff saw them on the floor to fix them immediately or report it to the nurse immediately.	F 690	immediately secured so it does not touch the floor. All nursing staff will be in-serviced by the Director of nursing on the handling, positioning, and securement of urinary catheter bags and tubing on 12/7/18. Any licensed nurse or nursing assistants not present on 12/7/18 will be in-serviced by the Director of Nursing before the start of their shift. All new hires will receive training on handling, positioning and securement of urinary catheter bags and tubing during the initial classroom orientation that is conducted prior to new staff being assigned to work the floor. The Director of nursing□s audits will be recorded and presented to the Quality Assurance Committee. C. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. The Quality Assurance Committee will be responsible for reviewing the audits completed by the Director of nursing. The audits will be presented by the Director of Nursing to the Quality Assurance Committee for evaluation monthly for 12 months. The Quality Assurance Committee and DON will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain	

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F 690	Continued From page 37	F 690	substantial compliance. The Administrator will be responsible for implementing this plan of correction.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications ready for use from 1 of 1 medication rooms. The findings included:	F 761	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is	12/14/18

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F 761	Continued From page 38 An observation made on 11/15/18 at 10:56 AM in the Medication Storage Room revealed the following expired medications: " 1 card of 60 Hydro-APAP 5-325 milligram (mg) tablets with an expiration date of 05/22/18 " 1 card of 10 Hydro-APAP 5-325 mg tablets with an expiration date of 06/12/18 " 1 card of 60 Hydro-APAP 5-325 mg tablets with an expiration date of 09/25/18 " 1 card of 60 Hydro-APAP 5-325 mg tablets with an expiration date of 11/06/18 " 1 card of 60 Hydro-APAP 5-325 mg tablets with an expiration date of 11/08/18 An interview conducted on 11/15/18 at 11:14 AM with Nurse #1 revealed the nurse's count all narcotics in the Medication Storage Room at the beginning of each shift. She stated she had counted them this morning but did not check the expiration dates on the cards. Nurse #1 stated the expiration dates should have been checked when the narcotics were counted and the expired cards pulled and sent back to the pharmacy. Nurse #1 further stated she didn't know why she didn't check the expiration dates when she counted the cards. An interview conducted with the Director of Nursing (DON) revealed it was her expectation for all expiration dates of narcotics to be checked when they were counted at the beginning of each shift. She stated all expired medications should have been pulled and sent back to the pharmacy. The DON further revealed she didn't think the nurse's had been using the extra supply of Hydro-APAP in the medication room and were re-ordering from the pharmacy when they ran out	F 761	accurate. We are submitting the POC because it is required by law. A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice and what led to this deficiency being cited. It is the policy of Alexandria Place to ensure all expired medications are removed from the facility. Appropriate nursing staff were immediately re-trained on the policy of handling and removing expired medications. All five cards of the Hydro-APAP 5-325 mg tablets that were expired were immediately removed from the medication room and sent back to the pharmacy. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. All residents taking medications have the potential to be affected by this practice. The first shift nurse manager and the Director of Nursing assessed all medications in the medication room for expired dates. No other expired medications were found, and no residents were affected. C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. All licensed nurses will be in-serviced by the Director of Nursing no later than 12/10/18 on the proper labeling, dating and discarding of expired medications.	

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F 761	Continued From page 39 on the medication cart and that was why some were expired.	F 761	Any licensed nurse not present on 12/10/18 will be in-serviced by the Director of Nursing on proper labeling, dating and discarding of expired medications before the start of their shift. All new hires will receive training on the proper labeling, dating and discarding of expired medications during the initial classroom orientation that is conducted prior to new staff being assigned to work the floor. On 12/7/18, the Director of Nursing conducted an audit on the medication storage room to ensure all medications were not expired. The Director of Nursing will audit the medication storage room three times a week for two weeks, weekly for two weeks and monthly thereafter. The audits will be presented to and reviewed by the Quality Assurance Committee at the monthly meeting. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. The Quality Assurance Committee will be responsible for reviewing the audits completed by the Director of Nursing. The audits will be presented by the Director of Nursing to the Quality Assurance Committee for evaluation monthly for 12 months. The Quality Assurance Committee and DON will be charged with	

