STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH CENTER	103 GOSSMAN DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 11/20/19 through 11/21/19. Eight of 14 allegatipons were substantiated resulting in deficiencies (F561, F580, F684 & F725).	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 561		12/19/19

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

Electronically Signed | 12/05/2019

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F 561	Continued From page 1 Based on record review, resident, family member and staff interview, the facility failed to provide showers as scheduled for 3 of 3 sampled residents reviewed for activities of daily living (ADL) (Residents # 2, 3 & 6). Findings included: 1. Resident #3 was originally admitted to the facility on 10/29/19 and was readmitted on 11/12/19 with multiple diagnoses including respiratory failure. The admission Minimum Data Set (MDS) assessment dated 10/18/19 revealed that Resident #3's cognition was intact, he had no rejection of care and he was totally dependent with bathing. The assessment under preferences for customary routine/activities indicated that it was very important for him to choose between a tub bath, shower, bed bath or sponge bath. The shower schedule for the 100 hall (rehabilitation (rehab) hall) was reviewed. The shower schedule listed Resident #3 to have a shower every Tuesday and Friday on night shift. The Nursing Assistant (NA) ADL worksheet which included the documentation of type of bath received was reviewed from 10/29/19 - 11/21/19. Four of 4 scheduled showers were not provided to Resident #3. The worksheet did not indicate that Resident #3 was provided or had received a shower on 11/1/19, 11/5/19, 11/15/19 and 11/19/19. Resident #3 was at the hospital on 11/8/19 and 11/12/19. The worksheet indicated that Resident #3 was provided a bed bath on 11/1/19, 11/3/19, 11/16/19, 11/17/19 and 11/18/19.	F 561	F561 – Self Determination A. With regards to residents #2, #3, and #6, all received a shower per their preference on 11/22/19. B. With regards to other residents having the potential of being affected in a similar manner, a 100% audit will be completed by 12/19/19 to assure that bathing preferences are documented. Our goal is to give all baths as scheduled per resident preference. Nurses and Certified Nursing Assistants (CNAs) will be in-serviced by the Director of Education or designee on or before 12/19/19 regarding resident bathing preferences and schedules. For PRN or inactive staff, said education will be given prior to their next scheduled shift. C. With regards to the monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, random audits will be conducted 3 times / week for 4 weeks by the Clinical Care Coordinator (CCC) or designee to ensure bathing preferences are documented and completed as scheduled. Concerns or issues will be addressed immediately to a supervisor for immediate action and reviewed at the next Monday – Friday stand up meeting. Quality Assurance (QA) members are present at the morning meetings. Additionally, the director of Social Service (DSS) or designee will interview 3	

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F 561	Continued From page 2 On 11/20/19 at 3:51 PM, Resident #3 was interviewed. A family member was in the room during the interview. Resident #3 stated that he was not offered any shower since he was admitted to the facility. Resident #3 stated that the facility was short of staff and he needed 2 persons assist in getting in and out of bed due to the lift. The family member added that she came to visit often and the facility was short of staff. The family member verified that the resident had not received a shower since he was admitted to the facility, but the NA provided him bed bath. The family member further stated that the resident would love to have a shower. On 11/20/19 at 4:10 PM, NA # 1 was interviewed. She stated that she started working at the facility in July 2019. She indicated that the normal staffing on the 100 hall was 3 NAs on day shift. The 100 hall was a rehab hall and most of the residents needed assistance with their ADL due to weakness, so sick or had broken bones. NA #1 revealed that the staffing most of the time was only 2 NAs. She tried her best to provide the care for her residents, however if she needed help, she had to wait until the other NA or a Nurse was available to help. NA #1 added that most of the time, residents were not provided showers as scheduled due to short of staff. On 11/20/19 at 4:20 PM, NA #2 was interviewed. NA #2 stated that the normal staffing on the 100 hall was 3 NAs and most of the time there were only 2 NAs assigned. The NA indicated that he/she could do the work but if the resident was a 2 person assist, he had to wait until a NA or a Nurse was available. There was no time to provide showers to residents when only 2 NAs on	F 561	residents or family members per week for 4 weeks to assure no concerns with bathing preferences. . Concerns or issues will be addressed immediately to a supervisor for immediate action and reviewed at the next Monday – Friday stand up meeting. Quality Assurance (QA) members are present at the morning meetings. Concerns or issues will be presented to the Quality Assurance (QA) Committee quarterly times 2 quarters. D. With regards to the person responsible for implementing the acceptable plan of correction, the facility administrator is responsible for the implementation of the above stated plan. The Director of Nursing or designee will serve as the overseer of the above stated plan in the facility administrator's absence.	

