STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-OUTER BANKS	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 The survey team entered the facility on 11/28/16 to conduct a complaint survey and exited on 11/30/16. Additional information was obtained on 12/08/16. Therefore, the exit date was changed to 12/08/16. Substandard quality of care was identified at F 224 and at F 314.	F 000		
F 224 SS=H	483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (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, physicians, and staff interview, the facility neglected to identify and remove wound packing left inside a sacral pressure ulcer for 1 of 6 residents (Resident #11) investigated for wound care which resulted in the decline of the sacral pressure ulcer and development of an abscess. Findings included: Resident #11 was admitted to the facility on 2/15/16 with diagnoses which included hypertension, dementia, muscle weakness (generalized), and neuromuscular dysfunction of bladder. Review of Resident #11's care plan initiated 4/29/16 revealed the resident was care planned for a pressure ulcer on the sacral area. The goal was that the resident's pressure ulcer would decrease in size by next review. The interventions were to measure and record descriptions of the	F 224	Affected Resident: Resident #11 was treated by Dr. Jenkins on 10/06/16 and packing was removed. Resident continues to reside at the facility with no further effects. Potentially Affected: For those residents receiving wound care on 10/06/16 Director of Nursing assessed all 16 wounds in facility to ensure residents didn□t have fine mesh gauze for packing, then DON reviewed current treatment orders for all wounds in the facility and no resident had an order to receive wound packing for treatment plan. Measures/Systemic changes: Director of Nursing and Administrative nurse educated all staff on Abuse policy: Education included: Prevention and Reporting of Abuse, Neglect, Misappropriation of resident property, and exploitation; signs and symptoms of abuse, neglect, misappropriation of	12/26/16

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

Electronically Signed | 12/26/2016

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F 224	Continued From page 1 area, location, and size weekly, and to treat the area per physician orders. Review of the resident's quarterly minimum data set dated 5/12/16 revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 2.5 centimeters by 2.0 centimeters. Review of a physician's order dated 7/18/16 revealed the Medical Director signed an order to cleanse the sacral pressure ulcer with wound cleanser, soak a fine mesh gauze with normal saline, and gently pack the wound and cover with a dry dressing secured with tape. Record review of the resident's Treatments Administration History for the dates of 7/18/16 - 7/22/16 revealed Resident #11 was documented to have received sacral wound care. According the documentation, the wound was packed with a fine mesh gauze, soaked with normal saline, covered with dry dressing, and secured with tape on 7/18/16, 7/19/16, 7/20/16, and 7/21/16 by Treatment Nurse #1 per physician's orders. Review of the weekly pressure ulcer documentation dated 7/21/16 at 3:23 PM signed by Treatment Nurse #1 revealed the sacral pressure ulcer was recorded as an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining (meaning the wound continued under intact skin) was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. 100% of the wound bed was documented to be granulation tissue (new healthy tissue growth that occurs during the wound healing process). Pressure ulcer care was	F 224	resident property and exploitation; How/When & to Whom to report suspected cases of abuse, neglect, misappropriation of resident property and exploitation & reasonable suspicion of crimes. Director of Nursing and Administrative Nurse educated all licensed and non-licensed nursing staff on pressure ulcer prevention-interventions, communication, risk factors, and preventative measures. Director of Nursing and Administrative nurses educated all nurses on pressure ulcer evaluation for avoidability and unavoidability, risk factors and communication with physician; packing wounds/measuring packing- number of gauze removed and packed with, measuring length of rope style packing, and for treatments requiring packing add measurements in treatment record to record that the amount of packing placed in the wound is the same amount of packing removed; if dressing removed at physician□s office, ensure office gives you amount or measurement of packing for documentation purposes. All treatment nurses were re-educated by Administrative nurse on wound care policies, evaluated and completed skills checklist- proper treatment options, pain management, evaluating treatment effects, identification co-morbid conditions, lab data review, multidisciplinary approach to prevention, documentation-weekly tracking, proper application of dressings, recognizing PVD, measuring pressure ulcers, staging,	