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F 761	Continued From page 40	F 761	ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide ordered assistive equipment for 1 of 1 residents reviewed for assistive devices (Resident #2). Findings included: Resident #2 was admitted to the facility 08/24/17 with diagnoses including Parkinson's disease, lack of coordination, and muscle weakness. Review of the annual Minimum Data Set (MDS) dated 08/09/18 revealed Resident #2 was severely impaired for cognition and required supervision with eating. Resident #2's care plan for nutrition last updated 11/01/18 revealed she was to receive a nosey cup with meals. (A nosey cup is a cup with a u shaped cut out on one side that allows the person using it to drink without bending their neck or	F 810	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice and what led to this deficiency being cited. It is the policy of Alexandria Place to ensure all orders from the physician and all care plans are followed. Resident #2□s care plan and orders were reviewed, and Resident #2 has been given a nosey cup as ordered with all three meals. The appropriate dietary aides were immediately re-trained on following tray card orders.	12/14/18

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F 810	Continued From page 41 tilting their head.) Review of Resident #2's Physician orders dated 09/01/17 revealed she was to receive a nosey cup with meal trays. Observation of Resident #2 on 11/13/18 on 12:32 PM revealed she was feeding herself and her nectar thickened beverages were in regular glasses. There was no nosey cup observed on Resident #2's meal tray. Observation of Resident #2 on 11/15/18 at 8:12 AM revealed she was eating breakfast with her nectar thickened liquid beverages in their original container. There was no nosey cup observed on Resident #2's meal tray. An interview with the Dietary Manager on 11/15/18 at 8:39 AM revealed the kitchen was responsible for putting nosey cup on residents' trays and she was not sure why Resident #2 did not receive a nosey cup on her tray. An interview with the Director of Nursing on 11/16/18 at 10:50 AM revealed she was aware that Resident #2 had not been receiving the nosey cup on her meal tray but if the Physician ordered the nosey cup Resident #2 should receive the nosey cup. An interview with the Administrator on 11/16/18 at 1:18 AM revealed she expected Physician orders to be followed and if a resident had orders to receive a nosey cup the resident should receive the nosey cup.	F 810	B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. All residents needing assistive devices have the potential to be affected by the deficient practice. All residents care planned to have assistive devices with meals were reviewed on 12/7/18 by the Director of Nursing and the Certified Dietary Manager to ensure they are receiving the appropriate assistive device as ordered and that the order is correct on the dietary tray card. The Certified Dietary Manager observed the dietary aides completing the tray line on 12/7/18 to ensure they are reading tray cards and adding the appropriate devices as ordered. No other residents were found to be affected. C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. All dietary aides and cooks will be in-serviced by the Certified Dietary Manager on 12/7/18 on how to read tray cards and ensure the required device is put on the resident tray as documented on the tray card. All dietary aids not present on 12/7/18 will be in-serviced by the Certified Dietary Manager before the start of their shift. All new hires will receive training on tray cards and assistive devices during the initial classroom orientation that is conducted prior to new staff being assigned to work the floor. On 12/12/18 the Director of Nursing in-serviced the appropriate nurses and	

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F 810	Continued From page 42	F 810	nursing assistants on reading tray cards to ensure residents were receiving the ordered assistive device that is documented on the tray card. Any nurse or nurse aide not present on 12/12/18, will receive an in-service by the Director of Nursing on tray cards and assistive devices before the beginning of their shift. All new hires will receive training on tray cards and assistive devices during the initial classroom orientation that is conducted prior to new staff being assigned to work. The Certified Dietary Manager will audit two meals a day daily for two weeks, weekly for two weeks and monthly time three months to ensure all residents needing assistive devices with meals have their ordered assistive device. The Certified Dietary Manager will document all observations and report them to the Quality Assurance Committee. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. The Quality Assurance Committee will be responsible for reviewing the audits completed by the Certified Dietary Manager. The audits will be presented to the Quality Assurance Committee for evaluation monthly for 12 months. The Quality Assurance Committee and	

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F 810	Continued From page 43	F 810	Certified Dietary Manager will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to date potentially hazardous food after opening for 1 of 1 walk in coolers, failed to remove expired food from 1 of 1 walk in coolers, failed to discard tuna salad after being opened in accordance with manufacturer guidelines, failed to discard thawed bacon per	F 812	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law.	12/14/18