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F 561	Continued From page 3	F 561		

the floor.

On 11/21/19 at 2:53 PM, NA #3 was interviewed. She stated that Resident #3 was scheduled to have a shower on night shift. She stated that most of the residents refused to have a shower at night including Resident #3. The residents preferred to have shower during the day. NA #3 stated that she had informed the nurse that Resident #3 had refused to have a shower at night.

On 11/21/19 at 3:14 PM, the Assistant Director of Nursing (ADON) was interviewed. She stated that she was responsible for updating the shower schedule. The ADON indicated that she was not aware that Resident #3 was refusing to have shower at night.

On 11/21/19 at 4:45 PM, the Director of Nursing (DON) was interviewed. He stated he expected the NAs to provide the shower as scheduled and to notify the nurse and to document when the resident refused shower. The DON stated that Resident #3 was alert and oriented and had not refused care. The DON also added that the staffing budget for the 100 hall was to have 3 NAs on day shift however there were only 2 NAs assigned.

2. Resident #6 was admitted to the facility on 11/11/19 with multiple diagnoses including Atrial Fibrillation, Hypertension and unsteady on feet. The admission Minimum Data Set (MDS) assessment dated 11/17/19 indicated that Resident #6 had cognitive impairment and

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F 561	Continued From page 4	F 561		

needed assistance with bathing. The assessment indicated that Resident #6 had no rejection of care. The assessment under preferences for customary routine/activities indicated that it was very important for her to choose between a tub bath, shower, bed bath or sponge bath.

The shower schedule for the 100 hall (rehabilitation (rehab) hall) was reviewed. The shower schedule listed Resident #6 to have a shower every Wednesday and Saturday on day shift.

The Nursing Assistant (NA) ADL worksheet which included the documentation of type of bath received was reviewed from 11/11/19 - 11/21/19. Three of 3 scheduled showers were not provided to Resident #6. The worksheet did not indicate that Resident #6 was provided or had received a shower on 11/13/19, 11/16/19 and 11/20/19. The worksheet indicated that the resident was provided a sponge bath on 11/13/19.

On 11/20/19 at 3:51 PM, Resident 6's family member was interviewed. The family member stated that Resident #6 was not offered any shower since she was admitted to the facility. The family member added that she came to visit every day and the facility was short of staff. The family member indicated that the resident preferred to have a shower.

On 11/20/19 at 4:10 PM, NA # 1 was interviewed. She stated that she started working at the facility in July 2019. She indicated that the normal staffing on the 100 hall was 3 NAs on day shift. The 100 hall was a rehab hall and most of the residents needed assistance with their ADL due

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F 561	Continued From page 5	F 561		

to weakness, so sick or had broken bones. NA #1 revealed that the staffing most of the time was only 2 NAs. She tried her best to provide the care for her residents, however if she needed help, she had to wait until the other NA or a Nurse was available to help. NA #1 added that most of the time, residents were not provided showers as scheduled due to short of staff.

On 11/20/19 at 4:20 PM, NA #2 was interviewed. NA #2 stated that the normal staffing on the 100 hall was 3 NAs and most of the time there were only 2 NAs assigned. The NA indicated that he could do the work but if the resident was a 2 person assist, he had to wait until a NA or a Nurse was available. There was no time to provide showers to residents when only 2 NAs on the floor.

On 11/21/19 at 4:45 PM, the Director of Nursing (DON) was interviewed. He stated he expected the NAs to provide the shower as scheduled and to notify the nurse and to document when the resident refused shower. The DON also added that the staffing budget for the 100 hall was to have 3 NAs on day shift however there were only 2 NAs assigned.

3. Resident #2 was originally admitted to the facility on 10/10/19 and was readmitted on 11/4/19 with multiple diagnoses including anxiety disorder and dementia. The admission Minimum Data Set (MDS) assessment dated 11/16/19 indicated that Resident #2's cognition was intact, she had no rejection of care and she was dependent with bathing.

