STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(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 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		1/18/19

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

Electronically Signed | 01/22/2019

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to treat one resident with dignity by leaving the resident lying in a large amount of urine and stool from 12:41 AM to 8:30 AM on 12/16/18 for 1 of 5 residents dependent on staff for incontinence care (Resident #13). Findings included: Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. The MDS revealed that he displayed verbal behaviors toward others but had no rejection of care. A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as	F 550	1. Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. 2.All residents requiring incontinence care were assessed by the Registered Nurse/ Interim Director of Nursing from 1/16/2019 through 1/18/2019 for any adverse effects with none observed. 3.All nursing staff were educated on proper incontinence care on 1/16/19 through 1/18/19 by the Registered Nurse/Interim Director of Nursing. All staff were educated by the Registered Nurse/ Interim Director of Nursing 1/16/19-1/18/19, that all staff are responsible for acknowledging call lights and to inform the appropriate staff if the need is outside of their scope and on the components of the Concern/Grievance policy. In addition, the above education will be included in subsequent new-hire orientations. 4. In order to ensure compliance the Director of Nursing/ Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered nurse will randomly check the compliance of Certified Nursing Assistants providing incontinence care-5 residents per week x 4weeks, then 2 residents per week x 4weeks. The Social Service Director will Interview random cognitive residents	

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F 550	Continued From page 2 needed. The Behavior Symptom CAA revealed that he had verbal aggression directed toward staff. A review of Resident #13's care plan, dated 03/14/18, indicated the resident had an ADL self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. A review of the care plan for Resident #13 revealed that he had the potential to be verbally aggressive toward caregivers. The care plan, regarding the resident being verbally aggressive toward caregivers, further revealed staff were to assess and anticipate resident's toileting needs and comfortable level and the resident needed monitoring, reminding, assistance to turn or reposition at least every 2 hours and more often as needed or requested. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice	F 550	about timely call light response-5 per week x 4 weeks then 2 residents per week x 4 weeks. The resident council minutes will be submitted at the next scheduled Quality Assurance Performance Improvement Committee meeting. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Committee meeting on 1/22/19. The Committee include the Medical Director, Administrator, Director of nursing, Registered Nurse Supervisor, Social Service Director, Dietary Manager, Medical Records/Human Resource Director, Maintenance Director, and line staff member. All Plan of Correction audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations until compliance is achieved.	

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recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on his personal computer voice recorder. He further indicated that Nurse #1 came into his room and he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up.

An interview was conducted with the Social Worker on 12/18/18 at 1:13 PM. She revealed there were no grievances filed for the month of December 2018.

An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM

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and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA #3 further stated that Nurse #2 told Resident #13 that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with NA #4 on 12/19/18 at 8:00 pm. NA #4 stated she worked third shift and frequently worked with Resident #13. NA #4 stated Resident #13 typically received incontinence care at 1:30 am and 5:30 am, at a minimum and that was close to shift change. She indicated that Resident #13 had never saturated his bed due to his incontinence but that he got a little sweaty because he had computer equipment in his room that made the room hot.

A phone interview was conducted with NA #2 on 12/19/18 at 8:21 PM. She stated that the nursing assistants who came in at 11:00 PM typically went

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to Resident #13's room at 1:30 AM and change him. She further stated that if Resident #13 was given a suppository, the NA's went to change the resident more often. She indicated that Resident #13 did not get a suppository during 2nd shift on 12/15/18. She further indicated that it was her perception that Resident #13 rang his call bell at 1:30 am and 5:30 am and both times went into his room, woke him up and changed him. She stated that Resident #13 had been telling 1st shift that he hadn't been changed, so the NAs woke him and changed him. She further stated that she reported any concerns to the oncoming shift. She did not mention that she reported any concerns to first shift regarding Resident #13 on 12/16/18.

A phone interview was conducted with the DON on 12/20/18 at 6:50 AM. She indicated that she expected all residents would be treated with respect and dignity and care to be provided when requested.

A phone interview was conducted with Nurse #2 on 12/20/18 at 9:13 AM. She indicated that she worked 7:00 am to 7:00 pm on 12/16/18 and that toward the end of her shift, Resident #13 told her he wanted to file a grievance because no one changed him for an extended time the early morning of 12/16/18. She stated that towards the end of first shift NA #3 confirmed Resident #13 was very wet. She further stated that she reported the information to the night shift Nurse #7. She indicated that she did not notify the social worker or file a grievance because the social worker checked on Resident #13 daily.

An interview was conducted with the Social Worker on 12/20/18 at 9:39 AM. She indicated that she did not talk to Resident #13 during the

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F 550	Continued From page 6 week of December 17th, 2018 and wasn't aware of any concerns involving Resident #13. She further indicated that in the past, Resident #13 complained about being soaked in urine when the previous Director of Nursing (DON) was working at the facility which was before December 2018. She revealed that she didn't remember Resident #13 filing any recent grievances. An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated she expected all residents to be treated with dignity and respect and told this to every staff member when she started working at the facility on 11/26/18. She further stated she expected concerns to be reported so follow-up could be done. She indicated staff were supposed to care for residents and it was a problem of dignity if care was not given. She indicated again she should have been told about the incident, so she could fix the problem.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		1/18/19

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F 584	Continued From page 7 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store clean linens in a room free of ceiling leaks and disrepair for one of one clean linen closets. The findings include: On 12/18/18 at 12:45 AM an observation was made of the facility's clean linen closet which was the only clean linen closet within the facility. Seven of 12 white acoustic ceiling tiles inside the clean linen closet were badly stained with a brown	F 584	1. The Laundry Supervisor moved the clean linen from the closet to an appropriate location 12/20/18. The Director of Maintenance replaced the stained tiles on 12/20/18. 2.The Maintenance Director will continue to check the facility for any other areas for stained , bulging ceiling tiles, replacing any stained. 3. The Administrator has in-serviced the	

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F 584	Continued From page 8 color, were broken and/or bulging. Brown, dried stains were observed on the wall and extended from the ceiling to the floor. Inside the linen closet were six open shelving units housing various linens, disposable incontinence briefs and resident equipment. The top shelf was approximately three feet from the ceiling and three sheets stored on the top shelf had dried brown stains which appeared to be the same color as the stained ceiling tiles. In addition, broken pieces of ceiling tile were observed on the top shelf near these three sheets. A nursing assistant present at the time of the observation stated this was the closet staff went to obtain linen for resident use. On 12/19/18 at 10:05 AM a nursing assistant was observed coming out of the clean linen closet with clean linens in her hand. On 12/19/18 at 10:45 AM the maintenance director stated after the recent heavy snow there had been leaking from the roof and it affected parts of the facility which included the clean linen closet. The maintenance director stated when the white acoustic ceiling tiles got wet they turned brown and bulged. The maintenance director stated the dried brown stains on the walls of the clean linen closet were from water leaking from the acoustic ceiling tiles when they got wet. The maintenance director stated there had been ongoing issues with a roof leak for years and the facility was in the process of trying to get repairs done. On 12/19/18 at 11:20 AM the laundry director stated the three stained sheets on the top shelf of the linen closet had been put in place to absorb water when there were leaks from the ceiling.	F 584	Maintenance Director and Environmental Supervisor regarding the regulation components of the facility physical environment of the regulations on 12/20/18. The education of the facility physical environment of the regulations will be included in subsequent new-hire orientations. 4.The Maintenance Director will be responsible for monitoring this aspect of the Plan of Correction. The Maintenance Director will observe facility ceiling tiles monthly x 4 months to assess for any water damage as evidence by stained and bulging tiles. Any noted will be documented on the Maintenance log, replaced and reported for the Administrator to sign off to ensure compliance. The Plan of Correction will be reviewed by the Quality Assurance Committee at the next scheduled Quality Assurance Performance Improvement Committee meeting on 1-22-19. The monthly audit findings and corrections will be reported to the QA Committee for review and or new recommendation to assist with ensuring continue compliance.	

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F 584	Continued From page 9 The laundry director stated the ceiling leak had been an ongoing problem and, when it leaked she tried to move the clean linens to areas within the closet that were not affected by the ceiling leak. On 12/20/18 at 9:30 AM the laundry director was observed moving linens within the linen closet because of the start of heavy rain (at the time of the observation.) The laundry director stated every time it rained she had to move the linen because of leaks in the clean linen closet. At the time of the observation seven of 12 white acoustic ceiling tiles remained badly stained with a brown color, were broken or bulging and dried brown stains were observed on the wall which extended from the ceiling to the floor. Pieces of broken tile remained on the top shelf within the clean linen room. An empty, rolling clothing cart was stored inside the clean linen closet and the laundry director noted it had to be rolled out of the closet when it rained if resident clothing was stored on the cart. On 12/20/18 at 11:14 AM the administrator stated she had just recently started working at the facility and, after the last snow storm, she observed the leaks in the clean linen closet. The administrator stated she contacted the owner of the building to inform him of the leaks and told the laundry director to remove all items from the clean linen closet and distribute them between the three clean linen carts until repairs were done to the clean linen room. The administrator stated she was not aware the items in the clean linen closet had not been removed as requested.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		1/18/19

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F 600	Continued From page 10 §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; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, wound physician interview, and hospice nurse interview, the facility staff neglected to acknowledge a resident's call bell and failed to provide incontinence care for 8 an hour time frame from 12:41 AM to 8:30 AM for 1 of 5 residents dependent on staff for incontinence care (Resident #13); failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1); and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 1 of 3 residents reviewed for pressure ulcers Findings include: 1. Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular	F 600	Resident #13- Incontinence was provided by a certified nursing assistant 12/16/18. Resident #1- Consistent wound care was provided by a licensed nurse beginning 12/18/18. Resident # 7- Consistent and correct wound care was provided by a licensed nurse on 12/19/18. 2.All residents requiring incontinence care have the potential to be affected with wounds. In order to ensure that other residents are not affected by the same alleged deficient practice, all residents requiring incontinence care were assessed for wounds 1/16/19 through 1/18/19 by the Registered Nurse/Interim Director of Nursing	

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F 600	Continued From page 11 dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. The MDS revealed that he displayed verbal behaviors toward others but had no rejection of care. A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as needed. The Behavior Symptom CAA revealed that he had verbal aggression directed toward staff. A review of Resident #13's care plan, dated 03/14/18, indicated the resident had an ADL self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. A review of the care plan for Resident #13 revealed that he had the potential to be verbally aggressive toward caregivers. The care plan, regarding the resident being verbally aggressive toward caregivers, further revealed staff were to	F 600	3.Certified Nursing Assistant staff were educated 1/16/19-1/18/19 on the provision of incontinence care by the Registered Nurse/Interim Director of Nursing. The Nurses were educated by Registered nurse/ Interim Director of Nursing 1/16/19-1/18/19 that they are responsible for completing wound care if the wound care nurse is on duty. They were also educated 1/16/19-1/18/19 regarding wound care procedures by the Treatment Nurse and or Interim Director of Nursing. Newly hired nursing staff will also be educated during subsequent orientation. 4.Monitoring performance In order to ensure compliance the Registered Nurse Supervisor and or Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse Supervisor and or Interim Director of Nursing will randomly check the compliance of Certified Nursing Assistants providing incontinence care- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The Registered Nurse Supervisor and or the Interim Director of Nursing will interview three (3) alert and oriented residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure compliance. The Registered nurse Supervisor and or Interim DON will randomly check compliance of Nurses providing and documenting wound care according to MD orders- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks.	

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F 600	Continued From page 12 assess and anticipate resident's toileting needs and comfortable level and the resident needed monitoring, reminding, assistance to turn or reposition at least every 2 hours and more often as needed or requested. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on his personal computer voice recorder. He further	F 600	The plan of correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee on 1/22/19. All Plan of Correction monthly audit data will be reported to the QA Committee and reviewed by the Committee for two months and recommendations given in order to help to ensure that the facility stay in compliance and if concerns are identified the QA committee will add on an addition three months to assist with maintaining compliance.	

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indicated that Nurse #1 came into his room and he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up.

An interview was conducted with the Social Worker on 12/18/18 at 1:13 PM. She revealed there were no grievances filed for the month of December 2018.

An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA

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#3 further stated that Nurse #2 told Resident #13 that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with NA #4 on 12/19/18 at 8:00 pm. NA #4 stated she worked third shift and frequently worked with Resident #13. NA #4 stated Resident #13 typically received incontinence care at 1:30 am and 5:30 am, at a minimum and that was close to shift change. She indicated that Resident #13 had never saturated his bed due to his incontinence but that he got a little sweaty because he had computer equipment in his room that made the room hot.

A phone interview was conducted with NA #2 on 12/19/18 at 8:21 PM. She stated that the nursing assistants who came in at 11:00 PM typically went to Resident #13's room at 1:30 AM and changed him. She further stated that if Resident #13 was given a suppository, the NA's went to change the resident more often. She indicated that Resident #13 did not get a suppository during 2nd shift on 12/15/18. She further indicated that it was her perception that Resident #13 rang his call bell at 1:30 am and 5:30 am and both times went into his room, woke him up and changed him. She stated that Resident #13 had been telling 1st shift that he hadn't been changed, so the NAs woke him and changed him. She further stated that she reported any concerns to the oncoming shift. She did not mention that she reported any concerns to first shift regarding Resident #13 on 12/16/18.

A phone interview was conducted with the DON

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on 12/20/18 at 6:50 AM. She indicated that she expected all residents would be treated with respect and dignity and care to be provided when requested.

A phone interview was conducted with Nurse #2 on 12/20/18 at 9:13 AM. She indicated that she worked 7:00 am to 7:00 pm on 12/16/18 and that toward the end of her shift, Resident #13 told her he wanted to file a grievance because no one changed him for an extended time the early morning of 12/16/18. She stated that towards the end of first shift NA #3 confirm Resident #13 was very wet. She further stated that she reported the information to the night shift Nurse #7. She indicated that she did not notify the social worker or file a grievance because the social worker checked on Resident #13 daily.

An interview was conducted with the Social Worker on 12/20/18 at 9:39 AM. She indicated that she did not talk to Resident #13 during the week of December 17th, 2018 and wasn't aware of any concerns involving Resident #13. She further indicated that in the past, Resident #13 complained about being soaked in urine when the previous Director of Nursing (DON) was working at the facility which was before December 2018. She revealed that she didn't remember Resident #13 filing any recent grievances.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated Resident #13 only wanted to be changed 2 times at night and the administrator thought care was being provided but when he fell asleep she thought maybe he didn't know he was being changed after care was given. The administrator felt staff were going in

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the room and changing him and her expectations were for residents to be checked every 2 hours to ensure they were dry and to provide care if needed. The administrator stated she was coming in the building all shifts to check on care and expected care to be provided to all residents on all shifts and that she was in the building Saturday night during 3rd shift and arrived around midnight and left at 1:30 AM. Resident #13 could be difficult to please, but she expected staff to follow his care plan and do rounds to check on him and all residents throughout their shift. The administrator revealed she was not aware of the incident or that a grievance had been filed. Her expectation was that all residents were to be treated with dignity and respect and this was told to every staff member when she started working at the facility on 11/26/18. The administrator also expected concerns to be reported so follow-up could be done, and staff were supposed to care for residents and it was a problem of dignity if care was not given. The administrator indicated again she should have been told about the incident, so she could fix the problem.

2. Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: right hip wound infection, dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), peripheral vascular disease, (PVD), type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always

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incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was at risk for breakdown due to her incontinence and needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks and had a history of chronic pruritis (itching).

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 11/24/18, indicated the following wound measurements in centimeters (cm): 8.5 cm in length x 1.4 cm in width x 1.2 cm in depth and 8.1 cm undermining at 12 o'clock.

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/05/18, indicated the following wound measurements in centimeters (cm): 4.2 cm in length x 1.2 cm in width x 0.8 cm in depth and 8.0 cm undermining at 12 o'clock.

A review of Resident #1's Physician Orders, dated 12/05/18, revealed the following:
1. Cleanse Right hip with wound cleanser, pat dry, pack with Dakins' soaked Kling gauze, and cover with dry dressing every day and as needed.
2. Cleanse Right hip periwound with wound cleanser, pat dry, apply Silvadene and cover with

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dry dressing every day and as needed.

A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing and would remain free from infection. The care plan further indicated the following interventions were in place for staff to administer treatments as ordered and were monitored for effectiveness, dressing was monitored to ensure it was intact and adhering and staff to report loose dressings to the treatment nurse, and the resident needed moisturizer applied to her skin.

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/12/18, indicated the following wound measurements in centimeters (cm): 5.1 cm in length x 1.1 cm in width x 2.0 cm in depth and 4.8 cm undermining at 3 o'clock (progress: improved).

A review of the December 2018 Treatment Administration Record (TAR) revealed the resident's right hip dressing change and periwound dressing change was not initialed as done on the following dates: 12/07/18; 12/08/18; 12/10/18; & 12/17/18.

A review of December 2018 TAR revealed the following treatments for Resident #1 were not initialed as done the following dates:
1. Apply zinc oxide to groin redness/area every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
2. Doxepin Cream 5%- apply to all body parts with abrasion every night on 3pm-11 pm until all areas are healed and then as needed. (not

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initialed on 12/07/18; 12/8/18; 12/11/18; 12/14/18; 12/15/18; 12/16/18; and 12/17/18)
3. Eucerin Cream- apply to Bilateral Lower Extremities twice daily for 7am-7 pm and 7pm to 7am (not initialed on 12/10/18 for 7am to 7 pm)
4. Eucerin Unscented Cream- apply to affected areas topically every day on upper extremities (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
5. Ketoconazole Shampoo 2%- apply to scalp once a week for itch on 11 p-7p (not initialed on12/07/18 and 12/14/18)
6. Vitamin A+D ointment for Desitin Clear with Vit A&D - apply topically to buttocks and thighs every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. At the time of the transfer, Nurse #6 was performing a skin assessment on the resident. During continuing observation of Nurse #6 and NA #5 repositioning the resident, the nurse did not change the dressing, as the dressing was undated.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the facility had a treatment nurse on Tuesdays, Wednesdays, and Thursdays during the week and a treatment nurse on Saturdays and Sundays every other weekend but there was no treatment nurse on Mondays and Fridays. Nurse #6 indicated that the wound on Resident #1's right hip started out as a bump about 2 weeks ago and the facility had a wound doctor. Nurse #6 further indicated the resident had undermining (destruction of tissue extending

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under the skin edges so that the pressure ulcer was larger at its base than at the skin surface) of the wound and it was a decubitus pressure ulcer. She indicated that the right hip wound treatment was for the wound to be packed and covered with a blue dry dressing.

An interview was conducted with the Treatment Nurse on 12/18/18 at 8:52 AM. She stated that she knew nothing about Resident #1's right hip wound until Saturday; 11/24/18, which was the date she saw the wound for the first time. She further stated that the right hip wound had already popped open and was draining and developed undermining. She indicated that she documented information in the facility doctor's book about Resident #1's right hip wound. She further indicated that she initiated treatment to the right hip on 11/24/18. She stated that when she was not at work, the treatments on residents were not consistently getting done because she would find the same dressings that she placed on residents from when she last worked. She indicated that on 12/05/18, she completed the treatments on all the residents and, when she went back to work on Tuesday; 12/11/18 she checked Resident #1's dressing and the blue foam was saturated with drainage, had no date on it, and the wound was not packed as ordered. She said the wound packing was ordered because Resident #1 had undermining of the wound.

An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. She stated that when the wound doctor first came to assess the resident's right hip wound after it opened up, he stated that the wound looked like a bad infection

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and he removed the dead tissue off of the top of the wound which revealed the undermining. She further stated that the undermining had decreased from 8 centimeters (cm) to 4 cm. During continued observation, the undated blue sponge was still noted on Resident #1's right hip and the periwound (skin surrounding the wound) was not covered with a dressing and had 4 small areas of thick yellow adherent tissue surrounding the dressing. Further observation indicated there was no odor noted from the old dressing or the wound itself. The Treatment Nurse stated that the dry dressing she removed from the wound should not have been there because the dressing did not follow the physician's order and it should have been changed daily. She further stated that Resident #1 never refused care, but she did scratch her right hip and around the wound which caused the dressing to hang loosely off the wound. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the dressing because the treatment order was as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment.

An interview was conducted with Nurse #6 on 12/18/18 at 2:04 PM. She stated that she did not change the dressing on 12/17/18 for Resident #1. She further stated that when the treatment nurse was not at the facility, the hall nurses were responsible for changing the dressing. She indicated that she notified oncoming 3rd shift, Nurse #8, on 12/17/18 that a treatment had not been done for Resident #1.

A phone interview was conducted with Nurse #8 on 12/19/18 at 9:53 AM. She indicated that she did not do the treatments on Resident #1 on

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12/17/18 because she was working by herself with only one NA.

A phone interview was conducted with Nurse #4 on 12/19/18 at 10:07 AM. She indicated that on 12/08/18, she only performed a dressing change on another resident, not Resident #1.

A phone interview was conducted with Nurse #7 on 12/19/18 at 10:27 AM. She stated that she worked with Resident #1 on 12/17/18, from 11:00 PM to 7:00 AM, and did not perform any treatments on Resident #1.

An interview was conducted with the Wound Doctor on 12/19/18 at 11:14 AM. He indicated that when the regular treatment nurse was not working every day, there was an issue with treatments being completed as ordered. He stated he was not sure if Resident #1 scratching her skin caused the infection of her right hip. He further stated that Resident #1 needed wound packing wet to moist dressings once a day and that the periwound deteriorated (per the Wound Care notes, dated 12/12/18, due to venous insufficiency). He indicated that the Silvadene was ordered for the periwound abrasion and the key to successful wound healing was to protect the wound and that the dressing was supposed to be covering the wound.

A phone interview was conducted with Nurse #2 on 12/19/18 at 11:55 AM. She stated she worked with Resident #1 on 12/08/18 and that no treatments were done.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She indicated her expectation was that treatment orders should be

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followed, and treatments completed as scheduled.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator indicated that she expected treatments to be done consistent with the physician orders. She further indicated she was not aware treatments were not being done as scheduled but expected all orders to be followed for type of treatment and schedule set for treatments.

3. Resident #7 admitted to the facility on 01/31/17 with multiple diagnoses that included dementia, kyphosis (excessive outward curvature of the spine), age-related osteoporosis, and chronic pain.

Review of a physician's order dated 08/30/18 for Resident #7 read in part, "skin prep (forms a film protecting skin) to bilateral top of foot and protect with foam dressing twice weekly and as needed."

Review of the significant change Minimum Data Set (MDS) dated 10/24/18 revealed Resident #7 was moderately impaired for daily decision making and displayed no rejection of care during the 7-day assessment period. Further review of the MDS indicated Resident #7 required extensive assistance with activities of daily living and had 2 unhealed pressure ulcers.

Review of a care plan, with a revised date of 10/25/18, revealed Resident #7 had the potential for pressure ulcer development related to needing

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assistance with mobility, incontinence and decreased oral intake with the goal she would be free from any signs or symptoms of infections related to altered skin integrity. The interventions included for staff to administer treatments as ordered and monitor for effectiveness.

Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer ankle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains a mild cleaning agent activated by moisture and gradually released into the wound area) 3 times a week."

Review of the December 2018 Treatment Administration Record (TAR) revealed treatment for Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and Friday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the treatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 12/07/18, 12/10/18 or 12/17/18. Further review of the TAR revealed no initials indicating the treatment for Resident #7's top of foot was completed on 12/17/18.

During an interview on 12/18/18 at 8:35 AM, the Wound Nurse (WN) explained she was responsible for completing wound treatments for residents on the days she worked, which were Tuesdays, Wednesdays and Thursdays each week, and the hall nurses were responsible for completing wound treatments the remaining days. The WN recalled changing the dressing on

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Resident #7's right outer ankle on 12/05/18 with the next dressing changes scheduled on 12/07/18 and 12/10/18. She stated when she returned to work on 12/11/18, the dressing in place was dated 12/05/18 with her initials, smelled and was hanging off the wound. The WN confirmed she did not work on 12/03/18, 12/07/18 or 12/10/18 and stated it was an ongoing issue that wound treatments were not being completed by the hall nurses on the days she was not scheduled to work. She added she completed treatments on the day she returned if she noticed they were not done by the hall nurses on the day scheduled.