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F 812	Continued From page 44 manufacturer's guidelines, failed to maintain the temperature of the nourishment room refrigerator for 1 of 1 nourishment room refrigerators, and failed to maintain the temperature log for 1 of 1 nourishment room refrigerators. The findings included: 1a. Initial observation of the walk in cooler on 11/13/18 at 9:47 AM revealed an undated pan of cheese slices available for use b. Initial observation of the walk in cooler on 11/13/18 at 9:49 AM revealed the following expired foods were available for use: One container of diced tomatoes with an expiration date of 11/12/18 One container of diced tomatoes with an expiration date of 11/06/18 One half gallon of 2% milk with an expiration date of 11/07/18 c. Initial tour of the walk in cooler on 11/13/18 at 9:51 AM revealed a container of tuna salad had been opened on 10/12/18 and was available for use d. Initial tour of the walk in cooler on 11/13/18 at 9:52 AM revealed a 15 pound box of bacon that was thawed on 10/30/18 and was available for use An interview with the Dietary Manager on 11/13/18 at 9:52 AM revealed the pan of cheese slices should have had a date of when they were placed in the pan and an expiration date since it	F 812	A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice and what led to this deficiency being cited. It is the policy of Alexandria Place to ensure that all expired and outdated foods are removed from the kitchen and are not available for use. It is also the policy of Alexandria Place to ensure the nourishment room refrigerator is in the temperature range of 32 to 42 degrees and is checked daily to ensure the temperature is appropriate The Diet Aids were immediately retrained on the refrigeration and food storage policies. Upon determination, all potentially hazardous foods from the walk-in cooler were discarded. The undated cheese slices, expired diced tomatoes, expired half gallon of 2% milk, expired tuna salad and 15-pound box of thawed bacon were immediately discarded. The nourishment room refrigerator was removed from use on 11/14/18 until the proper temperature could be documented. A new thermometer was placed in the refrigerator and within 15 minutes on 11/14/18 it read a proper temperature of 41 degrees and was properly documented on the temperature log. Nurses were immediately in-serviced on proper refrigeration temperatures and documentation. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice	

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	345441	A. BUILDING _____ B. WING _____	C 11/16/2018

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F 812	Continued From page 45 was no longer in the original packaging and there should have been no expired food available for use in the walk in cooler. The Dietary Manager stated she thought the tuna salad should be good after being opened on 10/12/18 until the expiration date of 11/16/18 but she would check. The Dietary Manager also stated she thought the bacon that was placed in the walk in cooler on 10/30/18 was good until the expiration date of 01/01/19 but she would check. The Dietary Manager stated she checked to make sure food was labeled and dated when she worked Monday through Friday but each employee was responsible for labeling and dating food when it was placed in the walk in cooler. The Dietary Manager stated all kitchen employees should be checking daily for expired food and discarding the expired food if found. A subsequent interview with the Dietary Manager on 11/14/18 at 9:23 AM revealed that per the manufacturer's guidelines bacon should only be used for up to 3 days after being thawed and should not have been available for use. The Dietary Manager also stated that per the manufacturer's guidelines tuna salad was only good for three days after being opened and should not have been available for use. An interview with the Administrator on 11/16/18 at 11:14 AM revealed she expected food to be dated when opened, used or discarded on or before the expiration date, and all food to be used according to the manufacturer's guidelines. 2. An observation of the nourishment room refrigerator on 11/14/18 at 9:15 AM revealed a temperature reading of 54 degrees	F 812	All residents have the potential to be affected by this deficient practice. All opened food items in the walk-in cooler were audited on 12/6/18 to ensure an open date was in place and was not expired. An audit was also done on 12/6/18 on thawing food items to ensure they were properly being thawed and used within the manufacturer's guideline. An audit was completed on12/7/18 on all nourishment room refrigerators to ensure they hold the proper temperature of 32 to 42 degrees and to ensure a staff member was documenting the refrigerator temperatures daily. No residents were affected. C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Certified Dietary Manager will in-service all dietary staff, with return back demonstration, on 12/7/18 on proper food labeling, dating and removing expired foods from use. Any dietary staff member not present on 12/7/18 will receive an in-service from the Certified Dietary Manager on proper food labeling, dating and the removal of expired foods from available use before the start of their shift. All new hires will receive training on proper food labeling, dating and removing expired foods from use during the initial classroom orientation that is conducted prior to new staff being assigned to work. The Certified Dietary manager will complete an audit of the walk in cooler weekly for 4 weeks and then monthly for three months to ensure there are no	