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F 224	Continued From page 2 documented as performed. Review of a physician's order dated 7/22/16 revealed the Medical Director signed to change the sacral pressure ulcer wound care order to hydrocolloid (a dressing to promote wound healing) dressing to be placed over the sacral pressure ulcer, checked every day, and changed every three days and as needed. The order to pack the wound with normal saline soaked fine mesh gauze was discontinued on this date. Review of the weekly pressure ulcer check dated 7/27/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound. Review of the weekly pressure ulcer check dated 8/4/16 revealed the wound was documented to be an unstageable pressure ulcer, 1.0 centimeters by 1.0 centimeters with no depth. Undermining was noted at 12 o'clock 1.0 centimeters, 3 o'clock 2.0 centimeters, 6 o'clock 1.0 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound. Review of a wound care physician's consult note dated 8/11/16 revealed the resident was assessed at a doctor's office by Physician #1. Physician #1 discussed options with the family for continued treatment. The order for the	F 224	surgical wound evaluation, documentation. Any new hire nurse designated for treatments will have onsite education provided by wound nurse. Any new employee will be educated on this information upon hire during orientation. The facility is working on a contract with outside wound physician with VOHRA services to evaluate and treat wounds in the facility via telemedicine. Monitoring: A monitoring tool was developed to monitor wounds requiring packing and ensuring nurses are measuring packing for wounds and documenting this information in the electronic health record. The Director of nursing or Administrative nurse to conduct 100% audit for residents receiving wound packing to ensure gauze or rope is being measured and documentation of packing placed and removed on treatment record in the electronic health record (E.H.R.) -weekly for 16 weeks, then every two weeks for sixteen weeks, then monthly for four months. All audits will be brought to QAPI meeting by the DON for review. Continued audits will be determined based on results of prior months of audits.	

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F 224	Continued From page 3	F 224		

hydrocolloid dressing was continued as a result of the consult. There was no documentation of fine mesh gauze observed in the wound.

Review of the resident's quarterly minimum data set dated 8/11/16 revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 1.5 centimeters by 1.5 centimeters with no depth. There was no documentation of fine mesh gauze observed in the wound.

Review of the weekly pressure ulcer check dated 8/19/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound.

Review of the weekly pressure ulcer check dated 8/25/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.3 centimeters by 0.3 centimeters with no depth. The wound was 100% granulation tissue. There was no documentation of fine mesh gauze observed in the wound.

Review of the weekly pressure ulcer check dated 8/29/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% epithelial tissue. There was no documentation of fine mesh gauze observed in the wound.

Review of the weekly pressure ulcer check dated 9/5/16 revealed the wound was documented to be a stage II pressure ulcer, 0.3 centimeters by

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0.3 centimeters with no depth. The wound was 100% epithelial tissue. There was no documentation of fine mesh gauze observed in the wound.

Review of the weekly pressure ulcer check dated 9/13/16 revealed the wound was documented to be a stage II pressure ulcer, 0.2 centimeters by 0.2 centimeters with no depth. The wound was 100% epithelial tissue. There was no documentation of fine mesh gauze observed in the wound.

Review of the weekly pressure ulcer check dated 9/26/16 revealed the wound was documented to be a stage I pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% epithelial tissue. There was no documentation of fine mesh gauze observed in the wound.

Review of Resident #11's progress note dated 10/5/16 revealed during the routine dressing change to sacral pressure ulcer, Treatment Nurse #2 noted a large 6 centimeters by 6 centimeters soft fluid-filled packet at the wound. The skin color at the wound was noted to be red. Treatment Nurse #2 notified the Medical Director and an appointment was scheduled with Physician #1 the next day.

Review of a wound care physician's consult note dated 10/6/16 revealed Physician #1 assessed Resident #11's pressure ulcer at his doctor's office. The assessment revealed the sacral ulcer had increased pain and redness. A large abscess was noted to be 12 centimeters by 12 centimeters by 5 centimeters on the resident's sacrum. Physician #1 performed an incision and drainage

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of the abscess and discovered 6 inches of fine mesh gauze in the subcutaneous tissue.

Review of Resident #11's most recent Minimum Data Set dated 11/13/16 revealed the resident had a stage III pressure ulcer.

Review of Resident #11's most recent weekly pressure ulcer check dated 11/28/16 revealed the resident's sacral pressure ulcer measurements were 2.5 centimeters by 1.5 centimeters by 0.7 centimeters.

Review of the resident's active diagnoses as of 11/30/16 revealed the resident's diagnoses included cutaneous abscess of buttock, cellulitis of buttock, and pressure ulcer of the sacral area.

During a telephone interview on 11/30/16 at 12:20 PM, Physician #1 stated when he observed Resident #11 on 8/11/16 he did not observe any fine mesh gauze in the wound. He further stated he only continued the ordered hydrocolloid dressing following this visit. Physician #1 stated that the facility placed a fine mesh gauze in the pressure ulcer on the sacrum intentionally or unintentionally at some point while the wound was still open. He further stated the gauze was either lost or forgotten about and the wound healed over the gauze. Physician #1 further stated that he had no doubt the gauze was the cause of the abscess that Resident #11 developed and he treated on 10/6/16. Physician #1 stated that someone in the facility's staff had made a mistake and either not followed the order correctly or had lost a gauze in the wound somehow. He further stated that the fine mesh gauze should not have been left in the wound.