An observation was made of Resident #7's wound care on 12/18/18 at 10:40 AM. The WN washed her hands and as she was removing the old dressing from the top of Resident #7's left foot she stated the dressing that was in place was Polymen which was the wrong treatment. The dressing was dated 12/17/18 and initialed by Nurse #5. The skin on top of Resident #7's left foot was intact with no redness or inflammation noticed. The WN indicated the treatment ordered was preventative and the dressing would be replaced to protect the area. The WN washed her hands and as she removed the bunny boot (foot/heal protector) from Resident #7's right foot, there was no dressing covering the right outer ankle and the wound was exposed to air. The wound was red with a small amount of yellow slough (dead tissue) and the skin surrounding the wound bed was a dark reddish color. The WN cleaned the ankle with wound cleanser, patted the area dry and applied Polymen dressing as ordered.

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During a telephone interview on 12/18/18 at 1:23 PM, Nurse #1 confirmed she worked as a hall nurse on 12/07/18 and did not complete wound treatment to Resident #7's right outer ankle. She explained she was never shown how to complete wound treatments and only reapplied a resident's dressing when it fell off. Nurse #1 added she was never informed she needed to complete treatments on the days the WN was not scheduled.

During an interview on 12/18/18 at 3:00 PM, Nurse #4 confirmed she was the nurse assigned to provide care to Resident #7 on 12/03/18. Nurse #4 stated she did not complete the wound treatment to Resident #7's right outer ankle or any other resident assigned because she was never trained to provide wound care. Nurse #4 explained the facility had a WN who completed the treatments for all residents and was never informed she needed to complete the treatments when the WN was not scheduled.

During a telephone interview on 12/18/18 at 3:31 PM, Nurse #5 confirmed she provided wound treatment to Resident #7 on 12/17/18 and stated she must have forgotten to initial the TAR when completed. Nurse #5 added the Hospice Nurse (HN) was present during the wound treatment. Nurse #5 explained she put a 4 inch (in) by 4 in bandage on the top of Resident #7's left foot and applied Tegaderm (transparent dressing used to cover and protect wound) and Polymen dressing to her right outer ankle. Nurse #5 added she reviewed the TAR prior to providing treatment and was unable to explain why there was no dressing on Resident #7's right outer ankle or why the

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wrong dressing was applied to the top of her left foot.

During a telephone interview on 12/18/18 at 4:08 PM, the HN confirmed she was present when Nurse #5 provided wound treatment to Resident #7 on 12/17/18. The HN explained she only observed the treatment provided for the pressure ulcer on Resident #7's right outer ankle and was not familiar with the treatment ordered for the top of her foot. She stated Nurse #5 followed the wound treatment orders and applied Tegaderm and a non-adhesive Polymen dressing to Resident #7's right outer ankle since Hospice was out of the adhesive Polymen dressing they normally used. She added it was possible the dressing had fallen off after treatment was provided.

During an interview on 12/19/18 at 11:14 AM, the Wound Physician (WP) indicated he had only been providing wound care at the facility for the past 3 weeks and was not able to confirm if there was an issue with wound treatments not being completed as ordered or scheduled. He added if a resident was on Hospice he tried to limit the dressing changes to avoid causing them discomfort. The WP stated when he treated Resident #7's wound earlier that morning, it showed improvement with no signs of infection and no changes were made to the current treatment as ordered by Hospice. He was unaware a dressing was not observed on Resident #7's wound on 12/18/18 and stated a dressing should have been applied and the wound not left exposed.

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F 600	Continued From page 28 During a telephone interview on 12/19/18 at 2:03 PM the Director of Nursing (DON) explained nursing staff were informed upon hire that providing wound treatment was a part of their job description. The DON stated she would expect the hall nurses to complete wound treatments as ordered and scheduled when the WN was absent. During a telephone interview on 12/20/18 at 9:41 AM, Nurse #2 confirmed she was the nurse assigned to provide care to Resident #7 on 12/10/18. Nurse #2 stated she did not complete the wound treatment to Resident #7's right outer ankle because she received Hospice services and the HN provided wound care. During an interview on 12/20/18 at 11:14 AM, the Administrator was unaware wound treatments were not being completed by the hall nurses when the WN was not scheduled to work. She stated she was aware of all the training needs in the building and felt the nurses needed more training in wound care. She added it was her expectation wound treatments were completed as scheduled and consistent with the physician orders.	F 600		
F 656 SS=G	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	F 656		1/18/19

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F 656	Continued From page 29 §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 (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 observations, record review, resident interviews, staff interviews, and physician	F 656	1. Resident #1 and #11 care plans were updated 1/17/19 with accurate	

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F 656	Continued From page 30 interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). The findings included: 1. Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as needed. A review of Resident #13's care plan, dated 03/14/18, indicated the resident had an ADL	F 656	descriptions by the Interim Director of Nursing/Regional RN. Residents #1 and #7 care plans regarding wound care were implemented 12/19/18 by the licensed nurse. 2.In order to ensure that other residents are not affected by the alleged deficient practice the care plans have been revamped by the Registered Nurse/ Interim Director of nursing as of 12/20/18 in which to help to identify specific needs of the residents. The care plans regarding ADL care of residents #1 nail care was implemented by the Certified Nursing Assistant on 12/20/2018 In regards to resident #13 incontinence care was performed by the Certified Nursing Assistant on 12/19/18. Resident #13 has been informed as of 12/20/19 that random audits will be completed with him to ensure call-lights are being addressed in a timely manner and he is being changed when needed. The Nurse and or Interim Don will audit at least three (3) cognitively residents regarding ADL care weekly x 4 weeks and then weekly x 2 weeks. The care plans of residents with wounds were audited 1/16/19 and 1/17/19 by the Regional RN for accurate descriptions and corrected. The wound care nurse's schedule has been changed effective 1/15/19 to	

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F 656	Continued From page 31 self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room.With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on	F 656	Monday-Friday to complete daily coverage. 3.Education was provided to the nursing staff 1/16/18-1/18/19 regarding their role to provide treatments in the event the wound nurse is not working. In-Service was also provided to the nursing staff 1/16/19-1/18/19 in the provision of ADL care including nail and incontinence care for residents requiring assistance. Education will be included in subsequent new-hire orientations. 4.Monitoring To ensure compliance the Registered Nurse and or Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse and or Interim Director of Nursing will randomly check compliance of Certified Nursing Assistants providing ADL care including incontinence care and nail care-5 residents per x 4 weeks then 2 residents per week x 4 weeks. The treatment nurse and or Registered Nurse will monitor the care plans for accurate description of wounds once (1) weekly x 4 weeks. The registered nurse/ Interim director of Nursing will randomly check the compliance of Nurses providing and documenting wound care according to MD orders-5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The plan of Correction will be reviewed at the next scheduled QA Performance	

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F 656	Continued From page 32 his personal computer voice recorder. He further indicated that Nurse #1 came into his room and he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up. An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA #3 further stated that Nurse #2 told Resident #13 that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance	F 656	Improvement Committee meeting 1/22/19 in which all monthly audit will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations in order to stay in compliance.	

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regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with the Director of Nursing (DON) on 12/19/18 at 1:53 PM. She stated that she expected all care plans for ADL's be followed.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated she expected care plans to be accurate and expected interventions to be followed in terms of care whether it was care for treatments or ADLs.

2. Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), right hip infection, peripheral vascular disease, (PVD), type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder.

2a. A review of Resident #1's Physician Orders, dated 12/05/18, revealed the following:
1. Cleanse Right hip with wound cleanser, pat dry, pack with Dakins' soaked Kling gauze, and cover with dry dressing every day and as needed.
2. Cleanse Right hip periwound with wound cleanser, pat dry, apply Silvadene and cover with dry dressing every day and as needed.

A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing

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and would remain free from infection. The care plan further indicated the following interventions were in place for staff to administer treatments as ordered and were monitored for effectiveness, dressing was monitored to ensure it was intact and adhering and staff to report loose dressings to the treatment nurse, and the resident needed moisturizer applied to her skin.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was at risk for breakdown due to her incontinence and needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

A review of the December 2018 Treatment Administration Record (TAR) revealed the resident's Right hip dressing change and periwound dressing change was not initialed as done on the following dates:12/07/18; 12/08/18; 12/10/18; & 12/17/18.

A review of December 2018 TAR revealed the

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following treatments for Resident #1 were not initialed as done the following dates:
1. Apply zinc oxide to groin redness/area every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
2. Doxepin Cream 5%- apply to all body parts with abrasion every night on 3pm-11 pm until all areas are healed and then as needed. (not initialed on 12/07/18; 12/8/18; 12/11/18; 12/14/18; 12/15/18; 12/16/18; and 12/17/18)
3. Eucerin Cream- apply to Bilateral Lower Extremities twice daily for 7am-7 pm and 7pm to 7am (not initialed on 12/10/18 for 7am to 7 pm)
4. Eucerin Unscented Cream- apply to affected areas topically every day on upper extremities (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
5. Ketoconazole Shampoo 2%- apply to scalp once a week for itch on 11 p-7p (not initialed on 12/07/18 and 12/14/18)
6. Vitamin A+D ointment for Desitin Clear with Vit A&D - apply topically to buttocks and thighs every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. At the time of the transfer, Nurse #6 was performing a skin assessment on the resident. During continuing observation of Nurse #6 and NA #5 repositioning the resident, the nurse did not change the dressing, as the dressing was undated.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the facility had a treatment nurse on Tuesdays, Wednesdays, and Thursdays during

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the week and a treatment nurse on Saturdays and Sundays every other weekend but there was no treatment nurse on Mondays and Fridays. Nurse #6 indicated that the wound on Resident #1's right hip started out as a bump about 2 weeks ago and the facility had a wound doctor. Nurse #6 further indicated the resident had undermining (destruction of tissue extending under the skin edges so that the pressure ulcer was larger at its base than at the skin surface) of the wound and it was a decubitus pressure ulcer. She indicated that the right hip wound treatment was for the wound to be packed and covered with a blue dry dressing.

An interview was conducted with the Treatment Nurse on 12/18/18 at 8:52 AM. She stated that she knew nothing about Resident #1's right hip wound until Saturday; 11/24/18, which was the date she saw the wound for the first time. She further stated that the right hip wound had already popped open and was draining and developed undermining. She indicated that she documented information in the facility doctor's book about Resident #1's right hip wound. She further indicated that she initiated treatment to the right hip on 11/24/18. She stated that when she was not at work, the treatments on residents were not consistently getting done because she would find the same dressings that she placed on residents from when she last worked. She indicated that on 12/05/18, she completed the treatments on all the residents and, when she went back to work on Tuesday; 12/11/18 she checked Resident #1's dressing and the blue foam was saturated with drainage, had no date on it, and the wound was not packed as ordered. She said the wound packing was ordered because Resident #1 had undermining of the wound.

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F 656	Continued From page 37 An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. She stated that when the wound doctor first came to assess the resident's right hip wound after it opened up, he stated that the wound looked like a bad infection and he removed the dead tissue off of the top of the wound which revealed the undermining. She further stated that the undermining had decreased from 8 centimeters (cm) to 4 cm. During continued observation, the undated blue sponge was still noted on Resident #1's right hip and the periwound (skin surrounding the wound) was not covered with a dressing and had 4 small areas of thick yellow adherent tissue surrounding the dressing. Further observation indicated there was no odor noted from the old dressing or the wound itself. The Treatment Nurse stated that the dry dressing she removed from the wound should not have been there because it the dressing did not follow the physician's order and it should have been changed daily. She further stated that Resident #1 never refused care, but she did scratch her right hip and around the wound which caused the dressing to hang loosely off the wound. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the dressing because the treatment order was as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment. An interview was conducted with Nurse #6 on 12/18/18 at 2:04 PM. She stated that she did not change the dressing on 12/17/18 for Resident #1. She further stated that when the treatment nurse was not at the facility, the hall nurses were	F 656		

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responsible for changing the dressing. She indicated that she notified oncoming 3rd shift, Nurse #8, on 12/17/18 that a treatment had not been done for Resident #1.

A phone interview was conducted with Nurse #8 on 12/19/18 at 9:53 AM. She indicated that she did not do the treatments on Resident #1 on 12/17/18 because she was working by herself with only one NA.

A phone interview was conducted with Nurse #4 on 12/19/18 at 10:07 AM. She indicated that on 12/08/18, she only performed a dressing change on another resident, not Resident #1.

A phone interview was conducted with Nurse #7 on 12/19/18 at 10:27 AM. She stated that she worked with Resident #1 on 12/17/18, from 11:00 PM to 7:00 AM, and did not perform any treatments on Resident #1.

An interview was conducted with the Wound Doctor on 12/19/18 at 11:14 AM. He indicated that when the regular treatment nurse was not working every day, there was an issue with treatments being completed as ordered. He stated he was not sure if Resident #1 scratching her skin caused the infection of her right hip. He further stated that Resident #1 needed wound packing wet to moist dressings once a day and that the periwound deteriorated (per the Wound Care notes, dated 12/12/18, due to venous insufficiency). He indicated that the Silvadene was ordered for the periwound abrasion and the key to successful wound healing was to protect the wound and that the dressing was supposed to be covering the wound.

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A phone interview was conducted with Nurse #2 on 12/19/18 at 11:55 AM. She stated that no treatments were done on Resident #1 on 12/08/18. She further stated that on 12/10/18, she only changed another resident's dressing, not Resident #1.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that Resident #1's treatment orders should be followed, and treatments completed as scheduled.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated that treatment orders should be followed and completed as scheduled.

2b. A review of Care Kardex (the system in place at the facility for nursing assistants to know resident specific needs) for Resident #1 revealed she was supposed to get nail care daily and as needed. Review of the December 2018 bed baths and nail care sheet for Resident #1 indicated no nail care was documented.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

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A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

A review of ADL Functional/Potential CAA associated with the 01/08/18 MDS revealed Resident #1 had a diagnosis of dementia. The CAA further revealed she required extensive assistance with personal hygiene but was able to assist with basic hygiene with setup and needed physical assistance with bathing or showering.

A review of the care plan, dated 01/08/18, for the Potential for Pressure Ulcer Development indicated Resident #1's self-inflicted scratches and wound would show signs of healing and remain free from infection. The care plan also revealed the following interventions were in place for potential for pressure ulcer development: staff to make sure fingernails were clean, trimmed, and had no jagged edges and staff to administer treatments as ordered and treatments were monitored for effectiveness.

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. Resident #1's nails on both hands were observed to be dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6

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stated that the resident definitely needed good nail care and NA's were supposed to cut her nails when they gave her a shower and also stated that Resident #1 did not refuse care.

An interview with NA #5 was conducted on 12/17/18 at 3:00 PM. NA #5 indicated that Resident #1 was supposed to have her nails cut during her shower and that Resident #1 did not refuse care.

An observation conducted of Resident #1 was conducted on 12/18/18 from 1:15 PM to 1:35 PM. The observation of the resident during the dressing changed revealed Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

An interview was conducted with NA #4 on 12/19/18 at 8:55 AM. She stated that she worked 3rd shift and did not do nail care on Resident #1 because that was done on day shift.

An observation of Resident #1 was conducted on 12/19/18 at 12:40 PM. During the observation, Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge and the resident put her right hand in her mouth.

An interview was conducted with NA #5 on 12/19/18 at 12:45 PM. She stated that nail care should be done after Resident#1's shower. After looking at Resident #1's fingernail, NA #5 stated

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that the resident's nails needed to be cut. NA #5 then left the resident's room without performing nail care.

An observation of Resident #1 in the Activity Room was conducted on 12/20/18 at 10:35 AM. Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that her expectation was that every time residents got a shower their nails should be checked and checked daily to determine if they needed to be cleaned or trimmed and the care plan should have been followed.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated that nail care should have been done consistent with the plan of care.

2c. A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

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A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing and would remain free from infection.

An interview was conducted with the MDS nurse on 12/19/18 at 12:26 PM. She indicated that she had to clarify with the treatment nurse on 12/19/18 because she didn't know why she documented the right hip unstageable pressure ulcer on the 12/06/18 care plan other than on 11/28/18, it was marked Unstaged on the facility Wound Tracking Report and had an X through the wound stages portion of the report.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that Resident #1's wound was not unstageable and was incorrectly staged on the Care Plan and her expectation was the wound should have been staged correctly.

A follow-up interview was conducted with the MDS nurse on 12/19/18 at 3:52 pm. She revealed that the Unstageable Pressure Ulcer should not have been listed on Resident #1's 12/06/18 care plan because the wound was an infection, not a pressure ulcer.

An interview was conducted with the

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Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated the care plan should be an accurate reflection of Resident #1's wound.

3. Resident #7 admitted to the facility on 01/31/17 with multiple diagnoses that included dementia, kyphosis (excessive outward curvature of the spine), age-related osteoporosis, and chronic pain.

Review of the significant change Minimum Data Set (MDS) dated 10/24/18 revealed Resident #7 was moderately impaired for daily decision making and displayed no rejection of care during the 7-day assessment period. Further review of the MDS indicated Resident #7 required extensive assistance with activities of daily living and had 2 unhealed pressure ulcers.

Review of a care plan, with a revised date of 10/25/18, revealed Resident #7 had the potential for pressure ulcer development related to needing assistance with mobility, incontinence and decreased oral intake with the goal she would be free from any signs or symptoms of infections related to altered skin integrity. The interventions included for staff to administer treatments as ordered and monitor for effectiveness.

Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer ankle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains a mild cleaning agent activated by moisture and gradually released into the wound area) 3 times a

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week."

Review of the December 2018 Treatment Administration Record (TAR) revealed treatment for Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and Friday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the treatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 12/07/18 or 12/10/18.

During an interview on 12/18/18 at 8:35 AM, the Wound Nurse (WN) explained she was responsible for completing wound treatments for residents on the days she worked, which were Tuesdays, Wednesdays and Thursdays each week, and the hall nurses were responsible for completing wound treatments the remaining days. The WN recalled changing the dressing on Resident #7's right outer ankle on 12/05/18 with the next dressing changes scheduled on 12/07/18 and 12/10/18. She stated when she returned to work on 12/11/18, the dressing in place was dated 12/05/18 with her initials, smelled and was hanging off the wound. The WN confirmed she did not work on 12/03/18, 12/07/18 or 12/10/18 and added it was an ongoing issue that wound treatments were not being completed on the days she was not scheduled to work. She added she completed treatments on the day she returned to work if she noticed they were not done by the hall nurses on the day scheduled.

During a telephone interview on 12/18/18 at 1:23 PM, Nurse #1 confirmed she worked as a hall

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nurse on 12/07/18 and did not complete wound treatment to Resident #7's right outer ankle. She explained she was never shown how to complete wound treatments and only reapplied a resident's dressing when it fell off. Nurse #1 added she was never informed she needed to complete treatments on the days the WN was not scheduled.

During an interview on 12/18/18 at 3:00 PM, Nurse #4 confirmed she was the nurse assigned to provide care to Resident #7 on 12/03/18. Nurse #4 stated she did not complete the wound treatment to Resident #7's right outer ankle or any other resident assigned because she was never trained to provide wound care. Nurse #4 explained the facility had a WN who completed the treatments for all residents and was never informed she needed to complete the treatments when the WN was not scheduled.

During a telephone interview on 12/19/18 at 2:03 PM the Director of Nursing (DON) explained nursing staff were informed upon hire that providing wound treatment was a part of their job description. The DON stated it was her expectation nursing staff would follow Resident #7's care plan and provide wound treatment as scheduled and ordered.

During a telephone interview on 12/20/18 at 9:41 AM, Nurse #2 confirmed she was the nurse assigned to provide care to Resident #7 on 12/10/18. Nurse #2 stated she did not complete the wound treatment to Resident #7's right outer ankle because she received Hospice services

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and the Hospice Nurse provided wound care.

During an interview on 12/20/18 at 11:14 AM, the Administrator was unaware wound treatments were not being completed by the hall nurses when the WN was not scheduled to work. She stated she was aware of all the training needs in the building and felt the nurses needed more training in wound care. She stated it was her expectation wound treatments were completed as scheduled and ordered and staff provided care consistent with a resident's care plan.

4. Resident #11 was admitted to the facility on 08/28/18 with diagnoses including anemia, atrial fibrillation, hypertension, cerebral vascular accident and renal insufficiency.

A review of the care plan with an initiation date of 11/21/18 revealed an identified problem that Resident #11 had potential for pressure ulcer development related to immobility and incontinence and had a stage II pressure ulcer on his coccyx and left hip and had a stage III pressure ulcer on his right heel. The goal was Resident #11 would be free from any further pressure ulcer development. Interventions to address problem were as follows: Staff were to administer treatments as ordered and monitor for effectiveness. Staff were to monitor/document/report as needed any changes in skin status (appearance, color, wound healing, signs and symptoms of infection, wound size, and stage).

A review of a wound physician's note dated 11/29/18 indicated Resident #11 had an unstageable pressure ulcer to coccyx, right hip,

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right heel, and right medial ankle.

A review of hospital wound discharge sheet dated 12/07/18 indicated Resident #11 had stage I pressure ulcer to left heel and deep tissue injury right heel, pressure ulcer to right medial ankle that was not staged, pressure ulcer to sacrum, left knee, and right head that was unstageable, and pressure ulcer to right hip that was not staged.

A review of the Admission Nursing Assessment (ANA) dated 12/07/18 revealed Resident #11 had an unstageable pressure ulcer to buttock, sacrum, right head, and left knee and a stage I pressure ulcer to left heel, and deep tissue injury to right heel.

A review of a wound physician's note dated 12/12/2018 indicated Resident #11 had an unstageable pressure ulcer to coccyx, right hip, right heel, left heel, and a stage IV pressure ulcer to right medial ankle.

On 12/19/18 at 10:36 AM an interview was conducted with the Minimum Data Set (MDS) nurse who stated she was responsible for updating the care plan to indicate pressure ulcer location and stage for Resident #11. The MDS nurse stated she was aware Resident #11 had pressure ulcers but had not reviewed the wound physician notes for 11/29/18 that indicated location and stage of Resident #11's pressure ulcers. She stated she had not reviewed the admission nursing assessment dated 12/07/18 and hospital discharge information dated 12/07/18 for pressure ulcer location and stage and had not reviewed the wound physician note dated 12/12/18 for pressure ulcer location and

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F 656	Continued From page 49 stage. The MDS nurse stated she did not update Resident #11's care plan to indicate pressure ulcer location and stage because she had been pulled from performing her duties as MDS nurse to administer medications and admit residents to the facility. On 12/19/18 at 10:53 AM an interview was conducted with the Administrator who stated the MDS nurse was responsible for updating Resident #11's care plan to indicate stage of pressure ulcers and location. She stated her expectation was that the MDS nurse would have updated the care plan to indicate Resident #11 had pressure ulcer areas. On 12/19/2018 at 2:35 PM a telephone interview was conducted with the Director of Nursing who stated it was her expectation that the MDS nurse would have updated the care plan to indicate stage and location of pressure ulcers for Resident #11.	F 656		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for Activities of Daily Living (ADL) care (Resident #13) and failed to provide nail care for 2 of 5 dependent residents reviewed for ADL care (Resident #1).	F 677	1.Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. Nail care was provided to Resident # 1 12/20/18 by the Certified Nursing Assistant. 2.The Registered Nurse/Interim Director	1/18/19

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F 677	Continued From page 50 The findings included: 1. Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. The MDS revealed had no rejection of care. A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as needed. A review of Resident #13's care plan, dated 03/14/18, indicated the resident had an ADL self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. A review of the care plan for Resident #13 revealed that he had the potential to be verbally	F 677	of Nursing completed an audit 1/16 -1/18/19 to assess for adverse effects to other residents with none observed. 3.The nursing staff were educated by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 in proper ADL care including nail and incontinence care for residents requiring assistance. The education will be included in subsequent new-hire orientation. 4.The Director of Nursing/Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse will randomly check compliance of Certified Nursing Assistants providing ADL care including incontinence care and nail care- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. The committee includes the Medical Director, Administrator, Director of Nursing, Registered Nurse, Social Services, Dietary, Medical Records/Human Resource Director, Maintenance Director, and line staff member. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review, recommendations and updated as needed to ensure continuous compliance.	