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F 561	Continued From page 6	F 561		

The shower schedule for the 100 hall (rehabilitation (rehab) hall) was reviewed. The shower schedule listed Resident #2 to have a shower every Monday and Thursday on day shift.

The Nursing Assistant (NA) ADL worksheet which included the documentation of type of bath received was reviewed from 10/10/19 - 11/7/19. Four of 4 scheduled showers were not provided to Resident #2. The worksheet did not indicate that Resident #2 was provided or had received a shower on 10/14/19, 10/17/19, 1021/19 and 10/24/19. The worksheet indicated that the resident was provided a sponge bath/bed bath on 10/10/19, 10/11/19, 10/12/19, 10/15/19, 10/16/19, 10/17/19, 10/19/19, 10/20/19, 10/21/19, 10/22/19 and 10/24/19.

On 11/20/19 at 1:08 PM, Resident#2's family member was interviewed. The family member stated that the resident was alert and oriented and she had been telling the family that she had not had a shower since admitted to the facility.

On 11/20/19 at 4:10 PM, NA # 1 was interviewed. She stated that she started working at the facility in July 2019. She indicated that the normal staffing on the 100 hall was 3 NAs on day shift. The 100 hall was a rehab hall and most of the residents needed assistance with their ADL due to weakness, so sick or had broken bones. NA #1 revealed that the staffing most of the time was only 2 NAs. She tried her best to provide the care for her residents, however if she needed help, she had to wait until the other NA or a Nurse was available to help. NA #1 added that most of the time, residents were not provided showers as scheduled due to short of staff.

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F 561	Continued From page 7 On 11/20/19 at 4:20 PM, NA #2 was interviewed. NA #2 stated that the normal staffing on the 100 hall was 3 NAs and most of the time there were only 2 NAs assigned. The NA indicated that he could do the work but if the resident was a 2 person assist he had to wait until a NA or a Nurse was available. There was no time to provide showers to residents when only 2 NAs on the floor. On 11/21/19 at 4:45 PM, the Director of Nursing (DON) was interviewed. He stated he expected the NAs to provide the shower as scheduled and to notify the nurse and to document when the resident refused shower. The DON also added that the staffing budget for the 100 hall was to have 3 NAs on day shift however there were only 2 NAs assigned.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		12/19/19

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F 580	Continued From page 8 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Responsible Party (RP) and Physician interview, the facility failed to immediately inform the resident's RP when there were changes in resident's medications for 1 of 3 sampled residents reviewed for notification of changes (Resident #2).	F 580	F-580 – Notification of Changes A. With regards to residents #2, their representative was informed of the medication changes at the time of survey when noted.	

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F 580	Continued From page 9 Findings included: Resident #2 was originally admitted to the facility on 10/10/19 with multiple diagnoses including anxiety disorder and dementia. Resident #2's hospital after visit summary (AVS) form dated 10/10/19 was reviewed. The form included a list of discharged medications which included Klonopin (an anti-anxiety medication) 0.5 milligrams (mgs) by mouth twice a day for 5 days. The Physician's progress note dated 10/14/19 was reviewed. Under assessment and plan, the note indicated that resident's anxiety was stable and to discontinue Klonopin after the resident completed the course of 5 days and to add Buspar (an anti-anxiety medication) 5 mgs by mouth 3 times a day and Aricept (used for dementia) 5 mgs by mouth daily. Resident #2 had doctor's orders dated 10/14/19 for Buspar 5 mgs by mouth 3 times a day and Aricept 5 mgs by mouth daily. This order was received by Nurse #7. Review of the Physician's progress notes and nurse's notes revealed no documentation that the resident's RP was informed of the changes in resident's medications. On 11/20/19 at 8:50 AM, Nurse # 7 was interviewed. She verified that she was the nurse who received the order for Buspar and Aricept on 10/14/19 for Resident #2. She also indicated that she did not inform the RP of the new orders. Nurse #7 further stated that a nursing staff was assigned to go with the physician during rounds. The nursing staff wrote the orders and	F 580	B. With regards to other residents having the potential of being affected in a similar manner, a 100% audit of the 7 days prior to survey was conducted to assure that all medication changes were communicated to residents and/or their representative. C. With regards to the monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Licensed nurses will be receive education from the Director of Education prior to 12/19/19 related to the notification of change policy. For PRN or inactive staff, said education will be given prior to their next scheduled shift. Additionally, random audits will be conducted 3 times / week for 4 weeks by the Director of Nursing (DON) or designee to ensure that residents and/or their representatives have been notified of medication changes as they occur. Concerns or issues will be addressed immediately to a supervisor for immediate communication and reviewed at the next Monday – Friday stand up meeting. Quality Assurance (QA) members are present at the morning meetings. Concerns or issues will be presented to the Quality Assurance (QA) Committee quarterly times 2 quarters. D. With regards to the person responsible for implementing the acceptable plan of correction, the facility administrator is responsible for the implementation of the above stated plan.	