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F 812	Continued From page 46 An interview with the Administrator on 11/14/18 at 9:49 AM revealed she expected the nourishment room refrigerator temperature to range from 32 to 42 degrees and that housekeeping was responsible for filling out the temperature log daily. The Administrator stated she was taking the nourishment room refrigerator out of use due to the temperature readings not meeting her expectations. 3. A review of the nourishment room refrigerator logs on 11/14/18 at 9:15 AM revealed staff recorded temperatures as 50 degrees on 09/01/18, 51 degrees on 09/06/18, 51 degrees on 09/10/18, 51 degrees on 09/15/18, 51 degrees on 09/16/18, and 51 degrees on 09/21/18. The rest of the September 2018 log was incomplete and there were no temperature logs for October 2018 or November 2018. A follow up interview with the Administrator on 11/14/18 at 10:02 AM revealed there was a miscommunication regarding who should fill out the temperature logs for the nourishment room refrigerator. The Administrator stated third shift nurses thought housekeeping was responsible for filling out the temperature logs and housekeeping thought third shift nurses were responsible for filling out the temperature logs so the logs did not get filled out. The Administrator further stated it was third shift nurses' responsibility to fill out the temperature logs and she would be doing an in-service to clarify who was responsible for filling out the temperature logs.	F 812	expired or outdated foods. The Certified Dietary Manager will document the audits and report them monthly to the Quality Assurance Committee. The Director of Nursing will in-service all licensed nurses, with return back demonstration, on 12/7/18 on checking and logging nourishment refrigerator temperatures. Any license nurse not present on 12/7/18 will be in-serviced by the Director of Nursing before the start of their shift. All new hires will receive training on checking and logging nourishment room refrigerator temperatures during the initial classroom orientation that is conducted prior to new staff being assigned to work. It is the responsibility of the licensed nurses to ensure temperatures are appropriate and logged daily. The Administrator will perform random temperature and logging checks to ensure logs are complete and the refrigerator temperatures are within normal limits of 32 degrees to 42 degrees three times a week for two weeks and then weekly for three months. The Administrator will document all audits completed and report them to the monthly Quality Assurance Committee meeting. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility.	

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F 812	Continued From page 47	F 812	The Quality Assurance Committee will be responsible for reviewing the audits completed by the Certified Dietary Manager and the Administrator. The audits will be presented to the Quality Assurance Committee for evaluation monthly for 12 months. The Quality Assurance Committee, Certified Dietary Manager and the Administrator will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		12/14/18

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F 842	Continued From page 48 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 49 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interview the facility failed to maintain an accurate Treatment Administration Record (TAR) for documenting refusal of a multipodus boot for 1 of 1 sampled residents (Resident # 19). Findings included: Resident #19 was admitted to the facility on 12/24/2013 with a diagnosis that included Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Hyperlipidemia, Thyroid disorder, Depression and Asthma. The Yearly Minimum Data Set (MDS) assessment dated 09/11/18 indicated Resident #19 was cognitively intact. Review of Resident #19's medical record revealed a physician order dated 07/07/18 which read in part, "Off load right heel with multipodis boot at all times." Review of Resident #19's TAR for November 2018 revealed an order dated 07/07/18 which read, "Offload right heel with multipodis boot at all times, checking placement daily at 6:00AM, 2:00PM, and 10:00PM. The TAR further indicated the order had been initialed as completed and applied on the dates of 11/13/18, 11/14/18, and	F 842	Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. Alexandria Place□s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. A. Address how corrective action will be accomplished for each resident found to be affected by the deficient practice and what led to this deficiency being cited. It is the policy of Alexandria Place to ensure Treatment Administration Records are documented and accurate. Treatment records for Resident #19 have been reviewed for accuracy and completion. Nurse #3 and Nurse #4 were immediately retrained on documenting a refused treatment. Nurse #3 and Nurse #4 have been immediately re-trained on accurately documenting ordered treatments along with how to properly document Resident #19□s refusal of treatment. Resident	