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aggressive toward caregivers. The care plan, regarding the resident being verbally aggressive toward caregivers, further revealed staff were to assess and anticipate resident's toileting needs .

An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on his personal computer voice recorder. He further indicated that Nurse #1 came into his room and

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he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up.

An interview was conducted with the Social Worker on 12/18/18 at 1:13 PM. She revealed there were no grievances filed for the month of December 2018.

An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA #3 further stated that Nurse #2 told Resident #13

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that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with NA #4 on 12/19/18 at 8:00 pm. NA #4 stated she worked third shift and frequently worked with Resident #13. NA #4 stated Resident #13 typically received incontinence care at 1:30 am and 5:30 am, at a minimum and that was close to shift change. She indicated that Resident #13 had never saturated his bed due to his incontinence but that he got a little sweaty because he had computer equipment in his room that made the room hot.

A phone interview was conducted with NA #2 on 12/19/18 at 8:21 PM. She stated that the nursing assistants who came in at 11:00 PM typically went to Resident #13's room at 1:30 AM and change him. She further stated that if Resident #13 was given a suppository, the NA's went to change the resident more often. She indicated that Resident #13 did not get a suppository during 2nd shift on 12/15/18. She further indicated that it was her perception that Resident #13 rang his call bell at 1:30 am and 5:30 am and both times went into his room, woke him up and changed him. She stated that Resident #13 had been telling 1st shift that he hadn't been changed, so the NAs woke him and changed him. She further stated that she reported any concerns to the oncoming shift. She did not mention that she reported any concerns to first shift regarding Resident #13 on 12/16/18.

A phone interview was conducted with the DON on 12/20/18 at 6:50 AM. She indicated that she

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expected all residents would be treated with respect and dignity and care to be provided when requested.

A phone interview was conducted with Nurse #2 on 12/20/18 at 9:13 AM. She indicated that she worked 7:00 am to 7:00 pm on 12/16/18 and that toward the end of her shift, Resident #13 told her he wanted to file a grievance because no one changed him for an extended time the early morning of 12/16/18. She stated that towards the end of first shift NA #3 confirm Resident #13 was very wet. She further stated that she reported the information to the night shift Nurse #7. She indicated that she did not notify the social worker or file a grievance because the social worker checked on Resident #13 daily.

An interview was conducted with the Social Worker on 12/20/18 at 9:39 AM. She indicated that she did not talk to Resident #13 during the week of December 17th, 2018 and wasn't aware of any concerns involving Resident #13. She further indicated that in the past, Resident #13 complained about being soaked in urine when the previous Director of Nursing (DON) was working at the facility which was before December 2018. She revealed that she didn't remember Resident #13 filing any recent grievances.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated she expected all residents to be treated with dignity and respect and told this to every staff member when she started working at the facility on 11/26/18. She further stated she expected concerns to be reported so follow-up could be done. She indicated staff were supposed to care for residents and it was a

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problem of dignity if care was not given. She indicated again she should have been told about the incident, so she could fix the problem.

2. Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), Right hip infection, peripheral vascular disease, (PVD), type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/8/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) revealed Resident #1 was at risk for breakdown due to her incontinence and needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks and had a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

A review of ADL Functional/Potential CAA revealed Resident #1 had a diagnosis of

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dementia. The CAA further revealed she required extensive assistance with personal hygiene but was able to assist with basic hygiene with setup). Resident #1 also needed physical assistance with bathing or showering.

A review of the care plan for the Potential for Pressure Ulcer Development indicated Resident #1's self-inflicted scratches. The care plan also revealed the following interventions were in place for potential for pressure ulcer development: staff to make sure fingernails were clean, trimmed, and had no jagged edges and staff to administer treatments as ordered and treatments were monitored for effectiveness.

A review of Care Kardex for Resident #1 revealed she was supposed to get nail care daily and as needed and the December 2018 bed baths and nail care sheet indicated no nail care was documented.

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with a nurse and nursing assistant present. Nurse #6 was performing a skin assessment on the resident. Resident #1's nails on both hands were dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the resident definitely needed good nail care and NA's were supposed to cut her nails when they give her a shower and also stated that Resident #1 was getting nail care and that

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Resident #1 did not refuse care. NA #5 concurred with Nurse #6 regarding Resident #1's nail care.

An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. Further observation of the resident during the dressing changed revealed Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the dressing because the treatment order is as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment.

An interview was conducted with NA #4 on 12/19/18 at 8:55 AM. She stated that she did not do nail care on Resident #1 because that was done on day shift.

An observation of Resident #1 was conducted on 12/19/18 at 12:40 PM. During the observation, Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge and the resident put her right hand in her mouth.

An interview was conducted with NA #5 on 12/19/18 at 12:45 PM. She stated that nail care should be done after Resident#1's shower. After looking at Resident #1's fingernail, NA #5 stated that the resident's nails needed to be cut. NA #5

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F 677	Continued From page 58 then left the resident's room without performing nail care. A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that her expectation was that every time residents get a shower their nails should be checked and checked daily to determine if they needed to be cleaned or trimmed and the care plan should have been followed. An observation of Resident #1 in the Activity Room was conducted on 12/20/18 at 10:35 AM. Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge. An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated she expected nails to be cleaned every day by NAs. She further stated NAs should be able to do this and should have time to do this during AM care. She indicated that she talked with the NAs about nail care in particular for residents that had contractures. She further indicated that nail care should have been done consistent with the plan of care. The administrator stated she expected care plans to be accurate and expected interventions to be followed in terms of care whether it was care for treatments or ADLs.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		1/18/19

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F 684	Continued From page 59 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 observations, record review, staff interviews, and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1). The findings included: Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: right hip wound infection, dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), peripheral vascular disease, (PVD), type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder. A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.	F 684	1.Resident #1 wound care has been provided consistently by the licensed nurse. 2.In order to ensure other residents are not affected by the alleged deficient practice the wound care nurse□s schedule has been changed effective 1/15/19 to Monday-Friday to complete daily coverage and all nurses have been informed that when the treatment nurse is off they are to perform wound care in the wound care nurse absence. 3.Education was provided to the nursing staff 1/16-1/18/19 by the Registered Nurse/Interim Director of Nursing regarding their role to provide treatments in the event the wound nurse is not working. They were also educated 1/16-1/18/19 regarding wound care procedures by the Registered Nurse/Interim Director of Nursing. Newly hired nursing staff will be educated during subsequent orientation events. 4.Monitoring to ensure compliance the Registered Nurse/Interim Director of Nursing will be responsible for this aspect of the Plan of Correction.	

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F 684	Continued From page 60 A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was at risk for breakdown due to her incontinence and needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 11/24/18, indicated the following wound measurements in centimeters (cm): 8.5 cm in length x 1.4 cm in width x 1.2 cm in depth and 8.1 cm undermining at 12 o'clock. A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/05/18, indicated the following wound measurements in centimeters (cm): 4.2 cm in length x 1.2 cm in width x 0.8 cm in depth and 8.0 cm undermining at 12 o'clock. A review of Resident #1's Physician Orders, dated 12/05/18, revealed the following: 1. Cleanse Right hip with wound cleanser, pat dry, pack with Dakins' soaked Kling gauze, and cover with dry dressing every day and as needed. 2. Cleanse Right hip periwound with wound cleanser, pat dry, apply Silvadene and cover with dry dressing every day and as needed. A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing and would remain free from infection. The care	F 684	The Registered Nurse will randomly check the compliance of Nurses providing consistent wound care according to MD orders- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations to continue the achievement of compliance.	

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plan further indicated the following interventions were in place for staff to administer treatments as ordered and were monitored for effectiveness, dressing was monitored to ensure it was intact and adhering and staff to report loose dressings to the treatment nurse, and the resident needed moisturizer applied to her skin.

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/12/18, indicated the following wound measurements in centimeters (cm): 5.1 cm in length x 1.1 cm in width x 2.0 cm in depth and 4.8 cm undermining at 3 o'clock (progress: improved).

A review of the December 2018 Treatment Administration Record (TAR) revealed the resident's Right hip dressing change and periwound dressing change was not initialed as done on the following dates: 12/07/18; 12/08/18; 12/10/18; & 12/17/18.

A review of December 2018 TAR revealed the following treatments for Resident #1 were not initialed as done the following dates:
1. Apply zinc oxide to groin redness/area every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
2. Doxepin Cream 5%- apply to all body parts with abrasion every night on 3pm-11 pm until all areas are healed and then as needed. (not initialed on 12/07/18; 12/8/18; 12/11/18; 12/14/18; 12/15/18; 12/16/18; and 12/17/18)
3. Eucerin Cream- apply to Bilateral Lower Extremities twice daily for 7am-7 pm and 7pm to 7am (not initialed on 12/10/18 for 7am to 7 pm)
4. Eucerin Unscented Cream- apply to affected areas topically every day on upper extremities

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(not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
5. Ketoconazole Shampoo 2%- apply to scalp once a week for itch on 11 p-7p (not initialed on 12/07/18 and 12/14/18)
6. Vitamin A+D ointment for Desitin Clear with Vit A&D - apply topically to buttocks and thighs every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. At the time of the transfer, Nurse #6 was performing a skin assessment on the resident. During continuing observation of Nurse #6 and NA #5 repositioning the resident, the nurse did not change the dressing, as the dressing was undated.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the facility had a treatment nurse on Tuesdays, Wednesdays, and Thursdays during the week and a treatment nurse on Saturdays and Sundays every other weekend but there was no treatment nurse on Mondays and Fridays. Nurse #6 indicated that the wound on Resident #1's right hip started out as a bump about 2 weeks ago and the facility had a wound doctor. Nurse #6 further indicated the resident had undermining (destruction of tissue extending under the skin edges so that the pressure ulcer was larger at its base than at the skin surface) of the wound and it was a decubitus pressure ulcer. She indicated that the right hip wound treatment was for the wound to be packed and covered with a blue dry dressing.

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An interview was conducted with the Treatment Nurse on 12/18/18 at 8:52 AM. She stated that she knew nothing about Resident #1's right hip wound until Saturday; 11/24/18, which was the date she saw the wound for the first time. She further stated that the right hip wound had already popped open and was draining and developed undermining. She indicated that she documented information in the facility doctor's book about Resident #1's right hip wound. She further indicated that she initiated treatment to the right hip on 11/24/18. She stated that when she was not at work, the treatments on residents were not consistently getting done because she would find the same dressings that she placed on residents from when she last worked. She indicated that on 12/05/18, she completed the treatments on all the residents and, when she went back to work on Tuesday; 12/11/18 she checked Resident #1's dressing and the blue foam was saturated with drainage, had no date on it, and the wound was not packed as ordered. She said the wound packing was ordered because Resident #1 had undermining of the wound.

An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. She stated that when the wound doctor first came to assess the resident's right hip wound after it opened up, he stated that the wound looked like a bad infection and he removed the dead tissue off of the top of the wound which revealed the undermining. She further stated that the undermining had decreased from 8 centimeters (cm) to 4 cm. During continued observation, the undated blue sponge was still noted on Resident #1's right hip and the periwound (skin surrounding the wound)

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was not covered with a dressing and had 4 small areas of thick yellow adherent tissue surrounding the dressing. Further observation indicated there was no odor noted from the old dressing or the wound itself. The Treatment Nurse stated that the dry dressing she removed from the wound should not have been there because it the dressing did not follow the physician's order and it should have been changed daily. She further stated that Resident #1 never refused care, but she did scratch her right hip and around the wound which caused the dressing to hang loosely off the wound. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the dressing because the treatment order was as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment.

An interview was conducted with Nurse #6 on 12/18/18 at 2:04 PM. She stated that she did not change the dressing on 12/17/18 for Resident #1. She further stated that when the treatment nurse was not at the facility, the hall nurses were responsible for changing the dressing. She indicated that she notified oncoming 3rd shift, Nurse #8, on 12/17/18 that a treatment had not been done for Resident #1.

A phone interview was conducted with Nurse #8 on 12/19/18 at 9:53 AM. She indicated that she did not do the treatments on Resident #1 on 12/17/18 because she was working by herself with only one NA.

A phone interview was conducted with Nurse #4 on 12/19/18 at 10:07 AM. She indicated that on 12/08/18, she only performed a dressing change on another resident, not Resident #1.

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A phone interview was conducted with Nurse #7 on 12/19/18 at 10:27 AM. She stated that she worked with Resident #1 on 12/17/18, from 11:00 PM to 7:00 AM, and did not perform any treatments on Resident #1.

An interview was conducted with the Wound Doctor on 12/19/18 at 11:14 AM. He indicated that when the regular treatment nurse was not working every day, there was an issue with treatments being completed as ordered. He stated he was not sure if Resident #1 scratching her skin caused the infection of her right hip. He further stated that Resident #1 needed wound packing wet to moist dressings once a day and that the periwound deteriorated (per the Wound Care notes, dated 12/12/18, due to venous insufficiency). He indicated that the Silvadene was ordered for the periwound abrasion and the key to successful wound healing was to protect the wound and that the dressing was supposed to be covering the wound.

A phone interview was conducted with Nurse #2 on 12/19/18 at 11:55 AM. She stated that she worked on 12/08/18 and no treatments were done on Resident #1. She further stated that on 12/10/18, she only changed another resident's dressing, not Resident #1.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She indicated her expectation was that treatment orders should be followed, and treatments completed as scheduled.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to

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F 684	Continued From page 66 12:25 PM. The administrator indicated that she expected treatments to be done consistent with the physician orders. She further indicated she was not aware treatments were not being done as scheduled but expected all orders to be followed for type of treatment and schedule set for treatments.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers. The findings included: 1. Resident #11 was readmitted to the facility on	F 686	1.Resident # 11 and #7 have received wound care as ordered by the licensed nurse. 2.In order to ensure other residents are not affected by the alleged deficient practice the wound care nurse□ schedule has been changed effective 1/15/19 to Monday-Friday to complete daily coverage and all nurses have been informed that when the treatment nurse is off they are to perform wound care in the wound care	1/18/19

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F 686	Continued From page 67 12/07/18 with diagnoses which included urinary tract infection, dementia, and pressure ulcer to sacral region, right heel, and right hip. A review of the most recent comprehensive Minimum Data Set (MDS) assessment dated 09/09/18 indicated Resident #11 was cognitively impaired and was coded as having an unstageable pressure ulcer on his heel that was not present on prior assessment. A review of Care Area Assessment (CAA) for pressure ulcer dated 09/09/18 indicated Resident #11 had a deep tissue injury (DTI) to right heel with treatment in place. A review of the care plan with an initiation date of 11/21/18 revealed an identified problem that Resident #11 had potential for pressure ulcer development related to immobility and incontinence and had a stage II pressure ulcer on his coccyx and left hip and had a stage III pressure ulcer on his right heel. The goal was Resident #11 would be free from any further pressure ulcer development. Interventions to address problem were as follows: Staff were to administer treatments as ordered and monitor for effectiveness. Staff were to monitor/document/report as needed any changes in skin status (appearance, color, wound healing, signs and symptoms of infection, wound size, and stage). A review of a wound physician's note dated 11/29/18 indicated Resident #11 had an unstageable pressure ulcer to coccyx, right hip, right heel, and right medial ankle. A review of MDS dated 11/30/18 indicated	F 686	nurse absence. 3.Education was provided to the nursing staff by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 regarding their role to provide treatments in the event the wound nurse is not working. They were also educated 1/16-1/18/19 regarding wound care procedures. In order to correct nurses not clarifying and implementing treatment orders, two nurses must sign off that the treatment orders have been clarified and implemented with each new or readmit resident whom requires wound care, this will be an on-going process. Newly hired nursing staff will be educated during subsequent orientation events. 4.The Registered Nurse Supervisor and or Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse Supervisor and or Interim/Director of Nursing will randomly check the compliance of Nurses providing consistent wound care according to MD orders- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review for	

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F 686	Continued From page 68 Resident #11 had unplanned discharge to the hospital with return anticipated. A review of hospital wound discharge sheet dated 12/07/18 indicated Resident #11 had pressure ulcer to left and right heel, right medial ankle, sacrum, right hip, and left knee and was to receive foam dressing to left heel and apply Santyl (debridement ointment and foam dressing to right medial ankle, sacrum, and right hip, and apply ¼ strength Dakin's solution (a solution used to kill germs and prevent germ growth in wounds) and Santyl to right heel. The treatment orders did not indicate when the wound treatment was to begin or how often wound treatment was to be administered. A review of the Admission Nursing Assessment (ANA) dated 12/07/18 revealed Resident #11 had a pressure ulcer to buttock, right and left heel, sacrum, right head and left knee which were not measured. Review of Resident #11's Medication Administration Record (MAR) dated 12/07/18 to 12/31/18 indicated there were no medication orders prescribed to treat areas on his left and right heel, right medial ankle, sacrum, right hip, buttock, and left knee. Review of Resident #11's Treatment Administration Record (TAR) from 12/07/18 through 12/10/18 indicated treatment to the right and left heel, sacrum, right hip, and right medial ankle were not completed per nurse documentation on the TAR. No treatment had been set up for areas on his left and right heel, right medial ankle, sacrum, right hip, buttock, and left knee for 12/08/18 to 12/10/18. A further	F 686	two months if concerns are identified the QA Committee will continue to review another three months in order to provide addition recommendations to assist with maintaining compliance.	

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review of the TAR from 12/12/18 through 12/31/18 indicated treatment orders were written by the wound physician on 12/12/18 were transcribed to the TAR and were documented as completed.

On 12/18/18 at 8:34 AM an interview was conducted with the wound nurse (WN) who stated she worked 3 days a week and was unsure when she was not working if Resident #11's pressure ulcers were treated. The WN stated it was the responsibility of the floor duty nurse to provide wound treatment when she was not on duty. The WN stated Resident #11 was readmitted to the facility from the hospital on 12/07/18. The WN stated she returned back to work on 12/11/18 and Resident #11 had hospital dressings on his pressure ulcer wounds and she saw no indication that wound treatment had been provided on 12/08/18, 12/09/18, and 12/10/18 by the floor duty nurse. The WN stated when she came on duty 12/11/18 Resident #11 had no wound treatment orders from the 12/07/18 admission. The WN stated the TAR did not indicate via nursing documentation that wound treatment had been provided to Resident #11 on 12/08/18, 12/09/18, and 12/10/18. The wound nurse stated she performed wound treatment for Resident #11 on 12/11/18.

On 12/18/18 at 1:10 PM a telephone interview was conducted with Nurse #1 who stated she worked 7:00 PM to 7:00 AM when Resident #11 was admitted to the facility on 12/07/18. She stated she was aware that Resident #11 had wounds. Nurse #1 stated it had been a very busy shift that night and she did not call the physician to clarify Resident #11 ' s wound treatment orders from the hospital discharge. She stated she had

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not had time to review the hospital wound discharge orders to determine if she needed to clarify the wound orders with the facility physician.

On 12/8/18 at 2:33 PM a telephone interview was conducted with Nurse #2 who worked the day shift on 12/07/18 and completed Resident #11's head to toe admission nursing assessment and noted he had several wounds. She stated she did not have time to complete his admission paperwork and had not called the physician to clarify wound treatment orders for Resident #11. Nurse #2 stated she informed the oncoming Nurse #1 that she had not finished Resident #11's admission paper work but did not informed Nurse #1 that she had not clarified wound treatment orders with the facility physician. Nurse #2 stated the process on admission was that staff were to clarify wound treatment orders with the physician if the orders were not clearly understood.

On 12/18/18 at 2:44 PM a telephone interview was conducted with Nurse #3 who stated she was scheduled to be the treatment nurse on 12/08/18 and 12/09/18 but had been pulled to administer medications. Nurse #3 stated she had not clarified with the facility physician wound treatment orders for Resident #11. Nurse #3 stated she had not performed wound treatment on Resident #11 on 12/08/18 and 12/09/2018. Nurse #3 stated she was unaware that wound treatment orders for Resident #11 had not been clarified with the facility physician.

On 12/18/18 at 2:55 PM an interview was conducted with Nurse #4 who stated she was working day shift when Resident #11 was admitted to the facility on 12/07/18 and helped Nurse #2 with clarifying pain medication orders

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with the physician for Resident #11. Nurse #4 stated she had not clarified wound treatment orders for Resident #11. Nurse #4 stated she was unaware that Resident #11 had wounds. Nurse #4 stated she had not informed the oncoming nurse that the wound treatment orders for Resident #11 had not been clarified with the facility physician. Nurse #4 stated she thought the wound nurse was responsible to clarify wound orders with the facility physician.

On 12/18/18 at 2:17 PM an interview was conducted with the Director of Nursing (DON) who stated the admitting nurse was responsible to clarify wound treatment orders with the facility physician and transcribe wound treatment orders onto the TAR. The DON stated it was the admitting nurse's responsibility to provide a head to toe resident assessment on admission and document any wounds and skin issues and obtain wound treatment orders from the physician. The DON stated it was her expectation that the admitting nurse would have clarified wound treatment orders with the physician and would have transcribed treatment orders onto Resident #11's TAR or would have communicated to the oncoming nurse if she was unable to clarify wound treatment orders with the facility physician for Resident #11. The DON stated it was her expectation that the floor duty nurse would have provided wound treatment for Resident #11 on 12/8/18, 12/09/18, and 12/10/18. The DON stated it was her expectation if the wound nurse was not on duty then the floor duty nurse would provide wound care for Resident #11.

On 12/18/18 at 4:07 PM a telephone interview was conducted with the facility physician who stated he had not received a call from the facility

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staff on 12/07/18 to clarify wound treatment orders for Resident #11. The physician stated staff would have called him to clarify wound orders and not the nurse practitioner. The physician stated it was his expectation that staff would have called him to clarify any questions with admission wound treatment orders for Resident #11. The physician stated it was his expectation that Resident #11 would have received wound treatment on 12/08/18, 12/09/18, and 12/10/18 because Resident #11 had some tough wounds. The physician stated it was his expectation that wound care would have been performed daily and deferred Resident #11's wound care to the wound physician.

On 12/18/18 at 4:34 a telephone interview was conducted with the wound physician who stated after reviewing the hospital discharge wound sheet for 12/07/18 that Resident #11 had a foam dressing applied to his pressure ulcer on the right medial ankle, coccyx, right hip, and left heel and felt the dressings did not need to be changed daily. The wound physician stated a foam dressing could stay in place for 3 to 5 days without being changed. The wound physician stated he could not determine if any harm occurred because Resident #11's wound treatments had not been provided on 12/08/18, 12/09/18, and 12/10/18.

On 12/19/18 at 10:58 AM an interview was conducted with the Administrator who stated her expectation was that the admitting nurse would have verified wound treatment orders with the facility physician and transcribed the orders onto the TAR. The Administrator stated her expectation was that Resident #11 would have received wound treatment on 12/08/18, 12/09/18,

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and 12/10/18.

On 12/19/18 at 11:08 an additional interview was conducted with the with the wound physician who stated he felt that the nurse should have clarified wound treatment orders with the hospital discharge physician or facility physician on admission 12/07/18 for Resident #11 to clarify how often wound treatment should have been provided.

2. Resident #7 admitted to the facility on 01/31/17 with multiple diagnoses that included dementia, kyphosis (excessive outward curvature of the spine), age-related osteoporosis, and chronic pain.

Review of a physician's order dated 08/30/18 for Resident #7 read in part, "skin prep (forms a film protecting skin) to bilateral top of foot and protect with foam dressing twice weekly and as needed."

Review of the significant change Minimum Data Set (MDS) dated 10/24/18 revealed Resident #7 was moderately impaired for daily decision making and displayed no rejection of care during the 7-day assessment period. Further review of the MDS indicated Resident #7 required extensive assistance with activities of daily living and had 2 unhealed pressure ulcers.