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F 580	Continued From page 10 transcribed the orders in the computer. The nursing staff who accompanied the physician during rounds, should be responsible for informing the RP of the new orders. Nurse #7 also indicated that when a physician made his round and wrote new orders, he should be responsible for calling the RP and for informing the RP of new changes in the resident's medications. On 11/20/19 at 1:08 PM, Resident #2's RP was interviewed. The RP stated that he/she was not informed when the resident's Klonopin was discontinued and when Buspar and Aricept were added. On 11/21/19 at 9:05 AM, Nurse # 5 was interviewed. Nurse #5 stated that she accompanied the physician during his rounds. She wrote orders for the physician and at times transcribed orders in the computer when she had time. When she had no time to transcribe the orders in the computer, she handed the orders to the nurse assigned to the resident. Nurse #5 indicated that she had not been informing the RP of new medication orders. She stated that she didn't know that she had to inform the RP of changes in medications or new medication orders. On 11/21/19 at 1:15 PM, the Physician of Resident #2 was interviewed. He stated that he normally called the resident's RP to discuss any major issues or acute episode and not for minor issues, but he was available anytime when families requested to talk to him. He expected the nurses to notify the RP for minor changes in resident's medications like new medication orders.	F 580	The Director of Nursing or designee will serve as the overseer of the above stated plan in the facility administrator's absence.	

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F 580	Continued From page 11 On 11/21/19 at 4:45 PM, the Director of Nursing (DON) was interviewed. He stated that most of his nursing staff came from the acute care setting and were not aware of the regulations in nursing homes. He indicated that he would train all nursing staff on notification of RP when there was a change in resident's treatment/medication.	F 580		
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 record review, staff and physician interviews from the facility and vascular surgeon's office, the facility failed to initiate physician orders on admission for the treatment of diabetic ulcers and failed to provide treatment for diabetic ulcers for 21 days. This affected 1 of 3 residents reviewed for well-being (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/28/19 and discharged to the hospital on 11/17/19. His diagnoses included Diabetes with foot ulcers, chronic ulcer of right foot, Peripheral Vascular Disease (PVD) and end stage renal disease with dependence on dialysis.	F 684	F-684 □ Quality of Care A. With regards to residents #1, said resident no longer resides at the facility. B. With regards to other residents having the potential of being affected in a similar manner, full body assessments will be completed prior to 12/19/19 by CCC or designee on all residents residing in the facility to assure that identified diabetic ulcers have treatment orders in place. C. With regards to the monitoring procedure to ensure that the plan of correction is effective and that the specific	12/19/19