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During an interview on 11/30/16 at 2:45 PM Treatment Nurse #2 stated Resident #11's sacral pressure ulcer was first identified on 4/27/16. Treatment Nurse #2 stated that she was not the wound care nurse at that time. She stated that when she began care of Resident #11's sacral pressure ulcer, the skin was healing and intact. She stated that the wound care orders at that time were for hydrocolloid dressing changed every three days and as needed. She further stated she had never packed the wound prior to it being reopened 10/6/16. Treatment Nurse #2 stated that she felt the resident had progressed well and she believed care was about to be discontinued, but on 10/5/16 she changed the resident's dressing and observed a fluid pack around the wound. She stated she alerted the medical director and the resident was sent to Physician #1's office the next day for wound care. She added a piece of wound packing in the resident's pressure ulcer was found by Physician #1. Treatment Nurse #2 stated that when changing a hydrocolloid dressing, she would inspect the wound for healing and make measurements. She further stated that when she began to care for the resident's wound full time, the wound had already closed and the skin was intact so she was unable to inspect inside the wound.

During an interview on 11/30/16 at 5:22 PM the Director of Nursing (DON) stated she that she expected the wound would be inspected by the wound care nurse upon return to the facility from the doctor's visit with new orders. She further stated her expectation was anything noted foreign or unusual in the wound during the assessment to be documented and reported. The Director of Nursing stated the nurses informed her of the

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F 224	Continued From page 7 abscess found on 10/6/16. The DON stated she believed the abscess could have caused harm to the resident, but did not know if the abscess was a result of the gauze being left in the resident. During an interview on 11/30/16 on 5:57 PM Treatment Nurse #2 stated she covered the Treatment Nurse #1's shift on 7/15/16 and then again on 7/23/16. During these dates the hydrocolloid dressing was ordered. She stated she did not remember ever placing fine mesh gauze in the resident's wound and that she checked the dressing each day and performed the weekly wound assessments as ordered. She further stated that due to the abscess Resident #11 had developed, the resident had increased reports of pain to the area. She stated that the resident was receiving pain medications for the increased pain. Treatment Nurse #1 no longer worked for the facility. Attempts were made to interview Treatment Nurse #1 with no return calls received.	F 224		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (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. (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. (f)(3) The resident has a right to interact with	F 242		12/26/16

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F 242	Continued From page 8 members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to honor the personal preference for time to get up for 1 of 4 sampled residents (Resident #1) and failed to honor the resident's wishes for a shower and toilet use for 1 of 4 sampled residents (Resident #3). Findings included: 1. Resident #1 was readmitted to the facility on2/19/16 with diagnoses which included multiple sclerosis, chronic pulmonary embolism, sepsis and chronic pain syndrome. The quarterly Minimum Data Set dated 11/16/16 indicated Resident #1 was cognitively intact and required extensive assistance for activities of daily living. He was totally dependent on one staff member for bathing. He had functional limitations on both sides of his lower extremities and used a wheel chair for mobility. He was independent with locomotion after help with set up. A review of the care plan last reviewed on 5/10/16 revealed Resident #1 had limited ability to bathe himself due to multiple sclerosis. The interventions included he required one person to provide assistance for bathing. Resident #1's preference for rising early had not been addressed on the care plan. On 11/29/16 at 10:00 AM Resident #1 was observed lying in bed. The resident stated he preferred to get up around 7:00 AM, but staff (unidentified by resident) had told him there was not enough staff to get him up at that time. Resident #1 identified Nursing Assistant (NA) #3	F 242	Affected Resident: Resident #1 care plan has been updated with preference of rising early around 7am. Resident #3 discharged home 10/28/16. Potentially Affected: For those residents who may be affected, the Administrative nurse or designee interviewed 100% of current residents as 12/23/2016. The interview included the following preference questions: bed bath or showers, time of day for bath or shower, all activities or you choose activities to attend, go to bed early or late, get up early or late, toileting, location for meals, community activities outside facility. For those residents who were identified as having preferences, their resident profiles were updated by MDS nurse and Administrative nurses to reflect resident preferences. The resident profile is available to all staff in the electronic health record. The resident profile is the means by which staff are notified of resident care needs/preferences. For all new admissions to the facility, the resident profile will be completed by licensed staff on the day of admission and ongoing to address any preferences for care. In addition, an activity assessment will be conducted on all residents on admission and quarterly and any resident preferences will be updated on an	