Review of a care plan, with a revised date of 10/25/18, revealed Resident #7 had the potential for pressure ulcer development related to needing assistance with mobility, incontinence and decreased oral intake with the goal she would be

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free from any signs or symptoms of infections related to altered skin integrity. The interventions included for staff to administer treatments as ordered and monitor for effectiveness.

Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer ankle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains a mild cleaning agent activated by moisture and gradually released into the wound area) 3 times a week."

Review of the December 2018 Treatment Administration Record (TAR) revealed treatment for Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and Friday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the treatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 12/07/18, 12/10/18 or 12/17/18. Further review of the TAR revealed no initials indicating the treatment for Resident #7's top of foot was completed on 12/17/18.

During an interview on 12/18/18 at 8:35 AM, the Wound Nurse (WN) explained she was responsible for completing wound treatments for residents on the days she worked, which were Tuesdays, Wednesdays and Thursdays each week, and the hall nurses were responsible for completing wound treatments the remaining days. The WN recalled changing the dressing on Resident #7's right outer ankle on 12/05/18 with the next dressing changes scheduled on 12/07/18

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and 12/10/18. She stated when she returned to work on 12/11/18, the dressing in place was dated 12/05/18 with her initials, smelled and was hanging off the wound. The WN confirmed she did not work on 12/03/18, 12/07/18 or 12/10/18 and stated it was an ongoing issue that wound treatments were not being completed by the hall nurses on the days she was not scheduled to work. She added she completed treatments on the day she returned if she noticed they were not done by the hall nurses on the day scheduled.

An observation was made of Resident #7's wound care on 12/18/18 at 10:40 AM. The WN washed her hands and as she was removing the old dressing from the top of Resident #7's left foot she stated the dressing that was in place was Polymen which was the wrong treatment. The dressing was dated 12/17/18 and initialed by Nurse #5. The skin on top of Resident #7's left foot was intact with no redness or inflammation noticed. The WN indicated the treatment ordered was preventative and the dressing would be replaced to protect the area. The WN washed her hands and as she removed the bunny boot (foot/heal protector) from Resident #7's right foot, there was no dressing covering the right outer ankle and the wound was exposed to air. The wound was red with a small amount of yellow slough (dead tissue) and the skin surrounding the wound bed was a dark reddish color. The WN cleaned the ankle with wound cleanser, patted the area dry and applied Polymen dressing as ordered.

During a telephone interview on 12/18/18 at 1:23 PM, Nurse #1 confirmed she worked as a hall

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nurse on 12/07/18 and did not complete wound treatment to Resident #7's right outer ankle. She explained she was never shown how to complete wound treatments and only reapplied a resident's dressing when it fell off. Nurse #1 added she was never informed she needed to complete treatments on the days the WN was not scheduled.

During an interview on 12/18/18 at 3:00 PM, Nurse #4 confirmed she was the nurse assigned to provide care to Resident #7 on 12/03/18. Nurse #4 stated she did not complete the wound treatment to Resident #7's right outer ankle or any other resident assigned because she was never trained to provide wound care. Nurse #4 explained the facility had a WN who completed the treatments for all residents and was never informed she needed to complete the treatments when the WN was not scheduled.

During a telephone interview on 12/18/18 at 3:31 PM, Nurse #5 confirmed she provided wound treatment to Resident #7 on 12/17/18 and stated she must have forgotten to initial the TAR when completed. Nurse #5 added the Hospice Nurse (HN) was present during the wound treatment. Nurse #5 explained she put a 4 inch (in) by 4 in bandage on the top of Resident #7's left foot and applied Tegaderm (transparent dressing used to cover and protect wound) and Polymen dressing to her right outer ankle. Nurse #5 added she reviewed the TAR prior to providing treatment and was unable to explain why there was no dressing on Resident #7's right outer ankle or why the wrong dressing was applied to the top of her left foot.

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During a telephone interview on 12/18/18 at 4:08 PM, the HN confirmed she was present when Nurse #5 provided wound treatment to Resident #7 on 12/17/18. The HN explained she only observed the treatment provided for the pressure ulcer on Resident #7's right outer ankle and was not familiar with the treatment ordered for the top of her foot. She stated Nurse #5 followed the wound treatment orders and applied Tegaderm and a non-adhesive Polymen dressing to Resident #7's right outer ankle since Hospice was out of the adhesive Polymen dressing they normally used. She added it was possible the dressing had fallen off after treatment was provided.

During an interview on 12/19/18 at 11:14 AM, the Wound Physician (WP) indicated he had only been providing wound care at the facility for the past 3 weeks and was not able to confirm if there was an issue with wound treatments not being completed as ordered or scheduled. He added if a resident was on Hospice he tried to limit the dressing changes to avoid causing them discomfort. The WP stated when he treated Resident #7's wound earlier that morning, it showed improvement with no signs of infection and no changes were made to the current treatment as ordered by Hospice. He was unaware a dressing was not observed on Resident #7's wound on 12/18/18 and stated a dressing should have been applied and the wound not left exposed.

During a telephone interview on 12/19/18 at 2:03

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F 686	Continued From page 78 PM the Director of Nursing (DON) explained nursing staff were informed upon hire that providing wound treatment was a part of their job description. The DON stated she would expect the hall nurses to complete wound treatments as ordered and scheduled when the WN was absent. During a telephone interview on 12/20/18 at 9:41 AM, Nurse #2 confirmed she was the nurse assigned to provide care to Resident #7 on 12/10/18. Nurse #2 stated she did not complete the wound treatment to Resident #7's right outer ankle because she received Hospice services and the HN provided wound care. During an interview on 12/20/18 at 11:14 AM, the Administrator was unaware wound treatments were not being completed by the hall nurses when the WN was not scheduled to work. She stated she was aware of all the training needs in the building and felt the nurses needed more training in wound care. She added it was her expectation wound treatments were completed as scheduled and consistent with the physician orders.	F 686		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 725		1/18/19

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F 725	Continued From page 79 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, staff and physician interviews, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer and wound treatments and assistance with incontinence and nail care. This affected 4 of 12 sampled residents (Residents #1, #7, #11, and #13). Staff neglected to provide Resident #13 with incontinence care for nearly an 8-hour time span which resulted in the resident lying in a large amount of urine and feces. Findings included: This tag is cross-referenced to:	F 725	1.Efforts continue in hiring process, filling shifts due to call-offs, and staff retention. A Human Resource Director started employment 1/7/19. 2. In order to ensure that none of residents are affected by allege deficient practice The Human resource Director was hired on 1/07/19 to assist the Administrator with the screening and hiring process. The effort to hire had began 12/01/2018 for C.N.A's, Nurses and Primary Department heads due to employees having to be held accountable and responsible to perform the duties and tasks that they were hired for and they had begin to quit without notice.	

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F 725	Continued From page 80 1a. F-550: Based on observations, record review, staff and resident interviews, the facility failed to treat one resident with dignity by leaving the resident lying in a large amount of urine and stool from 12:41 AM to 8:30 AM on 12/16/18 for 1 of 5 residents dependent on staff for incontinence care (Resident #13). b. F-600: Based on observations, record review, staff and resident interviews, wound physician interview, and hospice nurse interview, the facility staff neglected to acknowledge a resident's call bell and failed to provide incontinence care for 8 an hour time frame from 12:41 AM to 8:30 AM for 1 of 5 residents dependent on staff for incontinence care (Resident #13); failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1); and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 1 of 3 residents reviewed for pressure ulcers. c. F-677: Based on observations, record review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for Activities of Daily Living (ADL) care (Resident #13) and failed to provide nail care for 2 of 5 dependent residents reviewed for ADL care (Resident #1). d. F-684: Based on observations, record review, staff interviews and physician interviews, the	F 725	The Human Resource Director and Administrator have continued to conduct interviews twice a week and orientation once a week in order to continue the flow of hiring. The Human Resource Director has begin to network with colleges to obtain graduate nurses and nursing assistants, advertisement is posted and updated weekly on in-deed for Nurses and a D.O.N with a sign on incentive is posted. Because of this process we have hired 7 C.N.A's two of which are C.N.A/ Med-Techs, 1 RN MDS nurse, and 1 LPN. Current staff that has been with the facility are given a training incentive to train new staff to the daily routines. When a extra shift is picked up the employees receives their paid over-time incentive. 3. Education-Staff have been provided in-service on 1-10-19 regarding how call-offs affects the facility residents and their peers and how the facility can help to ensure the decrease of turn-over and call-offs. All employees and new hires are re-educated and educated to facility policies regarding call-offs. 4.Monitoring in order to ensure compliance by reviewing daily staffing sheets in daily stand up meeting x 4 weeks and Monthly there after by the Administrator and Department heads. If staffing needs are Identified the Lead C.N.A, Licensed Nurse and or Administrator will be responsible for covering shifts and the Administrator and	

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F 725	Continued From page 81 facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled resident reviewed with a wound infection (Resident #1). e. F-686: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers. During an interview on 12/18/18 at 11:30 PM Nurse #6 revealed she had been at the facility working as a hall nurse since 7:00 AM that morning. Nurse #6 explained she was scheduled to work the 7:00 AM to 7:00 PM shift but at 8:00 PM she was told to stay over and work the 7:00 PM to 7:00 AM shift due to a call-out. She added one of the 2 nurses scheduled to work the 7:00 PM to 7:00 AM shift called out and the other nurse wouldn't take the keys to her medication cart because she did not want to work by herself. Nurse #6 stated she felt that she could not leave and had to stay. During an interview on 12/18/18 at 12:30 AM Nurse Aide (NA) #6 confirmed there were times only one NA worked the 11:00 PM to 7:00 AM shift to provide resident care due to staff call-outs. She recalled being the only NA working the evening of 12/18/18. She added when short-staffed, it was difficult to get resident care provided such as early morning showers and	F 725	or Licensed nurse will be responsible for scheduling staff. This will be a on going process. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations given to help to ensure the staffing compliance.	

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getting residents up out of bed and ready for breakfast.

During an interview on 12/18/18 at 6:40 AM Nurse #9 stated they had worked short-staffed "a lot lately", sometimes with only one nurse and one NA for the entire building. Nurse #9 explained it was difficult for staff to get resident care provided when working short, such as getting residents up out of bed and ready for the day or showered and when working short, their main focus was to keep the residents safe and dry.

During an interview on 12/20/18 at 11:14 AM, the Administrator stated she and the Director of Nursing, who was no longer employed, were both responsible for the scheduling of staff. She explained the number of staff scheduled per day was based on the current census and acuity level of the residents in the building. She added at the current census, her goal was to have 4 NAs scheduled to work on both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts and 3 NAs scheduled to work the 11:00 PM to 7:00 AM shift. The Administrator stated since starting her employment on 11/26/18 one of the issues she dealt with was staff not giving sufficient notice when they called out of work which made it difficult to find replacements and contributed to the facility being short-staffed. The Administrator confirmed Nurse #6 worked 24 hours straight as a hall nurse on 12/18/18 to 12/19/18. She explained it happened due to staff call outs and although it was an unfortunate situation, Nurse #6 had agreed to stay. She added she has focused on filling open positions and the hiring process

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F 725	Continued From page 83 remained ongoing.	F 725		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		1/18/19

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F 732	Continued From page 84 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post daily nurse staffing information for the facility on 4 out of 4 days during the revisit and complaint investigation conducted 12/17/18 through 12/20/18. Findings included: An observation on 12/17/18 at 11:28 AM revealed a clipboard hanging on the wall across from the nurses' station with an undated and blank sheet titled "Daily Staffing Report." Observations conducted on 12/18/18 at 11:15 AM and 3:00 PM revealed an undated and blank daily staffing sheet. Observations conducted on 12/19/18 at 12:45 AM, 9:50 AM and 4:10 PM revealed an undated and blank daily staffing sheet. Further review revealed underneath the blank staffing sheet, there was a staffing sheet dated 12/13/18 with only the staffing information completed for third shift. Observations conducted on 12/20/18 at 6:30 AM revealed a staffing sheet dated 12/19/18 with only the staffing information completed for first and second shifts.	F 732	1.No residents were identified as having been affected. Mandatory postings have been compliant as of 12/21/19. 2. Mandatory posting will be the responsibility of the Interim Director of Nursing, the Registered Nurse, and or the Administrator. 3. Nursing Staff have received in-service regarding Posting of the Nursing staff as of 01/08/2019. 4. The Administrator will be responsible for this aspect of the Plan of Correction. The Administrator and/or the Human Resource Director will audit for compliance 3x week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1.22.19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations so compliance is continuously achieved.	

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	345307	A. BUILDING _____ B. WING _____	C 12/20/2018

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F 732	Continued From page 85 During an interview on 12/20/18 at 11:14 AM, the Administrator stated the Director of Nursing, who was no longer employed, was responsible for posting the daily staffing information. The Administrator was unable to explain why the staffing information was not posted and stated it was her expectation the staffing sheets were completed and posted daily.	F 732		
F 835 SS=G	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and physician interviews and record reviews the facility's administration failed to provide oversight of processes and policies and effective leadership to ensure that residents were free from neglect, treated in a dignified manner, provided with basic nursing care, received pressure ulcer treatments as ordered, and were provided with sufficient nursing staff to meet their needs for 4 of 12 sampled residents reviewed for neglect, dignity, and provision of nursing care (Resident's #13, #7, #1 and #11). Facility administration also failed to develop a facility wide assessment to determine the necessary resources to care for the resident population. Staff neglected to provide Resident #13 with incontinence care for nearly an 8-hour time span which resulted in the resident lying in large amount of urine and feces.	F 835	Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. 2.In order to ensure that others are not affected by the same alleged deficient practice all residents requiring incontinence care were assessed by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 for any adverse effects with none observed. 3. All scheduled nursing staff were allowed to work before in-service and non-scheduled staff were paid for one hour in-service. All were educated on proper incontinence care 1/16/-1/18/19 by the Registered	1/18/19

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F 835	Continued From page 86 Findings included: This tag was cross referenced to: 1a. F-550: Based on observations, record review, staff and resident interviews, the facility failed to treat one resident with dignity by leaving the resident lying in a large amount of urine and stool from 12:41 AM to 8:30 AM on 12/16/18 for 1 of 5 residents dependent on staff for incontinence care (Resident #13). b. F-600: Based on observations, record review, staff and resident interviews, wound physician interview, and hospice nurse interview, the facility staff neglected to acknowledge a resident's call bell and failed to provide incontinence care for 8 an hour time frame from 12:41 AM to 8:30 AM for 1 of 5 residents dependent on staff for incontinence care (Resident #13); failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1); and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 1 of 3 residents reviewed for pressure ulcers. c. F-656: Based on observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for	F 835	Nurse/Interim Director of Nursing. In addition, staff were educated by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 that all staff are responsible for acknowledging call lights and to tell the appropriate staff if the need is outside of their scope and on the components of the Concern/Grievance policy. The education will be included in subsequent new-hire orientations. No residents were identified as having been affected by the facility assessment. The facility Assessment was completed by the Administrator as of 12/26/18. The requirement and components of the Facility Assessment were reviewed by the Regional Nurse and the administrator 1/16/19. Department Heads were trained to the facility assessment as of 1/10/2019 by the Administrator regarding their responsibility to provide updated information with their department staffing. The Regional Nurse has trained all Administrative Staff to the cross reference tags including the audits as of 1/18/19 and will continue to provide oversight. Monitoring the facility assessment this will be the Regional Nurse responsibility once x's 12 months. The Facility Administrator will update the Facility Assessment as needed and or annually and present it to the QA	

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F 835	Continued From page 87 ADLs (Residents #1 and #13). d. F-677: Based on observations, record review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for Activities of Daily Living (ADL) care (Resident #13) and failed to provide nail care for 2 of 5 dependent residents reviewed for ADL care (Resident #1). e. F-684: Based on observations, record review, staff interviews and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled resident reviewed with a wound infection (Resident #1). f. F-686: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers. g. F-725: Based on observations, record reviews and resident and staff interviews, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer and wound treatments and assistance with incontinence and nail care. This affected 4 of 12 sampled residents (Residents #1, #7, #11, and #13). h. F-838: Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for the resident population competently	F 835	Committee for review and recommendations. The Regional Nurse will provide oversight and review the audits for two (2) months and the QA Committee will review for two (2)months if concerns are identified The QA Committee will provide addition three (3) months of review in order to maintain compliance. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee on 1/22/19.	

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F 835	Continued From page 88 during day to day operations and in an emergency situation. During an interview on 12/20/18 at 11:14 AM, the Administrator agreed there were still issues in the identified areas of concern and explained since starting her employment on 11/26/18 her focus had been on staffing. She added she "planned to work on the rest" once staffing was stable.	F 835		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;	F 838		1/18/19

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F 838	Continued From page 89 (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for the resident population competently during day to day	F 838	1.No residents were identified as having been affected by the allege deficient practice. The requirement and components of the Facility Assessment were reviewed by the	

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F 838	Continued From page 90 operations and in an emergency situation. The findings included: A request was made to review the facility assessment on 12/19/18. During an interview on 12/20/18 at 11:14 AM the administrator stated when she began working at the facility on 11/26/18 she asked the former administrator about the facility assessment and was informed there was not a facility assessment. The administrator stated she was aware a facility assessment should be in place and was actively working to create a facility assessment to determine what resources were necessary to care for the resident population competently during day to day operations and in an emergency situation.	F 838	Regional Nurse and the administrator 1/16/19. 2.The Facility Assessment was completed by the Administrator as of 12/26/2018 the Casper report was given to the Administrator by the Regional Nurse to add as a key component to the facility Assessment. 3. Department Heads have been educated to the facility assessment as of 1/10/2019. 4.The facility administrator will update the assessment as needed and on a annual basis and will present it to the Quality Assessment Performance Improvement Committee for review and recommendations once per month x 12 months. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident	F 867	The Statement of Deficiencies F867	1/18/19

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F 867	Continued From page 91 interviews, physician interviews and record reviews the facility's Quality Assessment and Assurance Committee failed to implement procedures and monitor interventions that were to implement in November 2018. This was for three recited deficiencies that were originally cited in October 2018 on a complaint survey. The deficiencies was in the areas of implementation of resident care plans (656), treatment of pressure sores (686) and providing sufficient nursing staffing (725). The continued failure during two federal surveys of record reflects a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross-referenced to: 1a. F-656: Based on observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). The facility was recited for failure to implement care plans. Tag F- 656 was originally cited during a complaint investigation survey on 10/25/18 for failure to implement care plan interventions for feeding a resident and failure to implement care plan interventions for wound dressing changes. b. F-686: Based on observations, record review	F 867	citation and Federal Regulation 483.75(g)(2) was reviewed in stand up with the department heads on 1/8/19.Which states that the quality assessment and assurance committee must develop and implement appropriate plans of action to correct identify quality deficiencies. In order to ensure other residents are not affected by the alleged deficient practice monitoring tools were created on 12/26/2018. The Department heads were educated on 01/8/2019 to the monitoring tools, usefulness of those tools and their responsibility regarding the audits. The Plan of Correction was reviewed by the committee on 1/08/19 to discuss and approve stated interventions, monitoring tools, and follow up by the committee. 4. Ongoing, the committee will review monitoring tools and audit data as specified in the Plan of Correction to ensure all monitoring tools are utilized and completed once per month x 2 months to help to ensure continue compliance if concerns are identified the QA committee will provide addition three (3) months review to assist with maintaining compliance.	

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F 867	Continued From page 92	F 867		

and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers.

The facility was recited for failure imitate and complete pressure ulcer treatments as ordered. Tag F- 686 was originally cited during a complaint investigation survey on 10/25/18 for failure to correctly treat pressure ulcers and failed to complete pressure ulcer treatments as ordered.

c. F-725: Based on observations, record reviews and resident, staff and physician interviews, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer and wound treatments and assistance with incontinence and nail care. This affected 4 of 12 sampled residents (Residents #1, #7, #11, and #13). Staff neglected to provide Resident #13 with incontinence care for nearly an 8-hour time span which resulted in the resident lying in a large amount of urine and feces.

The facility was recited for failure to provide sufficient nursing staffing. Tag F-725 was originally cited during a complaint investigation survey on 10/25/18 for failure to provide sufficient nursing staff to ensure residents received assistance with meals, bathing and wound care/treatments.

A review of the facility's Plan of Correction (POC) notebook, with an AOC date of 11/22/18, was conducted on 12/18/18. There were no monitoring or auditing tools completed as

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F 867	Continued From page 93 indicated in the facility's POC for the areas related to care plans, pressure ulcer care and sufficient nursing staffing. During an interview on 12/20/18 at 11:14 AM, the Administrator confirmed the facility's POC notebook from the complaint investigation completed on 10/25/18 was inclusive of all monitoring and auditing tools. She explained she was in the process of creating monitoring forms for the four areas, but it was a work in progress and not yet completed. She added since starting her employment on 11/25/18 she had focused on hiring staff and then "planned to work on the rest" once staffing was stable. The Administrator acknowledged the monitoring and auditing components for care plans, pressure ulcer care and staffing, were not being completed and stated going forward she planned to implement tools to monitor these areas.	F 867		

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F 000	INITIAL COMMENTS An onsite revisit was conducted on 12/20/18. During this survey no tags were corrected and the following tags were recited; F550, F584, F600, F656, F677, F686 and F725. The facility remains out of compliance.	F 000		
{F 550} SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	{F 550}		1/18/19

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

Electronically Signed | 01/18/2019

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{F 550}	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to treat one resident with dignity by leaving the resident lying in a large amount of urine and stool from 12:41 AM to 8:30 AM on 12/16/18 for 1 of 5 residents dependent on staff for incontinence care (Resident #13). Findings included: Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. The MDS revealed that he displayed verbal behaviors toward others but had no rejection of care.	{F 550}	1. Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. 2.All residents requiring incontinence care were assessed by the Registered Nurse/ Interim Director of Nursing from 1/16/2019 through 1/18/2019 for any adverse effects with none observed. 3.All nursing staff were educated on proper incontinence care on 1/16/19 through 1/18/19 by the Registered Nurse/Interim Director of Nursing. All staff were educated by the Registered Nurse/ Interim Director of Nursing 1/16/19-1/18/19, that all staff are responsible for acknowledging call lights and to inform the appropriate staff if the need is outside of their scope and on the components of the Concern/Grievance policy. In addition, the above education will be included in subsequent new-hire orientations. 4. In order to ensure compliance the Director of Nursing/ Interim Director of	

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{F 550}	Continued From page 2 A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as needed. The Behavior Symptom CAA revealed that he had verbal aggression directed toward staff. A review of Resident #13's care plan, dated 03/14/18, indicated the resident had an ADL self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. A review of the care plan for Resident #13 revealed that he had the potential to be verbally aggressive toward caregivers. The care plan, regarding the resident being verbally aggressive toward caregivers, further revealed staff were to assess and anticipate resident's toileting needs and comfortable level and the resident needed monitoring, reminding, assistance to turn or reposition at least every 2 hours and more often as needed or requested. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and	{F 550}	Nursing will be responsible for this aspect of the Plan of Correction. The Registered nurse will randomly check the compliance of Certified Nursing Assistants providing incontinence care-5 residents per week x 4weeks, then 2 residents per week x 4weeks. The Social Service Director will Interview random cognitive residents about timely call light response-5 per week x 4 weeks then 2 residents per week x 4 weeks. The resident council minutes will be submitted at the next scheduled Quality Assurance Performance Improvement Committee meeting. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Committee meeting on 1/22/19. The Committee include the Medical Director, Administrator, Director of nursing, Registered Nurse Supervisor, Social Service Director, Dietary Manager, Medical Records/Human Resource Director,Maintenance Director, and line staff member. All Plan of Correction audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations until compliance is achieved.	

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someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on his personal computer voice recorder. He further indicated that Nurse #1 came into his room and he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up.