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F 684	Continued From page 12 Review of the Hospital records dated 10/9/19 revealed Resident #1 was admitted to the hospital with unstageable (when the base of the ulcer is not visible due to presence of slough or eschar) ulcers between his toes and bilateral feet. Areas of black eschar (dead tissue found in a full thickness wound) was present to the right and left feet. The After-Visit Summary from the hospital, dated 10/28/19, included the following wound care orders: Normal Saline and Santyl to the right second and third toe ulcers daily and place a 2x2 gauze between the 2nd and 3rd toes. The Comprehensive Nursing Assessment completed by Nurse #1 and dated 10/29/19 indicated Resident #1 had bilateral bruising to both upper arms, an abrasion to the back of his left hand with dressing intact and pressure areas to both heels with dressing intact. A review of the October 2019 Physician Orders revealed no orders present for the treatment of Resident #1's bilateral toe and heel ulcers. Review of the October 2019 Treatment Administration Record (TAR) revealed no treatment orders present for the care of diabetic ulcers to Resident #1's bilateral toes or heels. A review of the November 2019 Physician Orders revealed no orders present for the treatment of Resident #1's bilateral toe and heel ulcers. The Admission Minimum Data Set (MDS) dated 11/3/19 indicated Resident #1 was cognitively intact. He required limited assistance for bed	F 684	deficiency cited remains corrected and/or in compliance with the regulatory requirements, THE NURSE ENTERING ADMISSION ORDERS WILL ENSURE THAT ALL DIABETIC ULCERS/WOUNDS HAVE TREATMENT ORDERS IN PLACE. THE CLINICAL CARE COORDINATOR WILL PROVIDE A SECOND CHECK OF ALL ADMISSION ORDERS ENTERED INTO THE E-MAR SYSTEM AND BE RESPONSIBLE TO ENSURE THAT TREATMENT ORDERS HAVE BEEN ENTERED AND INITIATED. Licensed nurses will be in-serviced by the Director of Education or designee by 12/19/19 that identified diabetic ulcers have treatment orders in place. Also, CNAs will be in-serviced prior to 12/19/19 by the Director of Education or designee that they should notify the nurse of any new skin issues and document notification in their Point Of Care notes. For PRN or inactive staff, said education will be given prior to their next scheduled shift. Additionally, random audits will be conducted 3 times / week for 4 weeks by the Director of Nursing (DON) or designee to ensure that diabetic ulcers have treatment orders in place and being completed. Concerns or issues will be addressed immediately to a supervisor for immediate correction and reviewed at the next Monday □ Friday stand up meeting. Quality Assurance (QA) Committee members are present at the morning meetings. . Concerns or issues will be presented to the Quality Assurance (QA) Committee quarterly times 2 quarters.	

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F 684	Continued From page 13 mobility and personal hygiene; extensive assistance with dressing and was dependent on staff for toileting, bathing and transfers. A diagnosis of nonpressure chronic ulcer of other part of right foot with unspecified severity was marked. Section M of the MDS assessment revealed Resident #1 was admitted with diabetic foot ulcer and skin tear and had an application of dressing other than to feet. Resident #1's medical record included a lab report dated 11/4/19, with normal limits for the white blood cell count (an elevated count could signify infection). A review of the Care Area Assessment (CAA) Summary dated 11/8/19 indicated Resident #1 had no areas of pressure noted on admission or during the look back period. Per the hospital note he had diabetic ulcers to his feet and a skin tear to his hand. A review of the care plan dated 11/8/19 revealed the following areas of focus, in part: - At risk for pain related to diabetic ulcers. - At risk for skin breakdown related to end stage renal disease and diabetic ulcers. Review of the November 2019 TAR's indicated Resident #1 had skin assessments completed on 11/4/19 and 11/11/19 with no new skin problems identified. No further information was found regarding the skin assessments. A lab report dated 11/11/19 revealed Resident #1's white blood cell count was within normal limits. Resident #1's medical record included a Nursing	F 684	D. With regards to the person responsible for implementing the acceptable plan of correction, the facility administrator is responsible for the implementation of the above stated plan. The Director of Nursing or designee will serve as the overseer of the above stated plan in the facility administrator's absence.	

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Progress Note written by Nurse #6 and dated 11/17/19. The note revealed bandages to both feet were soiled and once they were removed multiple wounds were observed to bilateral feet to include the toes and heels. Feet were cool to the touch and lower legs were discolored. Unstageable wounds were noted to both the left and right foot as well as a Stage 3 (full thickness skin loss) ulcer to the right 4th toe. All areas were cleansed with Normal Saline, painted with Betadine and wrapped in a clean dressing. Gauze was placed between toes and a foam cup was applied to bilateral heels for protection. The on-call practitioner was notified and provided an order to send Resident #1 to the Emergency Room for evaluation.

The November 2019 TAR indicated treatment orders for the diabetic ulcers to Resident #1's heels and toes starting on 11/17/19 written by Nurse #6, as follows:
- Paint unstageable wound to left lateral big toe with Betadine every day and as needed.
- Paint unstageable wound to the left lateral 2nd toe with Betadine every day and as needed.
- Paint unstageable wound to the left lateral 3rd toe with Betadine every day and as needed.
- Paint Stage 3 wound to left lateral pinkie toe with Betadine every day and as needed.
- Paint left heel with Betadine every day and as needed.
- Paint unstageable wound to the right 2nd toe with Betadine every day and as needed.
- Paint unstageable wound to right lateral big toe with Betadine every day and as needed.
- Paint unstageable wound to bottom of right big toe with Betadine every day and as needed.
- Paint unstageable wound to right 3rd toe with Betadine every day and as needed.