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F 242	Continued From page 9 as getting him out of bed at his preferred time. During an interview with Treatment Nurse #2 on 11/30/16 at 11:35 AM she stated Resident #1 preferred to be out of bed early and that he required 2 persons and the lift to get him out of bed. She stated in the past he was up by 6:00 AM but not now. She was unsure of why he was not up early because he had always wanted to be out of bed early. Resident #1 was interviewed on 11/30/16 at 11:45 AM. He stated he had just received a shower. He reported that when he gets out of bed depends on which staff are working. He stated he preferred to get out of bed early and the facility staff were aware of his preference. He stated he was not willing to get up at 3:00 AM when the staff said they could get him up. Resident #1 also stated when NA #3 was working he got up per his preference but otherwise he was at the mercy of the NAs who were working. An interview was held with Nursing Supervisor (NS) #1 on 11/30/16 at 2:00 PM. She stated she was aware Resident #1 liked to be up early, but had been told by the 11:00 PM to 7:00 AM shift they were unable to get him up at his preferred time due to only one NA and one nurse working on the hall. NS #1 added the NAs who worked with Resident #1 had told her that during his preferred time to get out of bed, they were doing their last rounds and the nurses were giving medication. NS #1 stated she had suggested the NAs start their rounds 15 minutes earlier in order to accommodate Resident #1, but had been told no by the NAs. The NS confirmed the facility had been fully staffed on 11/29/16 during the 7:00 AM to 3:00 PM shift and had no reason for Resident #1 to have still been in bed at 10:00 AM. During an interview with NA #3 on 11/30/16 at 2:37 PM he stated he was unsure how the NAs	F 242	ongoing basis. Measures/Systemic Changes: Administrator educated department heads on grievance reporting form for any concerns and attaching in service sheet for any education provided to resolve grievance on 12/20/2016. Director of Nursing and Administrative Nurses educated all staff in each department on following residents profile for preferences, where to locate information and who can assist with looking up information, and if a preference is voiced to write up on a grievance reporting form to ensure profile is updated 12/20-12/23/2016. For new admissions, all resident profiles will be reviewed in morning clinical meeting to ensure that any preferences for care are added to resident profiles. Monitoring: A monitoring tool was developed to monitor and ensure resident□s right to make choices are being honored. The audit tool will reflect a space to list resident names whom are being interviewed and ask if staff are honoring their preferences for Activities of Daily Living; bed bath/shower, meals location, wake-up time, bedtime, toileting, and Activities with a yes or no response. If a no is reflected then preferences will be obtained and placed on profile and careplan. DON or Administrative Nurse to conduct a random sample of 10% of residents to ensure preferences are being honored weekly for 8 weeks, then 10% of	

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F 242	Continued From page 10 working the 11:00 PM to 7:00 AM shift worked to get their job done and that they have their own way of doing things. NA #3 reported he knew the Resident #1 cared about when he got out of bed. NA #3 said he took it into consideration when Resident #1 wanted to get out of bed so he would adjust his break and meal schedule to ensure Resident #1 was out of bed on time. NA #3 also stated he went to the resident's room at 5:00 -5:30 AM and offered to get him up. NA #3 reported that Resident #1 would occasionally say no but most of the time said yes. NA #3 reported he only worked 2 days per week. On 11/30/16 at 3:45 PM the Director of Nursing (DON) reported she did not know Resident #1 wanted to get up early. She stated Resident #1 would wake up at 6:45 AM but that was at the change of shift so it was difficult to preform care at that time. She stated she became aware of Resident #1's preference to be out of bed early when it was verbalized during a staff meeting 2 weeks ago. 2. Resident #3 was admitted on 7/5/16 with diagnoses that included fracture of the shaft of the left fibula, generalized muscle weakness, chest pain, depression, hypertension and anemia. Progress notes, dated 7/5/16 at 1:55 PM indicated the resident was status post fall with left tibula and fibula fracture. The resident had a full length cast to mid-thigh with toes exposed. The 7/12/16 Admission Minimum Data Set (MDS) indicated Resident #3 required extensive assistance for toilet use, was frequently incontinent of bowel and bladder and no toileting program had been attempted. Choosing the type of bath was coded as not very important to the resident. Review of nurse's notes revealed Resident #3's cast was removed on 8/2/16.	F 242	residents every two weeks for 8 weeks then 10% of residents monthly for 2 months. DON will bring audit results to QAPI meeting. Continued audits will be determined based on results of prior month of audits.	

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PEAK RESOURCES-OUTER BANKS	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

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On 8/9/16, Resident #3 filed a grievance related to not being transferred to the toilet when she asked and also had concerns about bathing. The Director of Nursing (DON) at the time documented she spoke with the Nursing Assistant (NA) and the NA stated baths were given. The resident was advised staff would be instructed on the resident's preference for toileting. The form did not list the names of staff that were interviewed about the resident's choices for toilet use and bathing.