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An interview was conducted with the Social Worker on 12/18/18 at 1:13 PM. She revealed there were no grievances filed for the month of December 2018.

An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA #3 further stated that Nurse #2 told Resident #13 that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with NA #4 on 12/19/18 at 8:00 pm. NA #4 stated she worked third shift and frequently worked with Resident #13. NA #4 stated Resident #13 typically received incontinence care at 1:30 am and 5:30 am, at a minimum and that was close to shift change. She indicated that Resident #13 had

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never saturated his bed due to his incontinence but that he got a little sweaty because he had computer equipment in his room that made the room hot.

A phone interview was conducted with NA #2 on 12/19/18 at 8:21 PM. She stated that the nursing assistants who came in at 11:00 PM typically went to Resident #13's room at 1:30 AM and change him. She further stated that if Resident #13 was given a suppository, the NA's went to change the resident more often. She indicated that Resident #13 did not get a suppository during 2nd shift on 12/15/18. She further indicated that it was her perception that Resident #13 rang his call bell at 1:30 am and 5:30 am and both times went into his room, woke him up and changed him. She stated that Resident #13 had been telling 1st shift that he hadn't been changed, so the NAs woke him and changed him. She further stated that she reported any concerns to the oncoming shift. She did not mention that she reported any concerns to first shift regarding Resident #13 on 12/16/18.

A phone interview was conducted with the DON on 12/20/18 at 6:50 AM. She indicated that she expected all residents would be treated with respect and dignity and care to be provided when requested.

A phone interview was conducted with Nurse #2 on 12/20/18 at 9:13 AM. She indicated that she worked 7:00 am to 7:00 pm on 12/16/18 and that toward the end of her shift, Resident #13 told her he wanted to file a grievance because no one changed him for an extended time the early morning of 12/16/18. She stated that towards the end of first shift NA #3 confirmed Resident #13 was very wet. She further stated that she reported

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{F 550}	Continued From page 6 the information to the night shift Nurse #7. She indicated that she did not notify the social worker or file a grievance because the social worker checked on Resident #13 daily. An interview was conducted with the Social Worker on 12/20/18 at 9:39 AM. She indicated that she did not talk to Resident #13 during the week of December 17th, 2018 and wasn't aware of any concerns involving Resident #13. She further indicated that in the past, Resident #13 complained about being soaked in urine when the previous Director of Nursing (DON) was working at the facility which was before December 2018. She revealed that she didn't remember Resident #13 filing any recent grievances. An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated she expected all residents to be treated with dignity and respect and told this to every staff member when she started working at the facility on 11/26/18. She further stated she expected concerns to be reported so follow-up could be done. She indicated staff were supposed to care for residents and it was a problem of dignity if care was not given. She indicated again she should have been told about the incident, so she could fix the problem.	{F 550}		
{F 584} SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	{F 584}		1/18/19

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{F 584}	Continued From page 7 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store clean linens in a room free of ceiling leaks and disrepair for one of one clean linen closets.	{F 584}	1. The Laundry Supervisor moved the clean linen from the closet to an appropriate location 12/20/18. The Director of Maintenance replaced the	

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{F 584}	Continued From page 8 The findings include: On 12/18/18 at 12:45 AM an observation was made of the facility's clean linen closet which was the only clean linen closet within the facility. Seven of 12 white acoustic ceiling tiles inside the clean linen closet were badly stained with a brown color, were broken and/or bulging. Brown, dried stains were observed on the wall and extended from the ceiling to the floor. Inside the linen closet were six open shelving units housing various linens, disposable incontinence briefs and resident equipment. The top shelf was approximately three feet from the ceiling and three sheets stored on the top shelf had dried brown stains which appeared to be the same color as the stained ceiling tiles. In addition, broken pieces of ceiling tile were observed on the top shelf near these three sheets. A nursing assistant present at the time of the observation stated this was the closet staff went to obtain linen for resident use. On 12/19/18 at 10:05 AM a nursing assistant was observed coming out of the clean linen closet with clean linens in her hand. On 12/19/18 at 10:45 AM the maintenance director stated after the recent heavy snow there had been leaking from the roof and it affected parts of the facility which included the clean linen closet. The maintenance director stated when the white acoustic ceiling tiles got wet they turned brown and bulged. The maintenance director stated the dried brown stains on the walls of the clean linen closet were from water leaking from the acoustic ceiling tiles when they got wet. The maintenance director stated there had been	{F 584}	stained tiles on 12/20/18. 2.The Maintenance Director will continue to check the facility for any other areas for stained , bulging ceiling tiles, replacing any stained. 3. The Administrator has in-serviced the Maintenance Director and Environmental Supervisor regarding the regulation components of the facility physical environment of the regulations on 12/20/18. The education of the facility physical environment of the regulations will be included in subsequent new-hire orientations. 4.The Maintenance Director will be responsible for monitoring this aspect of the Plan of Correction. The Maintenance Director will observe facility ceiling tiles monthly x 4 months to assess for any water damage as evidence by stained and bulging tiles. Any noted will be documented on the Maintenance log, replaced and reported for the Administrator to sign off to ensure compliance. The Plan of Correction will be reviewed by the Quality Assurance Committee at the next scheduled Quality Assurance Performance Improvement Committee meeting on 1-22-19. The monthly audit findings and corrections will be reported to the QA Committee for review and or new recommendation to assist with ensuring continue compliance.	

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ongoing issues with a roof leak for years and the facility was in the process of trying to get repairs done.

On 12/19/18 at 11:20 AM the laundry director stated the three stained sheets on the top shelf of the linen closet had been put in place to absorb water when there were leaks from the ceiling. The laundry director stated the ceiling leak had been an ongoing problem and, when it leaked she tried to move the clean linens to areas within the closet that were not affected by the ceiling leak.

On 12/20/18 at 9:30 AM the laundry director was observed moving linens within the linen closet because of the start of heavy rain (at the time of the observation.) The laundry director stated every time it rained she had to move the linen because of leaks in the clean linen closet. At the time of the observation seven of 12 white acoustic ceiling tiles remained badly stained with a brown color, were broken or bulging and dried brown stains were observed on the wall which extended from the ceiling to the floor. Pieces of broken tile remained on the top shelf within the clean linen room. An empty, rolling clothing cart was stored inside the clean linen closet and the laundry director noted it had to be rolled out of the closet when it rained if resident clothing was stored on the cart.

On 12/20/18 at 11:14 AM the administrator stated she had just recently started working at the facility and, after the last snow storm, she observed the leaks in the clean linen closet. The administrator stated she contacted the owner of the building to inform him of the leaks and told the laundry director to remove all items from the clean linen

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{F 584}	Continued From page 10 closet and distribute them between the three clean linen carts until repairs were done to the clean linen room. The administrator stated she was not aware the items in the clean linen closet had not been removed as requested.	{F 584}		
{F 600} SS=G	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; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, wound physician interview, and hospice nurse interview, the facility staff neglected to acknowledge a resident's call bell and failed to provide incontinence care for 8 an hour time frame from 12:41 AM to 8:30 AM for 1 of 5 residents dependent on staff for incontinence care (Resident #13); failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1); and failed to complete pressure ulcer treatment as ordered and	{F 600}	Resident #13- Incontinence was provided by a certified nursing assistant 12/16/18. Resident #1- Consistent wound care was provided by a licensed nurse beginning 12/18/18. Resident # 7- Consistent and correct wound care was provided by a licensed nurse on 12/19/18. 2.All residents requiring incontinence care have the potential to be affected with	1/18/19

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{F 600}	Continued From page 11 scheduled for 3 days (Resident #7) for 1 of 3 residents reviewed for pressure ulcers. Findings include: 1. Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. The MDS revealed that he displayed verbal behaviors toward others but had no rejection of care. A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as needed. The Behavior Symptom CAA revealed that he had verbal aggression directed toward staff. A review of Resident #13's care plan, dated 03/14/18, indicated the resident had an ADL self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that	{F 600}	wounds. In order to ensure that other residents are not affected by the same alleged deficient practice, all residents requiring incontinence care were assessed for wounds 1/16/19 through 1/18/19 by the Registered Nurse/Interim Director of Nursing 3.Certified Nursing Assistant staff were educated 1/16/19-1/18/19 on the provision of incontinence care by the Registered Nurse/Interim Director of Nursing. The Nurses were educated by Registered nurse/ Interim Director of Nursing 1/16/19-1/18/19 that they are responsible for completing wound care if the wound care nurse is on duty. They were also educated 1/16/19-1/18/19 regarding wound care procedures by the Treatment Nurse and or Interim Director of Nursing. Newly hired nursing staff will also be educated during subsequent orientation. 4.Monitoring performance In order to ensure compliance the Registered Nurse Supervisor and or Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse Supervisor and or Interim Director of Nursing will randomly check the compliance of Certified Nursing Assistants providing incontinence care- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The Registered Nurse Supervisor and or the Interim Director of Nursing will interview three (3) alert and oriented residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure compliance.	

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{F 600}	Continued From page 12 incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. A review of the care plan for Resident #13 revealed that he had the potential to be verbally aggressive toward caregivers. The care plan, regarding the resident being verbally aggressive toward caregivers, further revealed staff were to assess and anticipate resident's toileting needs and comfortable level and the resident needed monitoring, reminding, assistance to turn or reposition at least every 2 hours and more often as needed or requested. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I	{F 600}	The Registered nurse Supervisor and or Interim DON will randomly check compliance of Nurses providing and documenting wound care according to MD orders- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The plan of correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee on 1/22/19. All Plan of Correction monthly audit data will be reported to the QA Committee and reviewed by the Committee for two months and recommendations given in order to help to ensure that the facility stay in compliance and if concerns are identified the QA committee will add on an addition three months to assist with maintaining compliance.	

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haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on his personal computer voice recorder. He further indicated that Nurse #1 came into his room and he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up.

An interview was conducted with the Social Worker on 12/18/18 at 1:13 PM. She revealed there were no grievances filed for the month of December 2018.

An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad

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was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA #3 further stated that Nurse #2 told Resident #13 that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with NA #4 on 12/19/18 at 8:00 pm. NA #4 stated she worked third shift and frequently worked with Resident #13. NA #4 stated Resident #13 typically received incontinence care at 1:30 am and 5:30 am, at a minimum and that was close to shift change. She indicated that Resident #13 had never saturated his bed due to his incontinence but that he got a little sweaty because he had computer equipment in his room that made the room hot.

A phone interview was conducted with NA #2 on 12/19/18 at 8:21 PM. She stated that the nursing assistants who came in at 11:00 PM typically went to Resident #13's room at 1:30 AM and changed him. She further stated that if Resident #13 was given a suppository, the NA's went to change the resident more often. She indicated that Resident #13 did not get a suppository during 2nd shift on 12/15/18. She further indicated that it was her perception that Resident #13 rang his call bell at 1:30 am and 5:30 am and both times went into his room, woke him up and changed him. She

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stated that Resident #13 had been telling 1st shift that he hadn't been changed, so the NAs woke him and changed him. She further stated that she reported any concerns to the oncoming shift. She did not mention that she reported any concerns to first shift regarding Resident #13 on 12/16/18.

A phone interview was conducted with the DON on 12/20/18 at 6:50 AM. She indicated that she expected all residents would be treated with respect and dignity and care to be provided when requested.

A phone interview was conducted with Nurse #2 on 12/20/18 at 9:13 AM. She indicated that she worked 7:00 am to 7:00 pm on 12/16/18 and that toward the end of her shift, Resident #13 told her he wanted to file a grievance because no one changed him for an extended time the early morning of 12/16/18. She stated that towards the end of first shift NA #3 confirm Resident #13 was very wet. She further stated that she reported the information to the night shift Nurse #7. She indicated that she did not notify the social worker or file a grievance because the social worker checked on Resident #13 daily.

An interview was conducted with the Social Worker on 12/20/18 at 9:39 AM. She indicated that she did not talk to Resident #13 during the week of December 17th, 2018 and wasn't aware of any concerns involving Resident #13. She further indicated that in the past, Resident #13 complained about being soaked in urine when the previous Director of Nursing (DON) was working at the facility which was before December 2018. She revealed that she didn't remember Resident #13 filing any recent grievances.

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An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated Resident #13 only wanted to be changed 2 times at night and the administrator thought care was being provided but when he fell asleep she thought maybe he didn't know he was being changed after care was given. The administrator felt staff were going in the room and changing him and her expectations were for residents to be checked every 2 hours to ensure they were dry and to provide care if needed. The administrator stated she was coming in the building all shifts to check on care and expected care to be provided to all residents on all shifts and that she was in the building Saturday night during 3rd shift and arrived around midnight and left at 1:30 AM. Resident #13 could be difficult to please, but she expected staff to follow his care plan and do rounds to check on him and all residents throughout their shift. The administrator revealed she was not aware of the incident or that a grievance had been filed. Her expectation was that all residents were to be treated with dignity and respect and this was told to every staff member when she started working at the facility on 11/26/18. The administrator also expected concerns to be reported so follow-up could be done, and staff were supposed to care for residents and it was a problem of dignity if care was not given. The administrator indicated again she should have been told about the incident, so she could fix the problem.

2. Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: right hip wound infection, dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), peripheral vascular disease, (PVD), type

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2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was at risk for breakdown due to her incontinence and needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks and had a history of chronic pruritis (itching).

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 11/24/18, indicated the following wound measurements in centimeters (cm): 8.5 cm in length x 1.4 cm in width x 1.2 cm in depth and 8.1 cm undermining at 12 o'clock.

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/05/18, indicated the following wound measurements in centimeters (cm): 4.2 cm in length x 1.2 cm in width x 0.8 cm in depth and 8.0 cm undermining at 12 o'clock.

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A review of Resident #1's Physician Orders, dated 12/05/18, revealed the following:
1. Cleanse Right hip with wound cleanser, pat dry, pack with Dakins' soaked Kling gauze, and cover with dry dressing every day and as needed.
2. Cleanse Right hip periwound with wound cleanser, pat dry, apply Silvadene and cover with dry dressing every day and as needed.

A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing and would remain free from infection. The care plan further indicated the following interventions were in place for staff to administer treatments as ordered and were monitored for effectiveness, dressing was monitored to ensure it was intact and adhering and staff to report loose dressings to the treatment nurse, and the resident needed moisturizer applied to her skin.

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/12/18, indicated the following wound measurements in centimeters (cm): 5.1 cm in length x 1.1 cm in width x 2.0 cm in depth and 4.8 cm undermining at 3 o'clock (progress: improved).

A review of the December 2018 Treatment Administration Record (TAR) revealed the resident's right hip dressing change and periwound dressing change was not initialed as done on the following dates: 12/07/18; 12/08/18; 12/10/18; & 12/17/18.

A review of December 2018 TAR revealed the

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following treatments for Resident #1 were not initialed as done the following dates:
1. Apply zinc oxide to groin redness/area every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
2. Doxepin Cream 5%- apply to all body parts with abrasion every night on 3pm-11 pm until all areas are healed and then as needed. (not initialed on 12/07/18; 12/8/18; 12/11/18; 12/14/18; 12/15/18; 12/16/18; and 12/17/18)
3. Eucerin Cream- apply to Bilateral Lower Extremities twice daily for 7am-7 pm and 7pm to 7am (not initialed on 12/10/18 for 7am to 7 pm)
4. Eucerin Unscented Cream- apply to affected areas topically every day on upper extremities (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
5. Ketoconazole Shampoo 2%- apply to scalp once a week for itch on 11 p-7p (not initialed on12/07/18 and 12/14/18)
6. Vitamin A+D ointment for Desitin Clear with Vit A&D - apply topically to buttocks and thighs every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. At the time of the transfer, Nurse #6 was performing a skin assessment on the resident. During continuing observation of Nurse #6 and NA #5 repositioning the resident, the nurse did not change the dressing, as the dressing was undated.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the facility had a treatment nurse on Tuesdays, Wednesdays, and Thursdays during

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the week and a treatment nurse on Saturdays and Sundays every other weekend but there was no treatment nurse on Mondays and Fridays. Nurse #6 indicated that the wound on Resident #1's right hip started out as a bump about 2 weeks ago and the facility had a wound doctor. Nurse #6 further indicated the resident had undermining (destruction of tissue extending under the skin edges so that the pressure ulcer was larger at its base than at the skin surface) of the wound and it was a decubitus pressure ulcer. She indicated that the right hip wound treatment was for the wound to be packed and covered with a blue dry dressing.

An interview was conducted with the Treatment Nurse on 12/18/18 at 8:52 AM. She stated that she knew nothing about Resident #1's right hip wound until Saturday; 11/24/18, which was the date she saw the wound for the first time. She further stated that the right hip wound had already popped open and was draining and developed undermining. She indicated that she documented information in the facility doctor's book about Resident #1's right hip wound. She further indicated that she initiated treatment to the right hip on 11/24/18. She stated that when she was not at work, the treatments on residents were not consistently getting done because she would find the same dressings that she placed on residents from when she last worked. She indicated that on 12/05/18, she completed the treatments on all the residents and, when she went back to work on Tuesday; 12/11/18 she checked Resident #1's dressing and the blue foam was saturated with drainage, had no date on it, and the wound was not packed as ordered. She said the wound packing was ordered because Resident #1 had undermining of the wound.

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An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. She stated that when the wound doctor first came to assess the resident's right hip wound after it opened up, he stated that the wound looked like a bad infection and he removed the dead tissue off of the top of the wound which revealed the undermining. She further stated that the undermining had decreased from 8 centimeters (cm) to 4 cm. During continued observation, the undated blue sponge was still noted on Resident #1's right hip and the periwound (skin surrounding the wound) was not covered with a dressing and had 4 small areas of thick yellow adherent tissue surrounding the dressing. Further observation indicated there was no odor noted from the old dressing or the wound itself. The Treatment Nurse stated that the dry dressing she removed from the wound should not have been there because the dressing did not follow the physician's order and it should have been changed daily. She further stated that Resident #1 never refused care, but she did scratch her right hip and around the wound which caused the dressing to hang loosely off the wound. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the dressing because the treatment order was as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment.

An interview was conducted with Nurse #6 on 12/18/18 at 2:04 PM. She stated that she did not change the dressing on 12/17/18 for Resident #1. She further stated that when the treatment nurse was not at the facility, the hall nurses were

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responsible for changing the dressing. She indicated that she notified oncoming 3rd shift, Nurse #8, on 12/17/18 that a treatment had not been done for Resident #1.

A phone interview was conducted with Nurse #8 on 12/19/18 at 9:53 AM. She indicated that she did not do the treatments on Resident #1 on 12/17/18 because she was working by herself with only one NA.

A phone interview was conducted with Nurse #4 on 12/19/18 at 10:07 AM. She indicated that on 12/08/18, she only performed a dressing change on another resident, not Resident #1.

A phone interview was conducted with Nurse #7 on 12/19/18 at 10:27 AM. She stated that she worked with Resident #1 on 12/17/18, from 11:00 PM to 7:00 AM, and did not perform any treatments on Resident #1.

An interview was conducted with the Wound Doctor on 12/19/18 at 11:14 AM. He indicated that when the regular treatment nurse was not working every day, there was an issue with treatments being completed as ordered. He stated he was not sure if Resident #1 scratching her skin caused the infection of her right hip. He further stated that Resident #1 needed wound packing wet to moist dressings once a day and that the periwound deteriorated (per the Wound Care notes, dated 12/12/18, due to venous insufficiency). He indicated that the Silvadene was ordered for the periwound abrasion and the key to successful wound healing was to protect the wound and that the dressing was supposed to be covering the wound.

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A phone interview was conducted with Nurse #2 on 12/19/18 at 11:55 AM. She stated she worked with Resident #1 on 12/08/18 and that no treatments were done.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She indicated her expectation was that treatment orders should be followed, and treatments completed as scheduled.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator indicated that she expected treatments to be done consistent with the physician orders. She further indicated she was not aware treatments were not being done as scheduled but expected all orders to be followed for type of treatment and schedule set for treatments.

3. Resident #7 admitted to the facility on 01/31/17 with multiple diagnoses that included dementia, kyphosis (excessive outward curvature of the spine), age-related osteoporosis, and chronic pain.

Review of a physician's order dated 08/30/18 for Resident #7 read in part, "skin prep (forms a film protecting skin) to bilateral top of foot and protect with foam dressing twice weekly and as needed."

Review of the significant change Minimum Data Set (MDS) dated 10/24/18 revealed Resident #7 was moderately impaired for daily decision making and displayed no rejection of care during the 7-day assessment period. Further review of

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the MDS indicated Resident #7 required extensive assistance with activities of daily living and had 2 unhealed pressure ulcers.

Review of a care plan, with a revised date of 10/25/18, revealed Resident #7 had the potential for pressure ulcer development related to needing assistance with mobility, incontinence and decreased oral intake with the goal she would be free from any signs or symptoms of infections related to altered skin integrity. The interventions included for staff to administer treatments as ordered and monitor for effectiveness.

Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer ankle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains a mild cleaning agent activated by moisture and gradually released into the wound area) 3 times a week."

Review of the December 2018 Treatment Administration Record (TAR) revealed treatment for Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and Friday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the treatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 12/07/18, 12/10/18 or 12/17/18. Further review of the TAR revealed no initials indicating the treatment for Resident #7's top of foot was completed on 12/17/18.

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During an interview on 12/18/18 at 8:35 AM, the Wound Nurse (WN) explained she was responsible for completing wound treatments for residents on the days she worked, which were Tuesdays, Wednesdays and Thursdays each week, and the hall nurses were responsible for completing wound treatments the remaining days. The WN recalled changing the dressing on Resident #7's right outer ankle on 12/05/18 with the next dressing changes scheduled on 12/07/18 and 12/10/18. She stated when she returned to work on 12/11/18, the dressing in place was dated 12/05/18 with her initials, smelled and was hanging off the wound. The WN confirmed she did not work on 12/03/18, 12/07/18 or 12/10/18 and stated it was an ongoing issue that wound treatments were not being completed by the hall nurses on the days she was not scheduled to work. She added she completed treatments on the day she returned if she noticed they were not done by the hall nurses on the day scheduled.

An observation was made of Resident #7's wound care on 12/18/18 at 10:40 AM. The WN washed her hands and as she was removing the old dressing from the top of Resident #7's left foot she stated the dressing that was in place was Polymen which was the wrong treatment. The dressing was dated 12/17/18 and initialed by Nurse #5. The skin on top of Resident #7's left foot was intact with no redness or inflammation noticed. The WN indicated the treatment ordered was preventative and the dressing would be replaced to protect the area. The WN washed her hands and as she removed the bunny boot (foot/heal protector) from Resident #7's right foot, there was no dressing covering the right outer ankle and the wound was exposed to air. The

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wound was red with a small amount of yellow slough (dead tissue) and the skin surrounding the wound bed was a dark reddish color. The WN cleaned the ankle with wound cleanser, patted the area dry and applied Polymen dressing as ordered.

During a telephone interview on 12/18/18 at 1:23 PM, Nurse #1 confirmed she worked as a hall nurse on 12/07/18 and did not complete wound treatment to Resident #7's right outer ankle. She explained she was never shown how to complete wound treatments and only reapplied a resident's dressing when it fell off. Nurse #1 added she was never informed she needed to complete treatments on the days the WN was not scheduled.

During an interview on 12/18/18 at 3:00 PM, Nurse #4 confirmed she was the nurse assigned to provide care to Resident #7 on 12/03/18. Nurse #4 stated she did not complete the wound treatment to Resident #7's right outer ankle or any other resident assigned because she was never trained to provide wound care. Nurse #4 explained the facility had a WN who completed the treatments for all residents and was never informed she needed to complete the treatments when the WN was not scheduled.

During a telephone interview on 12/18/18 at 3:31 PM, Nurse #5 confirmed she provided wound treatment to Resident #7 on 12/17/18 and stated she must have forgotten to initial the TAR when completed. Nurse #5 added the Hospice Nurse (HN) was present during the wound treatment.