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F 684	Continued From page 15 - Paint unstageable wound to right pinkie toe with Betadine every day and as needed. - Paint right heel with Betadine every day and as needed. - After Betadine has been applied and dried, separate each toe with dry gauze and wrap bilateral feet with Kerlix daily and as needed. - Apply heel protectors to bilateral feet. Change daily and as needed. - Assess bilateral feet for pedal pulses daily and notify physician if any changes or abnormalities are noted. - Assess wounds daily when providing wound care. Notify physician if any changes are noted or foul o odor/drainage is present. Review of the hospital records dated 11/17/19 to 11/18/19 revealed Resident #1 was brought to the Emergency Room with reports of discolored toes that were noted after having dressings changed at the facility. Areas of necrosis present to the right 2nd toe with ulcers in between toes. He had no evidence of fever or elevated white blood cell count. A computed tomography angiography (CTA) was performed and showed evidence of occlusion to the right peroneal artery (an artery running along the back part of the leg to the heel) and right tibial arteries (two arteries of the lower leg) appear to be patent to the level of the ankle. Vascular surgery was consulted and completed an assessment on 11/18/19. Recommendation was to proceed with an angiogram of the right lower extremity with possible right transmetatarsal amputation. Resident #1 was currently in the hospital at the time of the survey.	F 684		

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On 11/20/19 at 2:37pm a phone interview occurred with the Medical Director who was familiar with Resident #1. He recalled assessing him on 2 different occasions due to his heart concerns and the use of a Life Vest (a personal defibrillator worn by someone who is at risk for sudden cardiac arrest). The physician indicated Resident #1 had no complaints of foot pain or of not having his dressings changed and he was not aware the treatments had not been completed. He further stated he would have expected the treatments to be completed as ordered. The Medical Director stated due to Resident #1's chronic PVD, diabetes and the necrotic tissue present to his feet on admission, the damage was irreversible and progression towards a possible amputation was possible in the future.

On 11/20/19 at 2:48pm a phone call was placed to Nurse #2 who completed the skin assessment on 11/11/19. A message was left for a return call.

A phone interview was conducted with the Clinical Coordinator on 11/20/19 at 3:02pm. He stated the day Resident #1 was admitted to the facility, he handed the admission orders over to someone else due to the need to leave for a sick child and did not review them before he exited. Normally he reviewed the discharge orders to ensure all orders were captured but did not recall doing so for Resident #1. The Clinical Coordinator went on to say he was not aware Resident #1 had diabetic foot ulcers but would have expected the nurses who completed the skin assessments to identify, obtain treatment orders and report to him for wound care follow-up. The Clinical Coordinator oversaw the wound care for the rehab residents and could not recall receiving any information regarding diabetic foot ulcers for Resident #1.

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Nurse Aide (NA) #1 was interviewed on 11/20/19 at 3:25pm and indicated she was familiar with Resident #1 and had provided him with bed baths during his stay. She could recall seeing dressings to his feet but nothing on his toes that were dark in color. She was unable to recall drainage or odor noted during personal care or Resident #1 with complaints of pain to his feet.

A phone interview occurred with Nurse #4 on 11/20/19 at 4:50pm. She could not recall seeing any types of ulcers or discolorations to Resident #1's feet at the time of the skin assessment completed on 11/4/19.

On 11/20/19 at 5:45pm a phone interview was conducted with Nurse #3. He recalled entering Resident #1's admission orders on 10/28/19 into the Electronic Medical System but did not recall seeing the wound care orders. Stated normally he only entered the medications, diet and allergies and would not have entered the wound care orders. Nurse #3 went on to say when the nurse completing the admission assessment completed the skin assessment and found any issues, they would then look for any wound care orders on the discharge paperwork or initiate treatment orders per the facility standing orders.

A telephone interview occurred with Nurse #5 on 11/21/19 at 9:29am. She worked 6pm to 6am and was familiar with the resident. Nurse #5 could not recall Resident #1 with any complaints of pain to his feet, seeing any dressings to his feet and was not assigned to participate with skin assessments, dressing changes or showers as they occurred on the 6am to 6pm shift. She further stated when doing an admission

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assessment and a wound was identified Licensed Practical Nurses (LPN's) were told to describe the wound in the narrative note but to leave a note for the Clinical Coordinator who would then do a wound assessment and initiate wound care orders, as LPN's were not allowed to stage wounds or enter into the facility wound tracker.