The quarterly MDS, dated 10/11/16, revealed Resident #3 was cognitively intact with no rejection of care recorded. The MDS indicated the resident required extensive assistance for bed mobility and transfer, dressing, toilet use and personal hygiene. The resident was coded as frequently incontinent of urine and bowel with no toilet plan or retraining program attempted.

The care plan, reviewed 10/19/16, did not identify Resident #3 refused care and did not identify incontinence or type of bath preferred.

Resident #3 was discharged home on 10/28/16. Review of the shower record revealed Resident #3 was documented as receiving 5 showers during her facility stay.

The Activity Director (AD) was interviewed on 11/30/16 at 8:33 AM. She stated she had worked with Resident #3 as a NA. The AD stated showers were scheduled twice weekly for residents. If the resident preferred a different schedule, the nurse would be notified and adjustments made if possible. The AD stated Resident #3 enjoyed showers and had no history of refusing care.

The Rehabilitation Department Manager (RM) was interviewed on 11/30/16 at 1:36 PM. The RM stated she had evaluated Resident #3 and found her to be alert and oriented. She added

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while Resident #3 had physical deficits, she had been able to walk with assistance in her room and able to transfer from the chair to the toilet with supervision using a sliding board. The RM added the resident had expressed multiple concerns about toileting and bathing during therapy and she had done a lot of staff training regarding transfer of Resident #3 using the sliding board. The resident had reported staff told her to void in her brief instead of using the toilet. The RM stated due to the resident's severe osteoporosis and high risk of fractures, she thought staff were fearful to use the sliding board for transfers.

The Physical Therapy Assistant (PTA) was interviewed on 11/30/16 at 1:49 PM. The PTA had worked with the resident and described Resident #3 as alert, oriented and able to express her needs. The PTA reported Resident #3 had told therapy staff nursing staff would tell her to void in her brief rather than toilet her. The PTA stated she had filled out several concern forms related to toilet use. She added it was her understanding that prior to Resident #3's discharge home, the toileting issue had been resolved.

Nursing Supervisor (NS) #1 was interviewed on 11/30/16 at 2:00 PM. She acknowledged showers scheduled twice weekly for residents, but added that when showers were not given, residents received bed baths. She stated she, along with the other nursing supervisors, were responsible for making sure residents received showers. The NS acknowledged she remembered Resident #3 but was unaware of any problems with her receiving toileting and showers per her preference. The NS acknowledged a staff in-service had been held on showering residents, but could not recall any

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in-service provided to staff regarding Resident #3's preference for toilet use.
On 11/30/16 at 2:12 PM, Nurse #1 was interviewed. The nurse had worked with and remembered Resident #3. She described the resident as alert, oriented, able to express her needs, but at times could be forgetful. The nurse was unaware of any times Resident #3 refused care. She stated at a minimum residents should be offered showers twice weekly and was unaware Resident #3 had only received 5 showers during her facility stay. Nurse #1 added she had been unaware of any toileting issues involving Resident #3.
NA #3 was interviewed on 11/30/16 at 2:37 PM. He stated Resident #3 was alert, oriented, could tell staff when she needed to toilet and enjoyed showers. He stated when she had the cast on her leg, Resident #3 used a bed pan. When she became weight bearing, she used a bedside commode. The NA reported the resident had told him she was not being toileting per her preference and was being told to void in her brief, but was unsure what staff had been involved.
The NA reviewed the shower sheet for Resident #3 and stated he had no idea why she had received so few showers during her stay in the facility.
The Administrator was interviewed on 11/30/16 at 3:05 PM. The Administrator stated staff were assigned to residents to make sure during rounds call bells were in reach, the resident had water and to receive general concerns. The Administrator added the Social Worker (SW) had been assigned to Resident #3; she added the SW was out of the country and not available for interview. The Administrator was unaware staff had instructed Resident #3 to void in her brief rather than toilet her and was unaware she had

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F 242	Continued From page 14 not received showers per her preference. On review of grievances, the Administrator stated she would try to find the disciplinary action for the NAs or the in-service provided for the NAs related to Resident #3's 8/9/16 grievance, but reported later she was unable to find additional information. Multiple messages were left with the Responsible Party in order to speak with the resident. No return calls were received.	F 242		
F 314 SS=H	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, physicians, and staff interview, the facility failed to remove wound packing from a sacral pressure ulcer for 1 of 6 residents (Resident #11) investigated for wound care which resulted in the decline of the sacral pressure ulcer and development of an abscess.	F 314	Affected Resident: Resident #11 was treated by Dr. Jenkins on 10/06/16 and packing was removed. Resident continues to reside at the facility with no further effects. Potentially Affected Resident: For those residents receiving wound care	12/26/16