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Nurse #5 explained she put a 4 inch (in) by 4 in bandage on the top of Resident #7's left foot and applied Tegaderm (transparent dressing used to cover and protect wound) and Polymen dressing to her right outer ankle. Nurse #5 added she reviewed the TAR prior to providing treatment and was unable to explain why there was no dressing on Resident #7's right outer ankle or why the wrong dressing was applied to the top of her left foot.

During a telephone interview on 12/18/18 at 4:08 PM, the HN confirmed she was present when Nurse #5 provided wound treatment to Resident #7 on 12/17/18. The HN explained she only observed the treatment provided for the pressure ulcer on Resident #7's right outer ankle and was not familiar with the treatment ordered for the top of her foot. She stated Nurse #5 followed the wound treatment orders and applied Tegaderm and a non-adhesive Polymen dressing to Resident #7's right outer ankle since Hospice was out of the adhesive Polymen dressing they normally used. She added it was possible the dressing had fallen off after treatment was provided.

During an interview on 12/19/18 at 11:14 AM, the Wound Physician (WP) indicated he had only been providing wound care at the facility for the past 3 weeks and was not able to confirm if there was an issue with wound treatments not being completed as ordered or scheduled. He added if a resident was on Hospice he tried to limit the dressing changes to avoid causing them discomfort. The WP stated when he treated Resident #7's wound earlier that morning, it

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showed improvement with no signs of infection and no changes were made to the current treatment as ordered by Hospice. He was unaware a dressing was not observed on Resident #7's wound on 12/18/18 and stated a dressing should have been applied and the wound not left exposed.

During a telephone interview on 12/19/18 at 2:03 PM the Director of Nursing (DON) explained nursing staff were informed upon hire that providing wound treatment was a part of their job description. The DON stated she would expect the hall nurses to complete wound treatments as ordered and scheduled when the WN was absent.

During a telephone interview on 12/20/18 at 9:41 AM, Nurse #2 confirmed she was the nurse assigned to provide care to Resident #7 on 12/10/18. Nurse #2 stated she did not complete the wound treatment to Resident #7's right outer ankle because she received Hospice services and the HN provided wound care.

During an interview on 12/20/18 at 11:14 AM, the Administrator was unaware wound treatments were not being completed by the hall nurses when the WN was not scheduled to work. She stated she was aware of all the training needs in the building and felt the nurses needed more training in wound care. She added it was her expectation wound treatments were completed as scheduled and consistent with the physician orders.

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{F 656} SS=G	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 (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	{F 656}		1/18/19

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{F 656}	Continued From page 30 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 observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). The findings included: 1. Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and	{F 656}	1. Resident #1 and #11 care plans were updated 1/17/19 with accurate descriptions by the Interim Director of Nursing/Regional RN. Residents #1 and #7 care plans regarding wound care were implemented 12/19/18 by the licensed nurse. 2.In order to ensure that other residents are not affected by the alleged deficient practice the care plans have been revamped by the Registered Nurse/ Interim Director of nursing as of 12/20/18 in which to help to identify specific needs of the residents. The care plans regarding ADL care of residents #1 nail care was implemented by the Certified Nursing Assistant on 12/20/2018 In regards to resident #13 incontinence care was performed by the Certified Nursing Assistant on 12/19/18. Resident #13 has been informed as of 12/20/19 that random audits will be completed with him to ensure call-lights are being addressed in a timely manner and he is being changed when needed. The Nurse and or Interim Don will audit at least three (3) cognitively residents	

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{F 656}	Continued From page 31 Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as needed. A review of Resident #13's care plan, dated 03/14/18, indicated the resident had an ADL self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room.With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call	{F 656}	regarding ADL care weekly x 4 weeks and then weekly x 2 weeks. The care plans of residents with wounds were audited 1/16/19 and 1/17/19 by the Regional RN for accurate descriptions and corrected. The wound care nurse's schedule has been changed effective 1/15/19 to Monday-Friday to complete daily coverage. 3.Education was provided to the nursing staff 1/16/18-1/18/19 regarding their role to provide treatments in the event the wound nurse is not working. In-Service was also provided to the nursing staff 1/16/19-1/18/19 in the provision of ADL care including nail and incontinence care for residents requiring assistance. Education will be included in subsequent new-hire orientations. 4.Monitoring To ensure compliance the Registered Nurse and or Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse and or Interim Director of Nursing will randomly check compliance of Certified Nursing Assistants providing ADL care including incontinence care and nail care-5 residents per x 4 weeks then 2 residents per week x 4 weeks. The treatment nurse and or Registered Nurse will monitor the care plans for accurate description of wounds once (1) weekly x 4 weeks.	

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{F 656}	Continued From page 32 bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on his personal computer voice recorder. He further indicated that Nurse #1 came into his room and he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up. An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the	{F 656}	The registered nurse/ Interim director of Nursing will randomly check the compliance of Nurses providing and documenting wound care according to MD orders-5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The plan of Correction will be reviewed at the next scheduled QA Performance Improvement Committee meeting 1/22/19 in which all monthly audit will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations in order to stay in compliance.	

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chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA #3 further stated that Nurse #2 told Resident #13 that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with the Director of Nursing (DON) on 12/19/18 at 1:53 PM. She stated that she expected all care plans for ADL's be followed.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated she expected care plans to be accurate and expected interventions to be followed in terms of care whether it was care for treatments or ADLs.

2. Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), right hip infection, peripheral vascular disease, (PVD), type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder.

2a. A review of Resident #1's Physician Orders, dated 12/05/18, revealed the following:
1. Cleanse Right hip with wound cleanser, pat dry, pack with Dakins' soaked Kling gauze, and

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cover with dry dressing every day and as needed.
2. Cleanse Right hip periwound with wound cleanser, pat dry, apply Silvadene and cover with dry dressing every day and as needed.

A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing and would remain free from infection. The care plan further indicated the following interventions were in place for staff to administer treatments as ordered and were monitored for effectiveness, dressing was monitored to ensure it was intact and adhering and staff to report loose dressings to the treatment nurse, and the resident needed moisturizer applied to her skin.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was at risk for breakdown due to her incontinence and needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

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A review of the December 2018 Treatment Administration Record (TAR) revealed the resident's Right hip dressing change and periwound dressing change was not initialed as done on the following dates:12/07/18; 12/08/18; 12/10/18; & 12/17/18.

A review of December 2018 TAR revealed the following treatments for Resident #1 were not initialed as done the following dates:
1. Apply zinc oxide to groin redness/area every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
2. Doxepin Cream 5%- apply to all body parts with abrasion every night on 3pm-11 pm until all areas are healed and then as needed. (not initialed on 12/07/18; 12/8/18; 12/11/18; 12/14/18; 12/15/18; 12/16/18; and 12/17/18)
3. Eucerin Cream- apply to Bilateral Lower Extremities twice daily for 7am-7 pm and 7pm to 7am (not initialed on 12/10/18 for 7am to 7 pm)
4. Eucerin Unscented Cream- apply to affected areas topically every day on upper extremities (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
5. Ketoconazole Shampoo 2%- apply to scalp once a week for itch on 11 p-7p (not initialed on 12/07/18 and 12/14/18)
6. Vitamin A+D ointment for Desitin Clear with Vit A&D - apply topically to buttocks and thighs every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. At the time of the transfer, Nurse #6 was performing a skin assessment on the resident. During

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continuing observation of Nurse #6 and NA #5 repositioning the resident, the nurse did not change the dressing, as the dressing was undated.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the facility had a treatment nurse on Tuesdays, Wednesdays, and Thursdays during the week and a treatment nurse on Saturdays and Sundays every other weekend but there was no treatment nurse on Mondays and Fridays. Nurse #6 indicated that the wound on Resident #1's right hip started out as a bump about 2 weeks ago and the facility had a wound doctor. Nurse #6 further indicated the resident had undermining (destruction of tissue extending under the skin edges so that the pressure ulcer was larger at its base than at the skin surface) of the wound and it was a decubitus pressure ulcer. She indicated that the right hip wound treatment was for the wound to be packed and covered with a blue dry dressing.

An interview was conducted with the Treatment Nurse on 12/18/18 at 8:52 AM. She stated that she knew nothing about Resident #1's right hip wound until Saturday; 11/24/18, which was the date she saw the wound for the first time. She further stated that the right hip wound had already popped open and was draining and developed undermining. She indicated that she documented information in the facility doctor's book about Resident #1's right hip wound. She further indicated that she initiated treatment to the right hip on 11/24/18. She stated that when she was not at work, the treatments on residents were not consistently getting done because she would find the same dressings that she placed on residents

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from when she last worked. She indicated that on 12/05/18, she completed the treatments on all the residents and, when she went back to work on Tuesday; 12/11/18 she checked Resident #1's dressing and the blue foam was saturated with drainage, had no date on it, and the wound was not packed as ordered. She said the wound packing was ordered because Resident #1 had undermining of the wound.

An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. She stated that when the wound doctor first came to assess the resident's right hip wound after it opened up, he stated that the wound looked like a bad infection and he removed the dead tissue off of the top of the wound which revealed the undermining. She further stated that the undermining had decreased from 8 centimeters (cm) to 4 cm. During continued observation, the undated blue sponge was still noted on Resident #1's right hip and the periwound (skin surrounding the wound) was not covered with a dressing and had 4 small areas of thick yellow adherent tissue surrounding the dressing. Further observation indicated there was no odor noted from the old dressing or the wound itself. The Treatment Nurse stated that the dry dressing she removed from the wound should not have been there because it the dressing did not follow the physician's order and it should have been changed daily. She further stated that Resident #1 never refused care, but she did scratch her right hip and around the wound which caused the dressing to hang loosely off the wound. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the

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dressing because the treatment order was as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment.

An interview was conducted with Nurse #6 on 12/18/18 at 2:04 PM. She stated that she did not change the dressing on 12/17/18 for Resident #1. She further stated that when the treatment nurse was not at the facility, the hall nurses were responsible for changing the dressing. She indicated that she notified oncoming 3rd shift, Nurse #8, on 12/17/18 that a treatment had not been done for Resident #1.

A phone interview was conducted with Nurse #8 on 12/19/18 at 9:53 AM. She indicated that she did not do the treatments on Resident #1 on 12/17/18 because she was working by herself with only one NA.

A phone interview was conducted with Nurse #4 on 12/19/18 at 10:07 AM. She indicated that on 12/08/18, she only performed a dressing change on another resident, not Resident #1.

A phone interview was conducted with Nurse #7 on 12/19/18 at 10:27 AM. She stated that she worked with Resident #1 on 12/17/18, from 11:00 PM to 7:00 AM, and did not perform any treatments on Resident #1.

An interview was conducted with the Wound Doctor on 12/19/18 at 11:14 AM. He indicated that when the regular treatment nurse was not working every day, there was an issue with treatments being completed as ordered. He stated he was not sure if Resident #1 scratching her skin caused the infection of her right hip. He further stated that Resident #1 needed wound

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packing wet to moist dressings once a day and that the periwound deteriorated (per the Wound Care notes, dated 12/12/18, due to venous insufficiency). He indicated that the Silvadene was ordered for the periwound abrasion and the key to successful wound healing was to protect the wound and that the dressing was supposed to be covering the wound.

A phone interview was conducted with Nurse #2 on 12/19/18 at 11:55 AM. She stated that no treatments were done on Resident #1 on 12/08/18. She further stated that on 12/10/18, she only changed another resident's dressing, not Resident #1.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that Resident #1's treatment orders should be followed, and treatments completed as scheduled.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated that treatment orders should be followed and completed as scheduled.

2b. A review of Care Kardex (the system in place at the facility for nursing assistants to know resident specific needs) for Resident #1 revealed she was supposed to get nail care daily and as needed. Review of the December 2018 bed baths and nail care sheet for Resident #1 indicated no nail care was documented.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral

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symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

A review of ADL Functional/Potential CAA associated with the 01/08/18 MDS revealed Resident #1 had a diagnosis of dementia. The CAA further revealed she required extensive assistance with personal hygiene but was able to assist with basic hygiene with setup and needed physical assistance with bathing or showering.

A review of the care plan, dated 01/08/18, for the Potential for Pressure Ulcer Development indicated Resident #1's self-inflicted scratches and wound would show signs of healing and remain free from infection. The care plan also revealed the following interventions were in place for potential for pressure ulcer development: staff to make sure fingernails were clean, trimmed, and had no jagged edges and staff to administer treatments as ordered and treatments were monitored for effectiveness.

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at

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2:30 pm with Nurse #6 and NA #5 present. Resident #1's nails on both hands were observed to be dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the resident definitely needed good nail care and NA's were supposed to cut her nails when they gave her a shower and also stated that Resident #1 did not refuse care.

An interview with NA #5 was conducted on 12/17/18 at 3:00 PM. NA #5 indicated that Resident #1 was supposed to have her nails cut during her shower and that Resident #1 did not refuse care.

An observation conducted of Resident #1 was conducted on 12/18/18 from 1:15 PM to 1:35 PM. The observation of the resident during the dressing changed revealed Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

An interview was conducted with NA #4 on 12/19/18 at 8:55 AM. She stated that she worked 3rd shift and did not do nail care on Resident #1 because that was done on day shift.

An observation of Resident #1 was conducted on 12/19/18 at 12:40 PM. During the observation, Resident #1's nails on both hands were still dirty with a brownish red colored substance under her

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fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge and the resident put her right hand in her mouth.

An interview was conducted with NA #5 on 12/19/18 at 12:45 PM. She stated that nail care should be done after Resident#1's shower. After looking at Resident #1's fingernail, NA #5 stated that the resident's nails needed to be cut. NA #5 then left the resident's room without performing nail care.

An observation of Resident #1 in the Activity Room was conducted on 12/20/18 at 10:35 AM. Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that her expectation was that every time residents got a shower their nails should be checked and checked daily to determine if they needed to be cleaned or trimmed and the care plan should have been followed.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated that nail care should have been done consistent with the plan of care.

2c. A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she

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was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing and would remain free from infection.

An interview was conducted with the MDS nurse on 12/19/18 at 12:26 PM. She indicated that she had to clarify with the treatment nurse on 12/19/18 because she didn't know why she documented the right hip unstageable pressure ulcer on the 12/06/18 care plan other than on 11/28/18, it was marked Unstaged on the facility Wound Tracking Report and had an X through the wound stages portion of the report.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that Resident #1's wound was not unstageable and was incorrectly staged on the Care Plan and her expectation was the wound should have been staged correctly.

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A follow-up interview was conducted with the MDS nurse on 12/19/18 at 3:52 pm. She revealed that the Unstageable Pressure Ulcer should not have been listed on Resident #1's 12/06/18 care plan because the wound was an infection, not a pressure ulcer.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated the care plan should be an accurate reflection of Resident #1's wound.

3. Resident #7 admitted to the facility on 01/31/17 with multiple diagnoses that included dementia, kyphosis (excessive outward curvature of the spine), age-related osteoporosis, and chronic pain.

Review of the significant change Minimum Data Set (MDS) dated 10/24/18 revealed Resident #7 was moderately impaired for daily decision making and displayed no rejection of care during the 7-day assessment period. Further review of the MDS indicated Resident #7 required extensive assistance with activities of daily living and had 2 unhealed pressure ulcers.

Review of a care plan, with a revised date of 10/25/18, revealed Resident #7 had the potential for pressure ulcer development related to needing assistance with mobility, incontinence and decreased oral intake with the goal she would be free from any signs or symptoms of infections related to altered skin integrity. The interventions included for staff to administer treatments as

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{F 656}	Continued From page 45 ordered and monitor for effectiveness. Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer ankle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains a mild cleaning agent activated by moisture and gradually released into the wound area) 3 times a week." Review of the December 2018 Treatment Administration Record (TAR) revealed treatment for Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and Friday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the treatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 12/07/18 or 12/10/18. During an interview on 12/18/18 at 8:35 AM, the Wound Nurse (WN) explained she was responsible for completing wound treatments for residents on the days she worked, which were Tuesdays, Wednesdays and Thursdays each week, and the hall nurses were responsible for completing wound treatments the remaining days. The WN recalled changing the dressing on Resident #7's right outer ankle on 12/05/18 with the next dressing changes scheduled on 12/07/18 and 12/10/18. She stated when she returned to work on 12/11/18, the dressing in place was dated 12/05/18 with her initials, smelled and was hanging off the wound. The WN confirmed she did not work on 12/03/18, 12/07/18 or 12/10/18 and added it was an ongoing issue that wound	{F 656}		

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treatments were not being completed on the days she was not scheduled to work. She added she completed treatments on the day she returned to work if she noticed they were not done by the hall nurses on the day scheduled.

During a telephone interview on 12/18/18 at 1:23 PM, Nurse #1 confirmed she worked as a hall nurse on 12/07/18 and did not complete wound treatment to Resident #7's right outer ankle. She explained she was never shown how to complete wound treatments and only reapplied a resident's dressing when it fell off. Nurse #1 added she was never informed she needed to complete treatments on the days the WN was not scheduled.

During an interview on 12/18/18 at 3:00 PM, Nurse #4 confirmed she was the nurse assigned to provide care to Resident #7 on 12/03/18. Nurse #4 stated she did not complete the wound treatment to Resident #7's right outer ankle or any other resident assigned because she was never trained to provide wound care. Nurse #4 explained the facility had a WN who completed the treatments for all residents and was never informed she needed to complete the treatments when the WN was not scheduled.

During a telephone interview on 12/19/18 at 2:03 PM the Director of Nursing (DON) explained nursing staff were informed upon hire that providing wound treatment was a part of their job description. The DON stated it was her expectation nursing staff would follow Resident #7's care plan and provide wound treatment as

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scheduled and ordered.

During a telephone interview on 12/20/18 at 9:41 AM, Nurse #2 confirmed she was the nurse assigned to provide care to Resident #7 on 12/10/18. Nurse #2 stated she did not complete the wound treatment to Resident #7's right outer ankle because she received Hospice services and the Hospice Nurse provided wound care.

During an interview on 12/20/18 at 11:14 AM, the Administrator was unaware wound treatments were not being completed by the hall nurses when the WN was not scheduled to work. She stated she was aware of all the training needs in the building and felt the nurses needed more training in wound care. She stated it was her expectation wound treatments were completed as scheduled and ordered and staff provided care consistent with a resident's care plan.

4. Resident #11 was admitted to the facility on 08/28/18 with diagnoses including anemia, atrial fibrillation, hypertension, cerebral vascular accident and renal insufficiency.

A review of the care plan with an initiation date of 11/21/18 revealed an identified problem that Resident #11 had potential for pressure ulcer development related to immobility and incontinence and had a stage II pressure ulcer on his coccyx and left hip and had a stage III pressure ulcer on his right heel. The goal was Resident #11 would be free from any further pressure ulcer development. Interventions to address problem were as follows: Staff were to administer treatments as ordered and monitor for

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effectiveness. Staff were to monitor/document/report as needed any changes in skin status (appearance, color, wound healing, signs and symptoms of infection, wound size, and stage).

A review of a wound physician's note dated 11/29/18 indicated Resident #11 had an unstageable pressure ulcer to coccyx, right hip, right heel, and right medial ankle.

A review of hospital wound discharge sheet dated 12/07/18 indicated Resident #11 had stage I pressure ulcer to left heel and deep tissue injury right heel, pressure ulcer to right medial ankle that was not staged, pressure ulcer to sacrum, left knee, and right head that was unstageable, and pressure ulcer to right hip that was not staged.

A review of the Admission Nursing Assessment (ANA) dated 12/07/18 revealed Resident #11 had an unstageable pressure ulcer to buttock, sacrum, right head, and left knee and a stage I pressure ulcer to left heel, and deep tissue injury to right heel.

A review of a wound physician's note dated 12/12/2018 indicated Resident #11 had an unstageable pressure ulcer to coccyx, right hip, right heel, left heel, and a stage IV pressure ulcer to right medial ankle.

On 12/19/18 at 10:36 AM an interview was conducted with the Minimum Data Set (MDS) nurse who stated she was responsible for updating the care plan to indicate pressure ulcer location and stage for Resident #11. The MDS nurse stated she was aware Resident #11 had

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{F 656}	Continued From page 49 pressure ulcers but had not reviewed the wound physician notes for 11/29/18 that indicated location and stage of Resident #11's pressure ulcers. She stated she had not reviewed the admission nursing assessment dated 12/07/18 and hospital discharge information dated 12/07/18 for pressure ulcer location and stage and had not reviewed the wound physician note dated 12/12/18 for pressure ulcer location and stage. The MDS nurse stated she did not update Resident #11's care plan to indicate pressure ulcer location and stage because she had been pulled from performing her duties as MDS nurse to administer medications and admit residents to the facility. On 12/19/18 at 10:53 AM an interview was conducted with the Administrator who stated the MDS nurse was responsible for updating Resident #11's care plan to indicate stage of pressure ulcers and location. She stated her expectation was that the MDS nurse would have updated the care plan to indicate Resident #11 had pressure ulcer areas. On 12/19/2018 at 2:35 PM a telephone interview was conducted with the Director of Nursing who stated it was her expectation that the MDS nurse would have updated the care plan to indicate stage and location of pressure ulcers for Resident #11.	{F 656}		
{F 677} SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	{F 677}		1/18/19

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(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 677}	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for Activities of Daily Living (ADL) care (Resident #13) and failed to provide nail care for 2 of 5 dependent residents reviewed for ADL care (Resident #1). The findings included: 1. Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was cognitively intact and was totally dependent on staff for toileting. The MDS further indicated Resident #13 was always incontinent of bowel and bladder. The MDS revealed had no rejection of care. A review of the Activities of Daily Living (ADL) Rehabilitation Care Area Assessment (CAA) and Urinary Incontinence CAA associated with the 02/28/18 MDS noted Resident #13 needed assistance with toileting as the resident was incontinent of bowel and bladder and staff provided incontinent care routinely and as needed. A review of Resident #13's care plan, dated	{F 677}	1.Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. Nail care was provided to Resident # 1 12/20/18 by the Certified Nursing Assistant. 2.The Registered Nurse/Interim Director of Nursing completed an audit 1/16 -1/18/19 to assess for adverse effects to other residents with none observed. 3.The nursing staff were educated by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 in proper ADL care including nail and incontinence care for residents requiring assistance. The education will be included in subsequent new-hire orientation. 4.The Director of Nursing/Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse will randomly check compliance of Certified Nursing Assistants providing ADL care including incontinence care and nail care- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. The committee includes the Medical Director, Administrator, Director of Nursing, Registered Nurse, Social Services, Dietary, Medical Records/Human Resource Director,	

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{F 677}	Continued From page 51 03/14/18, indicated the resident had an ADL self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. A review of the care plan for Resident #13 revealed that he had the potential to be verbally aggressive toward caregivers. The care plan, regarding the resident being verbally aggressive toward caregivers, further revealed staff were to assess and anticipate resident's toileting needs . An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I	{F 677}	Maintenance Director, and line staff member. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review, recommendations and updated as needed to ensure continuous compliance.	

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haven't been cleaned up all night." Resident #13 stated NA #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on his personal computer voice recorder. He further indicated that Nurse #1 came into his room and he told her that he had not been cleaned up and she stated that she was "in the middle of sending someone to the hospital and can't make the NA's come in to help. Then, Nurse #1 left the resident's room and did not return to his room. At 8:30 AM, Resident #13 revealed that he rang his call light again and NA # 3 came into his room and cleaned him, and she washed his bed 3 times and the under pad was turned upside down and soaked up the urine and the pad looked like tobacco. Resident #13 tearfully reported he felt hurt because staff didn't clean him up.

An interview was conducted with the Social Worker on 12/18/18 at 1:13 PM. She revealed there were no grievances filed for the month of December 2018.