A phone call was placed to Nurse #2 on 11/21/19 at 9:44am. A message was left for a return call that was not received during the survey time.

On 11/21/19 at 9:48am a phone interview was held with Nurse #6. She was the weekend supervisor and familiar with Resident #1. She explained on 11/17/19 she was asked to evaluate wounds identified on Resident #1, that she was unaware he had. Kerlix wrap was present to bilateral feet with a date of 10/31/19 and no initials. When the Kerlix wrap was removed dried dressings were present to both heels and toes to both feet. Normal saline was used to soak the dressings off which revealed dark colored areas to bilateral heels and toes to both feet with minimal drainage and a foul odor. She further stated a review was made of the orders in the Electronic Medical Records which did not reveal any current orders for treatments, and she did not look at the hospital discharge orders. The resident had a normal temperature, but she felt due to the nature of the wounds an assessment at the Emergency Room was indicated. An order was obtained from the on-call practitioner and the resident and emergency contact were made aware of the transfer.

On 11/21/19 at 10:03am an interview occurred with the interim Administrator and Director of Nursing (DON). The DON explained several staff

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members had been trained on inputting admitting orders into the Electronic Medical Records (EMR) and Nurse #3 was one of them. Nurses were expected to put in all discharge orders to include wound care and the clinical coordinator should have reviewed them to ensure all orders had been transcribed correctly and completely. He felt it was a lack of education for missing the wound care orders at the time of admission but was unable to state why the diabetic ulcers were not identified with scheduled skin assessments or until 11/17/19. The interim Administrator stated as of 11/21/19 a plan of correction had been initiated for the failure to assess wounds and provide treatments timely. The plan of correction will include, in part: skin audits, clinic record audits and staff education. He further indicated an Initial Allegation Report and 5 working day investigation would be completed and sent in.

A phone interview was completed with Nurse #1 on 11/21/19 at 10:39am. She recalled completing the comprehensive nursing assessment when Resident #1 was admitted. She recalled Resident #1 having a foam dressing to his heels that she peeled back, looked at the heels and replaced. No odor was noted, and his toes were dark in color. She went on to say as an LPN she has been instructed to place a note for the Clinical Coordinator regarding wounds found on admission so he can assess and initiate treatment. Nurse #1 stated she left a note in the door of the Clinical Coordinator's office alerting him to the wounds that were present and the need for follow-up. She went on to explain that one nurse was responsible for putting the orders into the EMR and another completed the admission assessment to include assessing the skin. They have a high number of admissions

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daily and are still responsible for completing medication administration and treatments to other residents in a timely manner. She stated the nurse responsible for orders should have included labs, wound care, etc., but since she was not assigned to putting in the orders, she would not have looked at the discharge orders for wound care.

On 11/21/19 at 11:41am a phone interview was held with the Vascular Surgeon assisting with the care of Resident #1 currently in the hospital. He felt the diabetic ulcer to the right foot was not reversible as the diabetes affected the small vessels of the toes with the result of dying digits. He stated it was a natural course of the disease and an amputation was possible in the future as the toes were already necrotic at the time of admission to the facility on 10/28/19. He did not feel the lack of dressing changes increased the chance of amputation or necrosis but instead, would have made staff aware of the severity of changes as they occurred. He further stated the resident was not symptomatic of infection at the time of admission on 11/17/19 or currently. A right foot transmetatarsal amputation had been suggested but Resident #1 was undecided.

An interview occurred with the Clinical Coordinator on 11/21/19 at 1:45pm. He oversaw the wound care for the rehab unit. If wounds were present at the time of admission, a note was left for him and he followed up the same or next day. He could not recall receiving any written information regarding Resident #1's diabetic ulcers. The Clinical Coordinator stated Nurse #3 had been trained on putting in discharge orders into the EMR, should have included the wound care orders and could not speculate as to why