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F 314	Continued From page 15 Findings included: Resident #11 was admitted to the facility on 2/15/16 with diagnoses which included hypertension, dementia, muscle weakness (generalized), and neuromuscular dysfunction of bladder. Review of Resident #11's care plan initiated 4/29/16 revealed the resident was care planned for a pressure ulcer on the sacral area. The goal was that the resident's pressure ulcer would decrease in size by next review. The interventions were to measure and record descriptions of the area, location, and size weekly, and to treat the area per physician orders. Review of the resident's quarterly minimum data set dated 5/12/16 revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 2.5 centimeters by 2.0 centimeters. Review of a physician's order dated 7/18/16 revealed the Medical Director signed an order to cleanse the sacral pressure ulcer with wound cleanser, soak a fine mesh gauze with normal saline, and gently pack the wound and cover with a dry dressing secured with tape. Record review of the resident's Treatments Administration History for the dates of 7/18/16 - 7/22/16 revealed Resident #11 was documented to have received sacral wound care. According the documentation, the wound was packed with a fine mesh gauze, soaked with normal saline, covered with dry dressing, and secured with tape on 7/18/16, 7/19/16, 7/20/16, and 7/21/16 by	F 314	on 10/06/16 Director of Nursing assessed all 16 wounds in facility to ensure residents didn□t have fine mesh gauze for packing, then DON reviewed current treatment orders for all wounds in the facility and no resident had an order to receive wound packing for treatment plan. Measures/Systemic Changes: Director of Nursing and Administrative Nurse educated all licensed nursing staff on pressure ulcer prevention-interventions, communication, risk factors, and preventative measures on 12/13-12/23/2016. Director of Nursing and Administrative nurses educated all nurses on pressure ulcer evaluation for avoidability and unavoidability, risk factors and communication with physician; packing wounds/measuring packing- number of gauze removed and packed with, measuring length of rope style packing, and for treatments requiring packing add measurements in treatment record to record that the amount of packing placed in the wound is the same amount of packing removed; if dressing removed at physician□s office, ensure office gives you amount or measurement of packing for documentation purposes on 12/09-12/23/2016. All treatment nurses were re-educated by Administrative nurse on wound care policies, evaluated and completed skills checklist- proper treatment options, pain management, evaluating treatment effects, identification co-morbid conditions, lab data review, multidisciplinary approach to prevention,	

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F 314	Continued From page 16 Treatment Nurse #1 per physician's orders. Review of the weekly pressure ulcer documentation dated 7/21/16 at 3:23 PM signed by Treatment Nurse #1 revealed the sacral pressure ulcer was recorded as an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining (meaning the wound continued under intact skin) was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. 100% of the wound bed was documented to be granulation tissue (new healthy tissue growth that occurs during the wound healing process). Pressure ulcer care was documented as performed. Review of a physician's order dated 7/22/16 revealed the Medical Director signed to change the sacral pressure ulcer wound care order to hydrocolloid (a dressing to promote wound healing) dressing to be placed over the sacral pressure ulcer, checked every day, and changed every three days and as needed. The order to pack the wound with normal saline soaked fine mesh gauze was discontinued on this date. Review of the weekly pressure ulcer check dated 7/27/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.8 centimeters by 0.8 centimeters by 0.1 centimeters. Undermining was noted at 12 o'clock 1.5 centimeters, 3 o'clock 0.5 centimeters, 6 o'clock 0.5 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue. Review of the weekly pressure ulcer check dated 8/4/16 revealed the wound was documented to	F 314	documentation-weekly tracking, proper application of dressings, recognizing PVD, measuring pressure ulcers, staging, surgical wound evaluation, documentation on 12/06-12/23/2016. Any new hire nurse designated for treatments will have onsite education provided by wound nurse. Any new employee will be educated on this information upon hire during orientation. The facility is working on a contract with outside wound physician with VOHRA services to evaluate and treat wounds in the facility via telemedicine. Monitoring: A monitoring tool was developed to monitor wounds requiring packing and ensuring nurses are measuring packing for wounds and documenting this information in the electronic health record. The Director of nursing or Administrative nurse to conduct 100% audit for residents receiving wound packing to ensure gauze or rope is being measured and documentation of packing placed and removed on treatment record in the electronic health record (E.H.R.) -weekly for 16 weeks, then every two weeks for sixteen weeks, then monthly for four months. All audits will be brought to QAPI meeting by the DON for review. Continued audits will be determined based on results of prior months of audits.	

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be an unstageable pressure ulcer, 1.0 centimeters by 1.0 centimeters with no depth. Undermining was noted at 12 o'clock 1.0 centimeters, 3 o'clock 2.0 centimeters, 6 o'clock 1.0 centimeters, and 9 o'clock 0.5 centimeters. The wound was 100% granulation tissue.