An interview was conducted with NA #3 on 12/18/18 at 3:01 PM. She indicated that she went into Resident #13's room on 12/16/18 at 8:30 AM and had to change his whole bed because he was wet with urine from just below his shoulders to his knee cap. NA #3 stated she found Resident #13 soaked with urine and feces before but this was the worst she saw his bed that soaked. NA #3 stated that Resident #13 never refused incontinence care. NA #3 recalled the bed spread was wet all the way through and everything from the chux (disposable) pad to the washable pad

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was brown. In cleaning up the bed, NA #3 stated she took a chux (disposable) pad and placed the cotton side of the chux pad on mattress and the chux pad was soaked with urine. NA #3 stated that at the end of first shift, she notified Nurse #2 of the condition she found Resident #13 and what he reported regarding his need for assistance not being addressed from 12:41 AM to 8:30 AM. NA #3 further stated that Nurse #2 told Resident #13 that the social worker was the one who addressed the grievances and that Resident #13 mentioned something about writing a grievance regarding 3rd shift because he said it was not right how he was being treated.

A phone interview was conducted with NA #4 on 12/19/18 at 8:00 pm. NA #4 stated she worked third shift and frequently worked with Resident #13. NA #4 stated Resident #13 typically received incontinence care at 1:30 am and 5:30 am, at a minimum and that was close to shift change. She indicated that Resident #13 had never saturated his bed due to his incontinence but that he got a little sweaty because he had computer equipment in his room that made the room hot.

A phone interview was conducted with NA #2 on 12/19/18 at 8:21 PM. She stated that the nursing assistants who came in at 11:00 PM typically went to Resident #13's room at 1:30 AM and change him. She further stated that if Resident #13 was given a suppository, the NA's went to change the resident more often. She indicated that Resident #13 did not get a suppository during 2nd shift on 12/15/18. She further indicated that it was her perception that Resident #13 rang his call bell at 1:30 am and 5:30 am and both times went into his room, woke him up and changed him. She

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stated that Resident #13 had been telling 1st shift that he hadn't been changed, so the NAs woke him and changed him. She further stated that she reported any concerns to the oncoming shift. She did not mention that she reported any concerns to first shift regarding Resident #13 on 12/16/18.

A phone interview was conducted with the DON on 12/20/18 at 6:50 AM. She indicated that she expected all residents would be treated with respect and dignity and care to be provided when requested.

A phone interview was conducted with Nurse #2 on 12/20/18 at 9:13 AM. She indicated that she worked 7:00 am to 7:00 pm on 12/16/18 and that toward the end of her shift, Resident #13 told her he wanted to file a grievance because no one changed him for an extended time the early morning of 12/16/18. She stated that towards the end of first shift NA #3 confirm Resident #13 was very wet. She further stated that she reported the information to the night shift Nurse #7. She indicated that she did not notify the social worker or file a grievance because the social worker checked on Resident #13 daily.

An interview was conducted with the Social Worker on 12/20/18 at 9:39 AM. She indicated that she did not talk to Resident #13 during the week of December 17th, 2018 and wasn't aware of any concerns involving Resident #13. She further indicated that in the past, Resident #13 complained about being soaked in urine when the previous Director of Nursing (DON) was working at the facility which was before December 2018. She revealed that she didn't remember Resident #13 filing any recent grievances.

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An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. She stated she expected all residents to be treated with dignity and respect and told this to every staff member when she started working at the facility on 11/26/18. She further stated she expected concerns to be reported so follow-up could be done. She indicated staff were supposed to care for residents and it was a problem of dignity if care was not given. She indicated again she should have been told about the incident, so she could fix the problem.

2. Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), Right hip infection, peripheral vascular disease, (PVD), type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder.

A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/8/18, indicated she had severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer.

A review of the Pressure Ulcer Care Area Assessment (CAA) revealed Resident #1 was at risk for breakdown due to her incontinence and

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needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks and had a history of chronic pruritis (itching). The CAA also revealed she was prone to self-inflict scratches.

A review of ADL Functional/Potential CAA revealed Resident #1 had a diagnosis of dementia. The CAA further revealed she required extensive assistance with personal hygiene but was able to assist with basic hygiene with setup). Resident #1 also needed physical assistance with bathing or showering.

A review of the care plan for the Potential for Pressure Ulcer Development indicated Resident #1's self-inflicted scratches. The care plan also revealed the following interventions were in place for potential for pressure ulcer development: staff to make sure fingernails were clean, trimmed, and had no jagged edges and staff to administer treatments as ordered and treatments were monitored for effectiveness.

A review of Care Kardex for Resident #1 revealed she was supposed to get nail care daily and as needed and the December 2018 bed baths and nail care sheet indicated no nail care was documented.

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with a nurse and nursing assistant present. Nurse #6 was performing a skin assessment on the resident. Resident #1's nails on both hands were dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on

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the second digit of the right hand had a jagged edge.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the resident definitely needed good nail care and NA's were supposed to cut her nails when they give her a shower and also stated that Resident #1 was getting nail care and that Resident #1 did not refuse care. NA #5 concurred with Nurse #6 regarding Resident #1's nail care.

An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. Further observation of the resident during the dressing changed revealed Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the dressing because the treatment order is as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment.

An interview was conducted with NA #4 on 12/19/18 at 8:55 AM. She stated that she did not do nail care on Resident #1 because that was done on day shift.

An observation of Resident #1 was conducted on 12/19/18 at 12:40 PM. During the observation, Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length

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and the fingernail on the second digit of the right hand had a jagged edge and the resident put her right hand in her mouth.

An interview was conducted with NA #5 on 12/19/18 at 12:45 PM. She stated that nail care should be done after Resident#1's shower. After looking at Resident #1's fingernail, NA #5 stated that the resident's nails needed to be cut. NA #5 then left the resident's room without performing nail care.

A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She stated that her expectation was that every time residents get a shower their nails should be checked and checked daily to determine if they needed to be cleaned or trimmed and the care plan should have been followed.

An observation of Resident #1 in the Activity Room was conducted on 12/20/18 at 10:35 AM. Resident #1's nails on both hands were still dirty with a brownish red colored substance under her fingernails and the nails were ¼ inch in length and the fingernail on the second digit of the right hand had a jagged edge.

An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator stated she expected nails to be cleaned every day by NAs. She further stated NAs should be able to do this and should have time to do this during AM care. She indicated that she talked with the NAs about nail care in particular for residents that had contractures. She further indicated that nail care should have been done consistent with the plan of care. The administrator stated she expected

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{F 677}	Continued From page 59 care plans to be accurate and expected interventions to be followed in terms of care whether it was care for treatments or ADLs.	{F 677}		
F 684 SS=D	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 observations, record review, staff interviews, and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1). The findings included: Resident #1 was readmitted to the facility on 04/5/17 with an original admission on 01/10/17 with the following diagnoses: right hip wound infection, dementia without behavioral disturbance, generalized anxiety disorder, pruritus (itching), peripheral vascular disease, (PVD), type 2 diabetes mellitus, local infection of the skin and subcutaneous tissue (onset 01/11/17), and major depressive disorder. A review of Resident #1's Annual Minimum Data Set (MDS), dated 01/08/18, indicated she had	F 684	1.Resident #1 wound care has been provided consistently by the licensed nurse. 2.In order to ensure other residents are not affected by the alleged deficient practice the wound care nurse□s schedule has been changed effective 1/15/19 to Monday-Friday to complete daily coverage and all nurses have been informed that when the treatment nurse is off they are to perform wound care in the wound care nurse absence. 3.Education was provided to the nursing staff 1/16-1/18/19 by the Registered Nurse/Interim Director of Nursing regarding their role to provide treatments in the event the wound nurse is not working. They were also educated 1/16-1/18/19 regarding wound care	1/18/19

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F 684	Continued From page 60 severe cognitive impairment, she had behavioral symptoms of scratching herself, she was always incontinent of bowel and bladder and needed extensive assistance with 2 plus person physical assistance for transfers, bed mobility, toileting, and extensive assistance with 1-person physical assistance for personal hygiene. The MDS also indicated that she was at risk for pressure ulcer development but that she had no pressure ulcer. A review of the Pressure Ulcer Care Area Assessment (CAA) associated with the 01/08/18 MDS revealed Resident #1 was at risk for breakdown due to her incontinence and needed assistance with positioning. Resident #1 was also admitted with multiple areas of breakdown primarily to her legs and buttocks with a history of chronic pruritis (itching). A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 11/24/18, indicated the following wound measurements in centimeters (cm): 8.5 cm in length x 1.4 cm in width x 1.2 cm in depth and 8.1 cm undermining at 12 o'clock. A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/05/18, indicated the following wound measurements in centimeters (cm): 4.2 cm in length x 1.2 cm in width x 0.8 cm in depth and 8.0 cm undermining at 12 o'clock. A review of Resident #1's Physician Orders, dated 12/05/18, revealed the following: 1. Cleanse Right hip with wound cleanser, pat dry, pack with Dakins' soaked Kling gauze, and cover with dry dressing every day and as needed.	F 684	procedures by the Registered Nurse/Interim Director of Nursing. Newly hired nursing staff will be educated during subsequent orientation events. 4.Monitoring to ensure compliance the Registered Nurse/Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse will randomly check the compliance of Nurses providing consistent wound care according to MD orders- 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations to continue the achievement of compliance.	

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2. Cleanse Right hip periwound with wound cleanser, pat dry, apply Silvadene and cover with dry dressing every day and as needed.

A review of the care plan for the nonstageable area to right hip or potential for pressure ulcer development, dated 12/6/18, indicated Resident #1's pressure ulcer would show signs of healing and would remain free from infection. The care plan further indicated the following interventions were in place for staff to administer treatments as ordered and were monitored for effectiveness, dressing was monitored to ensure it was intact and adhering and staff to report loose dressings to the treatment nurse, and the resident needed moisturizer applied to her skin.

A review of the Facility Skin Condition Record for Non-Pressure Ulcer Skin Conditions for Right Hip Wound Infection, dated 12/12/18, indicated the following wound measurements in centimeters (cm): 5.1 cm in length x 1.1 cm in width x 2.0 cm in depth and 4.8 cm undermining at 3 o'clock (progress: improved).

A review of the December 2018 Treatment Administration Record (TAR) revealed the resident's Right hip dressing change and periwound dressing change was not initialed as done on the following dates: 12/07/18; 12/08/18; 12/10/18; & 12/17/18.

A review of December 2018 TAR revealed the following treatments for Resident #1 were not initialed as done the following dates:
1. Apply zinc oxide to groin redness/area every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
2. Doxepin Cream 5%- apply to all body parts

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with abrasion every night on 3pm-11 pm until all areas are healed and then as needed. (not initialed on 12/07/18; 12/8/18; 12/11/18; 12/14/18; 12/15/18; 12/16/18; and 12/17/18)
3. Eucerin Cream- apply to Bilateral Lower Extremities twice daily for 7am-7 pm and 7pm to 7am (not initialed on 12/10/18 for 7am to 7 pm)
4. Eucerin Unscented Cream- apply to affected areas topically every day on upper extremities (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)
5. Ketoconazole Shampoo 2%- apply to scalp once a week for itch on 11 p-7p (not initialed on 12/07/18 and 12/14/18)
6. Vitamin A+D ointment for Desitin Clear with Vit A&D - apply topically to buttocks and thighs every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18)

An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. At the time of the transfer, Nurse #6 was performing a skin assessment on the resident. During continuing observation of Nurse #6 and NA #5 repositioning the resident, the nurse did not change the dressing, as the dressing was undated.

An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the facility had a treatment nurse on Tuesdays, Wednesdays, and Thursdays during the week and a treatment nurse on Saturdays and Sundays every other weekend but there was no treatment nurse on Mondays and Fridays. Nurse #6 indicated that the wound on Resident #1's right hip started out as a bump about 2 weeks ago and the facility had a wound doctor.

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Nurse #6 further indicated the resident had undermining (destruction of tissue extending under the skin edges so that the pressure ulcer was larger at its base than at the skin surface) of the wound and it was a decubitus pressure ulcer. She indicated that the right hip wound treatment was for the wound to be packed and covered with a blue dry dressing.

An interview was conducted with the Treatment Nurse on 12/18/18 at 8:52 AM. She stated that she knew nothing about Resident #1's right hip wound until Saturday; 11/24/18, which was the date she saw the wound for the first time. She further stated that the right hip wound had already popped open and was draining and developed undermining. She indicated that she documented information in the facility doctor's book about Resident #1's right hip wound. She further indicated that she initiated treatment to the right hip on 11/24/18. She stated that when she was not at work, the treatments on residents were not consistently getting done because she would find the same dressings that she placed on residents from when she last worked. She indicated that on 12/05/18, she completed the treatments on all the residents and, when she went back to work on Tuesday; 12/11/18 she checked Resident #1's dressing and the blue foam was saturated with drainage, had no date on it, and the wound was not packed as ordered. She said the wound packing was ordered because Resident #1 had undermining of the wound.

An observation and interview were conducted with the Treatment Nurse on 12/18/18 from 1:15 PM to 1:35 PM. She was performing a dressing change on Resident #1's right hip. She stated that when the wound doctor first came to assess the

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resident's right hip wound after it opened up, he stated that the wound looked like a bad infection and he removed the dead tissue off of the top of the wound which revealed the undermining. She further stated that the undermining had decreased from 8 centimeters (cm) to 4 cm. During continued observation, the undated blue sponge was still noted on Resident #1's right hip and the periwound (skin surrounding the wound) was not covered with a dressing and had 4 small areas of thick yellow adherent tissue surrounding the dressing. Further observation indicated there was no odor noted from the old dressing or the wound itself. The Treatment Nurse stated that the dry dressing she removed from the wound should not have been there because it the dressing did not follow the physician's order and it should have been changed daily. She further stated that Resident #1 never refused care, but she did scratch her right hip and around the wound which caused the dressing to hang loosely off the wound. The Treatment Nurse stated that because the dressing may come off, she told the Na's to notify the hall nurses and they could change the dressing because the treatment order was as needed also. She also stated that all nurses were responsible for doing a weekly skin assessment.

An interview was conducted with Nurse #6 on 12/18/18 at 2:04 PM. She stated that she did not change the dressing on 12/17/18 for Resident #1. She further stated that when the treatment nurse was not at the facility, the hall nurses were responsible for changing the dressing. She indicated that she notified oncoming 3rd shift, Nurse #8, on 12/17/18 that a treatment had not been done for Resident #1.

A phone interview was conducted with Nurse #8

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on 12/19/18 at 9:53 AM. She indicated that she did not do the treatments on Resident #1 on 12/17/18 because she was working by herself with only one NA.

A phone interview was conducted with Nurse #4 on 12/19/18 at 10:07 AM. She indicated that on 12/08/18, she only performed a dressing change on another resident, not Resident #1.

A phone interview was conducted with Nurse #7 on 12/19/18 at 10:27 AM. She stated that she worked with Resident #1 on 12/17/18, from 11:00 PM to 7:00 AM, and did not perform any treatments on Resident #1.

An interview was conducted with the Wound Doctor on 12/19/18 at 11:14 AM. He indicated that when the regular treatment nurse was not working every day, there was an issue with treatments being completed as ordered. He stated he was not sure if Resident #1 scratching her skin caused the infection of her right hip. He further stated that Resident #1 needed wound packing wet to moist dressings once a day and that the periwound deteriorated (per the Wound Care notes, dated 12/12/18, due to venous insufficiency). He indicated that the Silvadene was ordered for the periwound abrasion and the key to successful wound healing was to protect the wound and that the dressing was supposed to be covering the wound.

A phone interview was conducted with Nurse #2 on 12/19/18 at 11:55 AM. She stated that she worked on 12/08/18 and no treatments were done on Resident #1. She further stated that on 12/10/18, she only changed another resident's dressing, not Resident #1.

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F 684	Continued From page 66 A telephone interview was conducted with the DON on 12/19/18 1:53 PM. She indicated her expectation was that treatment orders should be followed, and treatments completed as scheduled. An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator indicated that she expected treatments to be done consistent with the physician orders. She further indicated she was not aware treatments were not being done as scheduled but expected all orders to be followed for type of treatment and schedule set for treatments.	F 684		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure	{F 686}	1.Resident # 11 and #7 have received wound care as ordered by the licensed nurse.	1/18/19

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{F 686}	Continued From page 67 ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers. The findings included: 1. Resident #11 was readmitted to the facility on 12/07/18 with diagnoses which included urinary tract infection, dementia, and pressure ulcer to sacral region, right heel, and right hip. A review of the most recent comprehensive Minimum Data Set (MDS) assessment dated 09/09/18 indicated Resident #11 was cognitively impaired and was coded as having an unstageable pressure ulcer on his heel that was not present on prior assessment. A review of Care Area Assessment (CAA) for pressure ulcer dated 09/09/18 indicated Resident #11 had a deep tissue injury (DTI) to right heel with treatment in place. A review of the care plan with an initiation date of 11/21/18 revealed an identified problem that Resident #11 had potential for pressure ulcer development related to immobility and incontinence and had a stage II pressure ulcer on his coccyx and left hip and had a stage III pressure ulcer on his right heel. The goal was Resident #11 would be free from any further pressure ulcer development. Interventions to address problem were as follows: Staff were to administer treatments as ordered and monitor for effectiveness. Staff were to monitor/document/report as needed any changes in skin status (appearance, color, wound healing,	{F 686}	2.In order to ensure other residents are not affected by the alleged deficient practice the wound care nurse□ schedule has been changed effective 1/15/19 to Monday-Friday to complete daily coverage and all nurses have been informed that when the treatment nurse is off they are to perform wound care in the wound care nurse absence. 3.Education was provided to the nursing staff by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 regarding their role to provide treatments in the event the wound nurse is not working. They were also educated 1/16-1/18/19 regarding wound care procedures. In order to correct nurses not clarifying and implementing treatment orders, two nurses must sign off that the treatment orders have been clarified and implemented with each new or readmit resident whom requires wound care, this will be an on-going process. Newly hired nursing staff will be educated during subsequent orientation events. 4.The Registered Nurse Supervisor and or Interim Director of Nursing will be responsible for this aspect of the Plan of Correction. The Registered Nurse Supervisor and or Interim/Director of Nursing will randomly check the compliance of Nurses providing consistent wound care according to MD orders- 5 residents per week x 4 weeks,	

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{F 686}	Continued From page 68 signs and symptoms of infection, wound size, and stage). A review of a wound physician's note dated 11/29/18 indicated Resident #11 had an unstageable pressure ulcer to coccyx, right hip, right heel, and right medial ankle. A review of MDS dated 11/30/18 indicated Resident #11 had unplanned discharge to the hospital with return anticipated. A review of hospital wound discharge sheet dated 12/07/18 indicated Resident #11 had pressure ulcer to left and right heel, right medial ankle, sacrum, right hip, and left knee and was to receive foam dressing to left heel and apply Santyl (debridement ointment and foam dressing to right medial ankle, sacrum, and right hip, and apply ¼ strength Dakin's solution (a solution used to kill germs and prevent germ growth in wounds) and Santyl to right heel. The treatment orders did not indicate when the wound treatment was to begin or how often wound treatment was to be administered. A review of the Admission Nursing Assessment (ANA) dated 12/07/18 revealed Resident #11 had a pressure ulcer to buttock, right and left heel, sacrum, right head and left knee which were not measured. Review of Resident #11's Medication Administration Record (MAR) dated 12/07/18 to 12/31/18 indicated there were no medication orders prescribed to treat areas on his left and right heel, right medial ankle, sacrum, right hip, buttock, and left knee.	{F 686}	then 2 residents per week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review for two months if concerns are identified the QA Committee will continue to review another three months in order to provide addition recommendations to assist with maintaining compliance.	

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Review of Resident #11's Treatment Administration Record (TAR) from 12/07/18 through 12/10/18 indicated treatment to the right and left heel, sacrum, right hip, and right medial ankle were not completed per nurse documentation on the TAR. No treatment had been set up for areas on his left and right heel, right medial ankle, sacrum, right hip, buttock, and left knee for 12/08/18 to 12/10/18. A further review of the TAR from 12/12/18 through 12/31/18 indicated treatment orders were written by the wound physician on 12/12/18 were transcribed to the TAR and were documented as completed.

On 12/18/18 at 8:34 AM an interview was conducted with the wound nurse (WN) who stated she worked 3 days a week and was unsure when she was not working if Resident #11's pressure ulcers were treated. The WN stated it was the responsibility of the floor duty nurse to provide wound treatment when she was not on duty. The WN stated Resident #11 was readmitted to the facility from the hospital on 12/07/18. The WN stated she returned back to work on 12/11/18 and Resident #11 had hospital dressings on his pressure ulcer wounds and she saw no indication that wound treatment had been provided on 12/08/18, 12/09/18, and 12/10/18 by the floor duty nurse. The WN stated when she came on duty 12/11/18 Resident #11 had no wound treatment orders from the 12/07/18 admission. The WN stated the TAR did not indicate via nursing documentation that wound treatment had been provided to Resident #11 on 12/08/18, 12/09/18, and 12/10/18. The wound nurse stated she performed wound treatment for Resident #11 on 12/11/18.

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On 12/18/18 at 1:10 PM a telephone interview was conducted with Nurse #1 who stated she worked 7:00 PM to 7:00 AM when Resident #11 was admitted to the facility on 12/07/18. She stated she was aware that Resident #11 had wounds. Nurse #1 stated it had been a very busy shift that night and she did not call the physician to clarify Resident #11 ' s wound treatment orders from the hospital discharge. She stated she had not had time to review the hospital wound discharge orders to determine if she needed to clarify the wound orders with the facility physician.

On 12/8/18 at 2:33 PM a telephone interview was conducted with Nurse #2 who worked the day shift on 12/07/18 and completed Resident #11's head to toe admission nursing assessment and noted he had several wounds. She stated she did not have time to complete his admission paperwork and had not called the physician to clarify wound treatment orders for Resident #11. Nurse #2 stated she informed the oncoming Nurse #1 that she had not finished Resident #11's admission paper work but did not informed Nurse #1 that she had not clarified wound treatment orders with the facility physician. Nurse #2 stated the process on admission was that staff were to clarify wound treatment orders with the physician if the orders were not clearly understood.

On 12/18/18 at 2:44 PM a telephone interview was conducted with Nurse #3 who stated she was scheduled to be the treatment nurse on 12/08/18 and 12/09/18 but had been pulled to administer medications. Nurse #3 stated she had not clarified with the facility physician wound treatment orders for Resident #11. Nurse #3 stated she had not performed wound treatment on Resident #11 on 12/08/18 and 12/09/2018.

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Nurse #3 stated she was unaware that wound treatment orders for Resident #11 had not been clarified with the facility physician.

On 12/18/18 at 2:55 PM an interview was conducted with Nurse #4 who stated she was working day shift when Resident #11 was admitted to the facility on 12/07/18 and helped Nurse #2 with clarifying pain medication orders with the physician for Resident #11. Nurse #4 stated she had not clarified wound treatment orders for Resident #11. Nurse #4 stated she was unaware that Resident #11 had wounds. Nurse #4 stated she had not informed the oncoming nurse that the wound treatment orders for Resident #11 had not been clarified with the facility physician. Nurse #4 stated she thought the wound nurse was responsible to clarify wound orders with the facility physician.

On 12/18/18 at 2:17 PM an interview was conducted with the Director of Nursing (DON) who stated the admitting nurse was responsible to clarify wound treatment orders with the facility physician and transcribe wound treatment orders onto the TAR. The DON stated it was the admitting nurse's responsibility to provide a head to toe resident assessment on admission and document any wounds and skin issues and obtain wound treatment orders from the physician. The DON stated it was her expectation that the admitting nurse would have clarified wound treatment orders with the physician and would have transcribed treatment orders onto Resident #11's TAR or would have communicated to the oncoming nurse if she was unable to clarify wound treatment orders with the facility physician for Resident #11. The DON stated it was her expectation that the floor duty nurse would have

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provided wound treatment for Resident #11 on 12/8/18, 12/09/18, and 12/10/18. The DON stated it was her expectation if the wound nurse was not on duty then the floor duty nurse would provide wound care for Resident #11.