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F 684	Continued From page 21 that did not occur. Normally he would have gone back over the orders to ensure they were transcribed correctly and completely but a family emergency occurred, and he did not do so. He further stated he felt staffing played a big part in the wound care orders being missed as the number of admits per day is high and the nurses are also trying to complete medication administration and treatments in a timely manner as well as the admission assessment and inputting the orders. Resident #1 came in late that afternoon between 4pm to 5pm and was 1 of 4 admissions to that hall. The Assistant Director of Nursing (ADON) was interviewed on 11/21/19 at 3:45pm and stated she typically reviewed the new admission and readmission orders to verify they were transcribed correctly and completely within 24 to 48 hours of admission. She was unsure why Resident #1's orders were not verified or reviewed only to say she was off that day, there were 7 admissions to the facility, and it was an oversight. An interview occurred with the DON on 11/21/19 at 3:45pm. The DON was unable to state why the orders not being transcribed correctly, treatments did not occur, or the diabetic ulcers were not identified for 21 days. He could only state it was his expectation for admission orders to be transcribed completely and correctly and resident's skin to be reviewed completely with any abnormalities reported immediately.	F 684		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		12/19/19

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F 725	Continued From page 22 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 record review and family member, Physician and staff interviews, the facility failed to provide sufficient nursing staff to initiate physician's orders for treatment of diabetic ulcers and to provide treatment to diabetic ulcers for 1 (Resident #1)of 3 sampled residents reviewed for well -being and failed to provide showers for 3 (Residents # 2, #3 & #6) of 3 sampled residents reviewed for activities of daily living (ADL). Findings included:	F 725	F-725 □ Sufficient Nursing Staff A. With regards to residents #1, said resident no longer resides at the facility. With regards to residents #2, #3, and #6, all received a shower per their preference on 11/22/19. B. With regards to other residents having the potential of being affected in a similar manner, a 100% audit of residents will be	

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F 725	Continued From page 23 This tag is cross-referred to: F684: Based on record review, staff and physician interviews from the facility and vascular surgeon's office, the facility failed to initiate physician orders on admission for the treatment of diabetic ulcers and failed to provide treatment for diabetic ulcers for 21 days. This affected 1 of 3 residents reviewed for well-being (Resident #1). F561 - Based on record review, resident and staff interview, the facility failed to provide showers as scheduled for 3 of 3 sampled residents reviewed for activities of daily living (ADL) (Resident # 2, 3 & 6). On 11/21/19 at 3:45 PM, the Director of Nursing (DON) was interviewed. The DON stated that the average staffing on the 100 hall was 2 nurses and 2 NAs but was budgeted for 3 NAs. He further stated that there would be a Job Fair on 11/21/19 with hopes of hiring more NAs for the 100 hall.	F 725	completed by 12/19/19 to assure that bathing preferences are documented. Also, a full body assessment of all residents will be completed prior to 12/19/19 to assure that identified diabetic ulcers have treatment orders in place. Nurses and CNAs will be in-serviced by the Director of Education or designee on or before 12/19/19 regarding resident bathing preferences and schedules. C. With regards to the monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements,THE NURSE ENTERING ADMISSION ORDERS WILL ENSURE THAT ALL DIABETIC ULCERS/WOUNDS HAVE TREATMENT ORDERS IN PLACE. THE CLINICAL CARE COORDINATOR WILL PROVIDE A SECOND CHECK OF ALL ADMISSION ORDERS ENTERED INTO THE E-MAR SYSTEM AND BE RESPONSIBLE TO ENSURE THAT TREATMENT ORDERS HAVE BEEN ENTERED AND INITIATED. Random audits will be conducted 3 times / week for 4 weeks by the Clinical Care Coordinator (CCC) or designee to ensure bathing preferences are documented and completed as scheduled. Additionally, random audits will be conducted 3 times / week for 4 weeks by the Director of Nursing (DON) or designee to ensure that wounds have treatment orders in place and being completed. Nurse and CNA assignments will be reviewed and adjusted as necessary to better meet the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 24	F 725	needs of each resident. A job fair was conducted on campus on November 21, 2019 to help supplement our staff. The Director of Social Service or designee will interview 3 alert and oriented residents per week for 4 weeks to ensure their needs have been met. Concerns or issues will be addressed immediately to a supervisor for immediate correction and reviewed at the next Monday □ Friday stand up meeting. Quality Assurance (QA) Committee members are present at the morning meetings. . Concerns or issues will be presented to the Quality Assurance (QA) Committee quarterly times 2 quarters. D. With regards to the person responsible for implementing the acceptable plan of correction, the facility administrator is responsible for the implementation of the above stated plan. The Director of Nursing or designee will serve as the overseer of the above stated plan in the facility administrator's absence.	