Review of a wound care physician's consult note dated 8/11/16 revealed the resident was assessed at a doctor's office by Physician #1. Physician #1 discussed options with the family for continued treatment. The order for the hydrocolloid dressing was continued as a result of the consult.

Review of the resident's quarterly minimum data set dated 8/11/16 revealed the resident was assessed as having an unstageable pressure ulcer. The measurements of the pressure ulcer were 1.5 centimeters by 1.5 centimeters with no depth.

Review of the weekly pressure ulcer check dated 8/19/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% granulation tissue.

Review of the weekly pressure ulcer check dated 8/25/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.3 centimeters by 0.3 centimeters with no depth. The wound was 100% granulation tissue.

Review of the weekly pressure ulcer check dated 8/29/16 revealed the wound was documented to be an unstageable pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% epithelial tissue.

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Review of the weekly pressure ulcer check dated 9/5/16 revealed the wound was documented to be a stage II pressure ulcer, 0.3 centimeters by 0.3 centimeters with no depth. The wound was 100% epithelial tissue.

Review of the weekly pressure ulcer check dated 9/13/16 revealed the wound was documented to be a stage II pressure ulcer, 0.2 centimeters by 0.2 centimeters with no depth. The wound was 100% epithelial tissue.

Review of the weekly pressure ulcer check dated 9/26/16 revealed the wound was documented to be a stage I pressure ulcer, 0.5 centimeters by 0.5 centimeters with no depth. The wound was 100% epithelial tissue.

Review of Resident #11's progress note dated 10/5/16 revealed during the routine dressing change to sacral pressure ulcer, Treatment Nurse #2 noted a large 6 centimeters by 6 centimeters soft fluid-filled packet at the wound. The skin color at the wound was noted to be red. Treatment Nurse #2 notified the Medical Director and an appointment was scheduled with Physician #1 the next day.

Review of a wound care physician's consult note dated 10/6/16 revealed Physician #1 assessed Resident #11's pressure ulcer at his doctor's office. The assessment revealed the sacral ulcer had increased pain and redness. A large abscess was noted to be 12 centimeters by 12 centimeters by 5 centimeters on the resident's sacrum. Physician #1 performed an incision and drainage of the abscess and discovered 6 inches of fine mesh gauze in the subcutaneous tissue.

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Review of Resident #11's most recent Minimum Data Set dated 11/13/16 revealed the resident had a stage III pressure ulcer.

Review of Resident #11's most recent weekly pressure ulcer check dated 11/28/16 revealed the resident's sacral pressure ulcer measurements were 2.5 centimeters by 1.5 centimeters by 0.7 centimeters.

Review of the resident's active diagnoses as of 11/30/16 revealed the resident's diagnoses included cutaneous abscess of buttock, cellulitis of buttock, and pressure ulcer of the sacral area.

During a telephone interview on 11/30/16 at 12:20 PM, Physician #1 stated when he observed Resident #11 on 8/11/16 he did not observe any fine mesh gauze in the wound. He further stated he only continued the ordered hydrocolloid dressing following this visit. Physician #1 stated that the facility placed a fine mesh gauze in the pressure ulcer on the sacrum intentionally or unintentionally at some point while the wound was still open. He further stated the gauze was either lost or forgotten about and the wound healed over the gauze. Physician #1 further stated that he had no doubt the gauze was the cause of the abscess that Resident #11 developed and he treated on 10/6/16. Physician #1 stated that someone in the facility's staff had made a mistake and either not followed the order correctly or had lost a gauze in the wound somehow. He further stated that the fine mesh gauze should not have been left in the wound.

During an interview on 11/30/16 at 2:45 PM Treatment Nurse #2 stated Resident #11's sacral

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pressure ulcer was first identified on 4/27/16. Treatment Nurse #2 stated that she was not the wound care nurse at that time. She stated that when she began care of Resident #11's sacral pressure ulcer, the skin was healing and intact. She stated that the wound care orders at that time were for hydrocolloid dressing changed every three days and as needed. She further stated she had never packed the wound prior to it being reopened 10/6/16. Treatment Nurse #2 stated that she felt the resident had progressed well and she believed care was about to be discontinued, but on 10/5/16 she changed the resident's dressing and observed a fluid pack around the wound. She stated she alerted the medical director and the resident was sent to Physician #1's office the next day for wound care. She added a piece of wound packing in the resident's pressure ulcer was found by Physician #1. She further stated that when she placed fine mesh gauze in a wound no more than one continuous length of fine gauze should be placed and there should be enough fine mesh gauze in the wound to be observed and taken hold of to be removed. Treatment Nurse #2 stated that when changing a hydrocolloid dressing, she would inspect the wound for healing and make measurements. She further stated that when she began to care for the resident's wound full time, the wound had already closed and the skin was intact so she was unable to inspect inside the wound.