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F 842	Continued From page 50 11/15/18 for 6:00AM, 2:00PM, and 10:00PM. The TAR indicated the order had been initialed as completed and applied at 6:00AM on 11/16/18. An observation of Resident #19 on 11/13/18 at 11:02AM revealed she did not have a multipodus boot in place to her right heel. An observation of Resident #19 on 11/14/18 at 9:10AM revealed she did not have a multipodus boot in place to her right heel. An observation of Resident #19 on 11/15/18 at 8:45AM revealed she did not have a multipodus boot in place to her right heel. An observation and interview with Resident #19 on 11/15/18 at 2:38PM revealed she did not have a multipodus boot in place. Resident #19 confirmed that she had not had the multipodus boot on for the week and had refused to have the multipodus boot applied due to her leg being swollen. During an interview on 11/15/18 at 2:46PM Nurse #3 stated a multipodus boot was ordered for Resident #19 to be worn at all times. The interview revealed Resident #19 had refused application of the multipodus boot on 11/15/18. The interview revealed Nurse #3 had documented application of the multipodus boot on Resident #19's TAR in mistake. During an interview on 11/15/18 at 3:48PM Nurse Supervisor #1 stated a multipodus boot was ordered for Resident #19 to be worn at all times. The interview revealed if Resident #19 had refused application of the multipodus boot, her expectation of the nurse would be to document	F 842	#19□s attending wound physician was notified of the refusal to wear the multipodus boot. B. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice. All residents with ordered treatments have the potential to be affected by this deficient practice. The Director of nursing assessed all residents with ordered treatments on 12/5/18 and 12/6/18 to ensure accuracy and completion of documentation and treatment. No other residents were affected. C. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not occur. The Director of Nursing will re-train and in-service all licensed nurses on complete and accurate documentation of ordered treatments and refusal of ordered treatments by 12/10/18. Any licensed nurse not present on 12/10/18 will be in-serviced by the Director of Nursing before the start of their shift on complete and accurate documentation of ordered treatments and the refusal of ordered treatments. All new hires will receive training on accurate documentation or ordered treatments and refusal of ordered treatments during the initial classroom orientation that is conducted prior to new staff being assigned to work the floor The Director of Nursing will be tasked with completing audits on the Treatment	

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F 842	Continued From page 51 the resident's refusal on the TAR. Nurse Supervisor #1 stated Resident #19 was receiving care from the Wound Center. She stated during this interview she notified the Wound Center on 11/14/18 regarding treatment orders for Resident #19. An observation and interview with Resident #19 on 11/16/18 at 8:38AM revealed she did not have a multipodus boot in place to her right heel. Resident #19 confirmed that she had not worn the multipodus boot overnight or on the morning of 11/16/18. An interview was conducted on 11/16/18 at 8:59AM with the Director of Nursing. The interview revealed refusal should have been documented on Resident #19's TAR using a (N) coded for refusal instead of the nurse's initials and a green check on the dates of 11/13/18, 11/14/18, 11/15/18, and 11/16/18. During an interview on 11/16/18 at 9:12AM with Nurse #4 she stated she had initialed application of Resident #19's multipodus boot on the dates of 11/13/18 and 11/14/18. The interview revealed Nurse #4 had forgotten to document refusal for Resident #19's multipodus boot and acknowledged she had initialed Resident #19's TAR on 11/13/18 and 11/14/18 in error.	F 842	Administration Record for completion and accuracy. The Director of Nursing will audit all Treatment Administration Records daily for one week, weekly for two weeks and monthly for three months. All discrepancies identified will be corrected immediately during the audit. These audits will be documented and reported at the monthly Quality Assurance meetings. D. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained. The facility must develop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. The Quality Assurance Committee will be responsible for reviewing the audits completed by the Director of Nursing. The Director of Nursing will audit 5 Treatment Administration Records for accuracy and completion daily for one week, weekly for two weeks and monthly for three months. These audits will be presented and reviewed by the Quality Assurance Committee monthly for 12 months. The Quality Assurance Committee and DON will be charged with ensuring that corrections are achieved and sustained, or new plans of correction are devised to achieve and maintain substantial compliance. The Administrator will be responsible for implementing this plan of correction.	

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