On 12/18/18 at 4:07 PM a telephone interview was conducted with the facility physician who stated he had not received a call from the facility staff on 12/07/18 to clarify wound treatment orders for Resident #11. The physician stated staff would have called him to clarify wound orders and not the nurse practitioner. The physician stated it was his expectation that staff would have called him to clarify any questions with admission wound treatment orders for Resident #11. The physician stated it was his expectation that Resident #11 would have received wound treatment on 12/08/18, 12/09/18, and 12/10/18 because Resident #11 had some tough wounds. The physician stated it was his expectation that wound care would have been performed daily and deferred Resident #11's wound care to the wound physician.

On 12/18/18 at 4:34 a telephone interview was conducted with the wound physician who stated after reviewing the hospital discharge wound sheet for 12/07/18 that Resident #11 had a foam dressing applied to his pressure ulcer on the right medial ankle, coccyx, right hip, and left heel and felt the dressings did not need to be changed daily. The wound physician stated a foam dressing could stay in place for 3 to 5 days without being changed. The wound physician stated he could not determine if any harm occurred because Resident #11's wound treatments had not been provided on 12/08/18, 12/09/18, and 12/10/18.

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{F 686}	Continued From page 73 On 12/19/18 at 10:58 AM an interview was conducted with the Administrator who stated her expectation was that the admitting nurse would have verified wound treatment orders with the facility physician and transcribed the orders onto the TAR. The Administrator stated her expectation was that Resident #11 would have received wound treatment on 12/08/18, 12/09/18, and 12/10/18. On 12/19/18 at 11:08 an additional interview was conducted with the with the wound physician who stated he felt that the nurse should have clarified wound treatment orders with the hospital discharge physician or facility physician on admission 12/07/18 for Resident #11 to clarify how often wound treatment should have been provided. 2. Resident #7 admitted to the facility on 01/31/17 with multiple diagnoses that included dementia, kyphosis (excessive outward curvature of the spine), age-related osteoporosis, and chronic pain. Review of a physician's order dated 08/30/18 for Resident #7 read in part, "skin prep (forms a film protecting skin) to bilateral top of foot and protect with foam dressing twice weekly and as needed." Review of the significant change Minimum Data Set (MDS) dated 10/24/18 revealed Resident #7 was moderately impaired for daily decision making and displayed no rejection of care during the 7-day assessment period. Further review of the MDS indicated Resident #7 required	{F 686}		

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extensive assistance with activities of daily living and had 2 unhealed pressure ulcers.

Review of a care plan, with a revised date of 10/25/18, revealed Resident #7 had the potential for pressure ulcer development related to needing assistance with mobility, incontinence and decreased oral intake with the goal she would be free from any signs or symptoms of infections related to altered skin integrity. The interventions included for staff to administer treatments as ordered and monitor for effectiveness.

Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer ankle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains a mild cleaning agent activated by moisture and gradually released into the wound area) 3 times a week."

Review of the December 2018 Treatment Administration Record (TAR) revealed treatment for Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and Friday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the treatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 12/07/18, 12/10/18 or 12/17/18. Further review of the TAR revealed no initials indicating the treatment for Resident #7's top of foot was completed on 12/17/18.

During an interview on 12/18/18 at 8:35 AM, the

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Wound Nurse (WN) explained she was responsible for completing wound treatments for residents on the days she worked, which were Tuesdays, Wednesdays and Thursdays each week, and the hall nurses were responsible for completing wound treatments the remaining days. The WN recalled changing the dressing on Resident #7's right outer ankle on 12/05/18 with the next dressing changes scheduled on 12/07/18 and 12/10/18. She stated when she returned to work on 12/11/18, the dressing in place was dated 12/05/18 with her initials, smelled and was hanging off the wound. The WN confirmed she did not work on 12/03/18, 12/07/18 or 12/10/18 and stated it was an ongoing issue that wound treatments were not being completed by the hall nurses on the days she was not scheduled to work. She added she completed treatments on the day she returned if she noticed they were not done by the hall nurses on the day scheduled.

An observation was made of Resident #7's wound care on 12/18/18 at 10:40 AM. The WN washed her hands and as she was removing the old dressing from the top of Resident #7's left foot she stated the dressing that was in place was Polymen which was the wrong treatment. The dressing was dated 12/17/18 and initialed by Nurse #5. The skin on top of Resident #7's left foot was intact with no redness or inflammation noticed. The WN indicated the treatment ordered was preventative and the dressing would be replaced to protect the area. The WN washed her hands and as she removed the bunny boot (foot/heal protector) from Resident #7's right foot, there was no dressing covering the right outer ankle and the wound was exposed to air. The wound was red with a small amount of yellow

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slough (dead tissue) and the skin surrounding the wound bed was a dark reddish color. The WN cleaned the ankle with wound cleanser, patted the area dry and applied Polymen dressing as ordered.

During a telephone interview on 12/18/18 at 1:23 PM, Nurse #1 confirmed she worked as a hall nurse on 12/07/18 and did not complete wound treatment to Resident #7's right outer ankle. She explained she was never shown how to complete wound treatments and only reapplied a resident's dressing when it fell off. Nurse #1 added she was never informed she needed to complete treatments on the days the WN was not scheduled.

During an interview on 12/18/18 at 3:00 PM, Nurse #4 confirmed she was the nurse assigned to provide care to Resident #7 on 12/03/18. Nurse #4 stated she did not complete the wound treatment to Resident #7's right outer ankle or any other resident assigned because she was never trained to provide wound care. Nurse #4 explained the facility had a WN who completed the treatments for all residents and was never informed she needed to complete the treatments when the WN was not scheduled.

During a telephone interview on 12/18/18 at 3:31 PM, Nurse #5 confirmed she provided wound treatment to Resident #7 on 12/17/18 and stated she must have forgotten to initial the TAR when completed. Nurse #5 added the Hospice Nurse (HN) was present during the wound treatment. Nurse #5 explained she put a 4 inch (in) by 4 in

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bandage on the top of Resident #7's left foot and applied Tegaderm (transparent dressing used to cover and protect wound) and Polymen dressing to her right outer ankle. Nurse #5 added she reviewed the TAR prior to providing treatment and was unable to explain why there was no dressing on Resident #7's right outer ankle or why the wrong dressing was applied to the top of her left foot.

During a telephone interview on 12/18/18 at 4:08 PM, the HN confirmed she was present when Nurse #5 provided wound treatment to Resident #7 on 12/17/18. The HN explained she only observed the treatment provided for the pressure ulcer on Resident #7's right outer ankle and was not familiar with the treatment ordered for the top of her foot. She stated Nurse #5 followed the wound treatment orders and applied Tegaderm and a non-adhesive Polymen dressing to Resident #7's right outer ankle since Hospice was out of the adhesive Polymen dressing they normally used. She added it was possible the dressing had fallen off after treatment was provided.

During an interview on 12/19/18 at 11:14 AM, the Wound Physician (WP) indicated he had only been providing wound care at the facility for the past 3 weeks and was not able to confirm if there was an issue with wound treatments not being completed as ordered or scheduled. He added if a resident was on Hospice he tried to limit the dressing changes to avoid causing them discomfort. The WP stated when he treated Resident #7's wound earlier that morning, it showed improvement with no signs of infection

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{F 686}	Continued From page 78 and no changes were made to the current treatment as ordered by Hospice. He was unaware a dressing was not observed on Resident #7's wound on 12/18/18 and stated a dressing should have been applied and the wound not left exposed. During a telephone interview on 12/19/18 at 2:03 PM the Director of Nursing (DON) explained nursing staff were informed upon hire that providing wound treatment was a part of their job description. The DON stated she would expect the hall nurses to complete wound treatments as ordered and scheduled when the WN was absent. During a telephone interview on 12/20/18 at 9:41 AM, Nurse #2 confirmed she was the nurse assigned to provide care to Resident #7 on 12/10/18. Nurse #2 stated she did not complete the wound treatment to Resident #7's right outer ankle because she received Hospice services and the HN provided wound care. During an interview on 12/20/18 at 11:14 AM, the Administrator was unaware wound treatments were not being completed by the hall nurses when the WN was not scheduled to work. She stated she was aware of all the training needs in the building and felt the nurses needed more training in wound care. She added it was her expectation wound treatments were completed as scheduled and consistent with the physician orders.	{F 686}		
{F 725}	Sufficient Nursing Staff	{F 725}		1/18/19

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{F 725} SS=G	Continued From page 79 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, staff and physician interviews, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer and wound treatments and assistance with incontinence and nail care. This affected 4 of 12 sampled residents (Residents #1, #7, #11, and #13). Staff neglected to provide Resident #13 with	{F 725}	1.Efforts continue in hiring process, filling shifts due to call-offs, and staff retention. A Human Resource Director started employment 1/7/19. 2. In order to ensure that none of residents are affected by allege deficient practice The Human resource Director	

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{F 725}	Continued From page 80 incontinence care for nearly an 8-hour time span which resulted in the resident lying in a large amount of urine and feces. Findings included: This tag is cross-referenced to: 1.a. F-550: Based on observations, record review, staff and resident interviews, the facility failed to treat one resident with dignity by leaving the resident lying in a large amount of urine and stool from 12:41 AM to 8:30 AM on 12/16/18 for 1 of 5 residents dependent on staff for incontinence care (Resident #13). b. F-600: Based on observations, record review, staff and resident interviews, wound physician interview, and hospice nurse interview, the facility staff neglected to acknowledge a resident's call bell and failed to provide incontinence care for 8 an hour time frame from 12:41 AM to 8:30 AM for 1 of 5 residents dependent on staff for incontinence care (Resident #13); failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1); and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 1 of 3 residents reviewed for pressure ulcers. c. F-677: Based on observations, record review, resident, and staff interviews, the facility failed to	{F 725}	was hired on 1/07/19 to assist the Administrator with the screening and hiring process. The effort to hire had began 12/01/2018 for C.N.A's, Nurses and Primary Department heads due to employees having to be held accountable and responsible to perform the duties and tasks that they were hired for and they had begin to quit without notice. The Human Resource Director and Administrator have continued to conduct interviews twice a week and orientation once a week in order to continue the flow of hiring. The Human Resource Director has begin to network with colleges to obtain graduate nurses and nursing assistants, advertisement is posted and updated weekly on in-deed for Nurses and a D.O.N with a sign on incentive is posted. Because of this process we have hired 7 C.N.A's two of which are C.N.A/ Med-Techs, 1 RN MDS nurse, and 1 LPN. Current staff that has been with the facility are given a training incentive to train new staff to the daily routines. When a extra shift is picked up the employees receives their paid over-time incentive. 3. Education-Staff have been provided in-service on 1-10-19 regarding how call-offs affects the facility residents and their peers and how the facility can help to ensure the decrease of turn-over and call-offs. All employees and new hires are re-educated and educated to facility policies regarding call-offs.	

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{F 725}	Continued From page 81 provide toileting assistance for 2 of 5 dependent residents reviewed for Activities of Daily Living (ADL) care (Resident #13) and failed to provide nail care for 2 of 5 dependent residents reviewed for ADL care (Resident #1). d. F-684: Based on observations, record review, staff interviews and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled resident reviewed with a wound infection (Resident #1). e. F-686: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers. During an interview on 12/18/18 at 11:30 PM Nurse #6 revealed she had been at the facility working as a hall nurse since 7:00 AM that morning. Nurse #6 explained she was scheduled to work the 7:00 AM to 7:00 PM shift but at 8:00 PM she was told to stay over and work the 7:00 PM to 7:00 AM shift due to a call-out. She added one of the 2 nurses scheduled to work the 7:00 PM to 7:00 AM shift called out and the other nurse wouldn't take the keys to her medication cart because she did not want to work by herself. Nurse #6 stated she felt that she could not leave and had to stay.	{F 725}	4.Monitoring in order to ensure compliance by reviewing daily staffing sheets in daily stand up meeting x 4 weeks and Monthly there after by the Administrator and Department heads. If staffing needs are Identified the Lead C.N.A, Licensed Nurse and or Administrator will be responsible for covering shifts and the Administrator and or Licensed nurse will be responsible for scheduling staff. This will be a on going process. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1/22/19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance Performance Committee for review and recommendations given to help to ensure the staffing compliance.	

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During an interview on 12/18/18 at 12:30 AM Nurse Aide (NA) #6 confirmed there were times only one NA worked the 11:00 PM to 7:00 AM shift to provide resident care due to staff call-outs. She recalled being the only NA working the evening of 12/18/18. She added when short-staffed, it was difficult to get resident care provided such as early morning showers and getting residents up out of bed and ready for breakfast.

During an interview on 12/18/18 at 6:40 AM Nurse #9 stated they had worked short-staffed "a lot lately", sometimes with only one nurse and one NA for the entire building. Nurse #9 explained it was difficult for staff to get resident care provided when working short, such as getting residents up out of bed and ready for the day or showered and when working short, their main focus was to keep the residents safe and dry.

During an interview on 12/20/18 at 11:14 AM, the Administrator stated she and the Director of Nursing, who was no longer employed, were both responsible for the scheduling of staff. She explained the number of staff scheduled per day was based on the current census and acuity level of the residents in the building. She added at the current census, her goal was to have 4 NAs scheduled to work on both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts and 3 NAs scheduled to work the 11:00 PM to 7:00 AM shift. The Administrator stated since starting her employment on 11/26/18 one of the issues she dealt with was staff not giving sufficient notice

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{F 725}	Continued From page 83 when they called out of work which made it difficult to find replacements and contributed to the facility being short-staffed. The Administrator confirmed Nurse #6 worked 24 hours straight as a hall nurse on 12/18/18 to 12/19/18. She explained it happened due to staff call outs and although it was an unfortunate situation, Nurse #6 had agreed to stay. She added she has focused on filling open positions and the hiring process remained ongoing.	{F 725}		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		1/18/19

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F 732	Continued From page 84 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post daily nurse staffing information for the facility on 4 out of 4 days during the revisit and complaint investigation conducted 12/17/18 through 12/20/18. Findings included: An observation on 12/17/18 at 11:28 AM revealed a clipboard hanging on the wall across from the nurses' station with an undated and blank sheet titled "Daily Staffing Report." Observations conducted on 12/18/18 at 11:15 AM and 3:00 PM revealed an undated and blank daily staffing sheet. Observations conducted on 12/19/18 at 12:45 AM, 9:50 AM and 4:10 PM revealed an undated and blank daily staffing sheet. Further review revealed underneath the blank staffing sheet, there was a staffing sheet dated 12/13/18 with	F 732	1.No residents were identified as having been affected. Mandatory postings have been compliant as of 12/21/19. 2. Mandatory posting will be the responsibility of the Interim Director of Nursing,the Registered Nurse, and or the Administrator. 3. Nursing Staff have received in-service regarding Posting of the Nursing staff as of 01/08/2019. 4. The Administrator will be responsible for this aspect of the Plan of Correction. The Administrator and/or the Human Resource Director will audit for compliance 3x week x 4 weeks. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee 1.22.19. All Plan of Correction monthly audit data will be reported by each auditor to subsequent monthly Quality Assurance	

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F 732	Continued From page 85 only the staffing information completed for third shift. Observations conducted on 12/20/18 at 6:30 AM revealed a staffing sheet dated 12/19/18 with only the staffing information completed for first and second shifts. During an interview on 12/20/18 at 11:14 AM, the Administrator stated the Director of Nursing, who was no longer employed, was responsible for posting the daily staffing information. The Administrator was unable to explain why the staffing information was not posted and stated it was her expectation the staffing sheets were completed and posted daily.	F 732	Performance Committee for review and recommendations so compliance is continuously achieved.	
F 835 SS=G	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and physician interviews and record reviews the facility's administration failed to provide oversight of processes and policies and effective leadership to ensure that residents were free from neglect, treated in a dignified manner, provided with basic nursing care, received pressure ulcer treatments as ordered, and were provided with sufficient nursing staff to meet their needs for 4 of 12	F 835	Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. 2.In order to ensure that others are not affected by the same alleged deficient practice all residents requiring incontinence care were assessed by the Registered Nurse/Interim Director of	1/18/19

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F 835	Continued From page 86 sampled residents reviewed for neglect, dignity, and provision of nursing care (Resident's #13, #7, #1 and #11). Facility administration also failed to develop a facility wide assessment to determine the necessary resources to care for the resident population. Staff neglected to provide Resident #13 with incontinence care for nearly an 8-hour time span which resulted in the resident lying in large amount of urine and feces. Findings included: This tag was cross referenced to: 1a. F-550: Based on observations, record review, staff and resident interviews, the facility failed to treat one resident with dignity by leaving the resident lying in a large amount of urine and stool from 12:41 AM to 8:30 AM on 12/16/18 for 1 of 5 residents dependent on staff for incontinence care (Resident #13). 1b. F-600: Based on observations, record review, staff and resident interviews, wound physician interview, and hospice nurse interview, the facility staff neglected to acknowledge a resident's call bell and failed to provide incontinence care for 8 an hour time frame from 12:41 AM to 8:30 AM for 1 of 5 residents dependent on staff for incontinence care (Resident #13); failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled residents reviewed with a wound infection (Resident #1); and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 1 of 3 residents reviewed for pressure ulcers.	F 835	Nursing 1/16-1/18/19 for any adverse effects with none observed. 3. All scheduled nursing staff were allowed to work before in-service and non-scheduled staff were paid for one hour in-service. All were educated on proper incontinence care 1/16/-1/18/19 by the Registered Nurse/Interim Director of Nursing. In addition, staff were educated by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 that all staff are responsible for acknowledging call lights and to tell the appropriate staff if the need is outside of their scope and on the components of the Concern/Grievance policy. The education will be included in subsequent new-hire orientations. No residents were identified as having been affected by the facility assessment. The facility Assessment was completed by the Administrator as of 12/26/18. The requirement and components of the Facility Assessment were reviewed by the Regional Nurse and the administrator 1/16/19. Department Heads were trained to the facility assessment as of 1/10/2019 by the Administrator regarding their responsibility to provide updated information with their department staffing. The Regional Nurse has trained all Administrative Staff to the cross reference tags including the audits	

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F 835	Continued From page 87 1c. F-656: Based on observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). 1d. F-677: Based on observations, record review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for Activities of Daily Living (ADL) care (Resident #13) and failed to provide nail care for 2 of 5 dependent residents reviewed for ADL care (Resident #1). 1e. F-684: Based on observations, record review, staff interviews and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled resident reviewed with a wound infection (Resident #1). 1f. F-686: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers. 1g. F-725: Based on observations, record	F 835	as of 1/18/19 and will continue to provide oversight. Monitoring the facility assessment this will be the Regional Nurse responsibility once x's 12 months. The Facility Administrator will update the Facility Assessment as needed and or annually and present it to the QA Committee for review and recommendations. The Regional Nurse will provide oversight and review the audits for two (2) months and the QA Committee will review for two (2)months if concerns are identified The QA Committee will provide addition three (3) months of review in order to maintain compliance. The Plan of Correction will be reviewed at the next scheduled Quality Assurance Performance Improvement Committee on 1/22/19.	

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F 835	Continued From page 88 reviews and resident and staff interviews, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer and wound treatments and assistance with incontinence and nail care. This affected 4 of 12 sampled residents (Residents #1, #7, #11, and #13). 1h. F-838: Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for the resident population competently during day to day operations and in an emergency situation. During an interview on 12/20/18 at 11:14 AM, the Administrator agreed there were still issues in the identified areas of concern and explained since starting her employment on 11/26/18 her focus had been on staffing. She added she "planned to work on the rest" once staffing was stable.	F 835		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must	F 838		1/18/19

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F 838	Continued From page 89 address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and	F 838		

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F 838	Continued From page 90 (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for the resident population competently during day to day operations and in an emergency situation. The findings included: A request was made to review the facility assessment on 12/19/18. During an interview on 12/20/18 at 11:14 AM the administrator stated when she began working at the facility on 11/26/18 she asked the former administrator about the facility assessment and was informed there was not a facility assessment. The administrator stated she was aware a facility assessment should be in place and was actively working to create a facility assessment to determine what resources were necessary to care for the resident population competently during day to day operations and in an emergency situation.	F 838	1.No residents were identified as having been affected by the allege deficient practice. The requirement and components of the Facility Assessment were reviewed by the Regional Nurse and the administrator 1/16/19. 2.The Facility Assessment was completed by the Administrator as of 12/26/2018 the Casper report was given to the Administrator by the Regional Nurse to add as a key component to the facility Assessment. 3. Department Heads have been educated to the facility assessment as of 1/10/2019. 4.The facility administrator will update the assessment as needed and on a annual basis and will present it to the Quality Assessment Performance Improvement Committee for review and recommendations once per month x 12 months. The Plan of Correction will be reviewed at the next scheduled Quality Assurance	

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F 838	Continued From page 91	F 838	Performance Improvement Committee 1/22/19.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, physician interviews and record reviews the facility's Quality Assessment and Assurance Committee failed to implement procedures and monitor interventions that were to be implement in November 2018. This was for three recited deficiencies that were originally cited on October 25, 2018 during a complaint survey. The deficiencies were in the areas of implementation of resident care plans (656), treatment of pressure sores (686) and providing sufficient nursing staffing (725). The continued failure during two federal surveys of record reflects a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross-referenced to: 1a. F-656: Based on observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1	F 867	The Statement of Deficiencies F867 citation and Federal Regulation 483.75(g)(2) was reviewed in stand up with the department heads on 1/8/19.Which states that the quality assessment and assurance committee must develop and implement appropriate plans of action to correct identify quality deficiencies. In order to ensure other residents are not affected by the alleged deficient practice monitoring tools were created on 12/26/2018. The Department heads were educated on 01/8/2019 to the monitoring tools, usefulness of those tools and their responsibility regarding the audits. The Plan of Correction was reviewed by the committee on 1/08/19 to discuss and approve stated interventions, monitoring tools, and follow up by the committee. 4. Ongoing, the committee will review	1/18/19

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F 867	Continued From page 92 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). The facility was recited for failure to implement care plans. Tag F- 656 was originally cited during a complaint investigation survey on 10/25/18 for failure to implement care plan interventions for feeding a resident and failure to implement care plan interventions for wound dressing changes. b. F-686: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcer treatment as ordered and scheduled for 3 days (Resident #7) for 2 of 3 residents reviewed for pressure ulcers. The facility was recited for failure to initiate and complete pressure ulcer treatments as ordered. Tag F-686 was originally cited during a complaint investigation survey on 10/25/18 for failure to correctly treat pressure ulcers and failure to complete pressure ulcer treatments as ordered. c. F-725: Based on observations, record reviews and resident, staff and physician interviews, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer and wound treatments and assistance with incontinence and nail care. This affected 4 of 12 sampled residents (Residents #1, #7, #11, and #13). Staff neglected to provide Resident #13 with incontinence care for nearly an 8-hour time	F 867	monitoring tools and audit data as specified in the Plan of Correction to ensure all monitoring tools are utilized and completed once per month x 2 months to help to ensure continue compliance if concerns are identified the QA committee will provide addition three (3) months review to assist with maintaining compliance.	

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F 867	Continued From page 93	F 867		

span which resulted in the resident lying in a large amount of urine and feces.

The facility was recited for failure to provide sufficient nursing staffing. Tag F-725 was originally cited during a complaint investigation survey on 10/25/18 for failure to provide sufficient nursing staff to ensure residents received assistance with meals, bathing and wound care/treatments.

A review of the facility's Plan of Correction (POC) notebook on 12/18/18, for citations from the facility's 10/25/18 complaint investigation revealed each citation contained an Allegation of Compliance (AOC) date of 11/22/18. There were no monitoring or auditing tools completed as indicated in the facility's POC for the areas related to care plans, pressure ulcer care and sufficient nursing staffing.

During an interview on 12/20/18 at 11:14 AM, the Administrator confirmed the facility's POC notebook from the complaint investigation completed on 10/25/18 was inclusive of all monitoring and auditing tools. She explained she was in the process of creating monitoring forms for the areas cited, but it was a work in progress and not yet completed. She added since starting her employment on 11/25/18 she had focused on hiring staff and then "planned to work on the rest" once staffing was stable. The Administrator acknowledged the monitoring and auditing components for care plans, pressure ulcer care and staffing, were not being completed and stated going forward she planned to implement tools to monitor these areas.