During observation on 11/30/16 at 2:52 Treatment Nurse #2 provided wound care to Resident #11's sacral pressure ulcer. The resident's wound was observed to have an opening approximately 2.0 centimeters by 1.5 centimeters by 0.7 centimeters with 3 centimeters of undermining from 1 o'clock

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to 7 o'clock. The wound care nurse provided wound care according to the physician ' s orders.

During an interview on 11/30/16 at 5:22 PM the Director of Nursing (DON) stated it was her expectation that wound care with nu-gauze be provided according to the doctor's orders. She further stated that she expected the wound would be inspected by the wound care nurse upon return to the facility from the doctor's visit with new orders. She further stated her expectation was anything noted foreign or unusual in the wound during the assessment to be documented and reported. The Director of Nursing stated the nurses informed her of the abscess found on 10/6/16. The DON stated she believed the abscess could have caused harm to the resident, but did not know if the abscess was a result of the gauze being left in the resident.

During an interview on 11/30/16 on 5:57 PM Treatment Nurse #2 stated that after the abscess had been found on 10/6/16 she reported it to the charge nurse and the DON. She stated she covered the Treatment Nurse #1's shift on 7/15/16 and then again on 7/23/16. During these dates the hydrocolloid dressing was ordered. She stated she did not remember ever placing fine mesh gauze in the resident's wound and that she checked the dressing each day and performed the weekly wound assessments as ordered. She further stated that due to the abscess Resident #11 had developed, the resident had increased reports of pain to the area. She stated that the resident was receiving pain medications for the increased pain.

Treatment Nurse #1 no longer worked for the facility. Attempts were made to interview

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F 314	Continued From page 22 Treatment Nurse #1 with no return calls received.	F 314		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		12/26/16

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F 431	Continued From page 23 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to secure bottles of medication in 1 of 3 medication carts (medication cart #1) and failed to secure insulin in a locked cart for 1 of 1 diabetic carts (diabetic cart #1) observed during medication pass. Findings included: The facility policy, titled, " Storage of Medications " , revised September 2003, revealed: · Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes. On 11/29/16 at 8:53 AM, a medication cart attended by Nurse #3 was observed with the nurse not within visual range of the cart. On top of the medication cart #1 was an unlabeled clear cup with a purple liquid, a bottle of Aspirin, a bottle of Folic Acid, a bottle of Senna, a bottle of	F 431	Affected Resident: No resident was affected. Medication cart immediately locked. Medications placed back in cart. Nurse coached and in-serviced on medication storage policy. Potentially: All medication/treatment/diabetic carts checked. No other carts were unlocked. No residents were effected. Measures/Systemic Changes Policy on medication storage reviewed by Director of Nursing/Administrator on 11/29/2016. No policy changes were made. Director of Nursing and Administrative Nurse in-serviced all licensed nurses on policy for storage of medications, policy and procedure for medication administration on 11/29-12/23/2016. The nurses were educated on securing medications in locked medication carts and securing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 24 Colace, a bottle of multivitamin and a bottle of Miralax. Next to medication cart #1, was an unlocked cart with tape that identified the cart as the " Diabetic Cart " . Diabetic cart #1 was observed to be unlocked. The top drawer of the diabetic cart was noticed to be unlocked. Nurse #3 returned from a room approximately 3 doors down from where the medication cart and the diabetic cart were parked in the hall at 8:57 AM. She stated she had been taught to keep all medications securely locked. She added she had forgotten to put the medications away before going into the resident ' s room to give the resident their morning medications and had forgotten to lock the diabetic cart. The nurse opened the diabetic cart and confirmed there were open vials of insulin, insulin pens and syringes in diabetic cart #1. The Director of Nursing (DON) was interviewed on 11/29/16 at 3:58 PM. She stated medications should be stored in a locked cabinet at all times. The DON added there was always the risk of the nurse being called away during an emergency or dementia residents passing the cart could take the medications. The DON stated there was not an appropriate time for medications to be left on top of the cart. She added medications should not be placed in clear cups without identifying information	F 431	insulin in locked diabetic carts when medication cart is unattended. Monitoring: A monitoring tool was developed to monitor proper storage of drugs: form reflects an area for what carts were audited and yes/no for carts being locked as the criteria. DON or Administrative Nurse to conduct audit of all carts 3x/week for 4 weeks then 2x/week for 4 weeks, then 1x/week for 4 weeks, then once a month for 3 months. DON to bring audit results to QAPI meeting. Continued audits will be determined based on results of prior 6 months of audits.	