| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345376 | A. BUILDING _____ B. WING _____ | C 09/27/2017 |

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| CUMBERLAND NURSING AND REHABILITATION CENTER | 2461 LEGION ROAD FAYETTEVILLE, NC 28306 |

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| F 000 | INITIAL COMMENTS<br><br>On 9/10 - 9/13/17 we were onsite conducting new complaint investigations and the follow up. A two day complaint came in which we started on 9/20/17 and concluded on 9/27/17. The survey activity was combined. | F 000 | | |
| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(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-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(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);<br><br>(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<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(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) | F 157 | | 11/5/17 |

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

Electronically Signed | 10/20/2017

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| F 157 | Continued From page 1<br>is available and provided upon request to the physician.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, family and physician ' s interviews, facility staff failed to notify the physician and the Responsible Party of a fall and bruises for 1 of 6 residents reviewed for falls (Resident #45).<br><br>The findings included:<br><br>Resident #45 was admitted to the facility on 6/30/16 and had a diagnosis of myocardial infarction (MI or heart attack)) atrial fibrillation, pacemaker and dementia.<br><br>The Care Area Assessment (CAA) for Cognitive Status dated 5/23/17 noted the resident was alert but at times confused and disoriented. The CAA for Falls noted the resident was at risk for falls as she was not always steady with her transfers/ambulation and was working with therapy. The CAA noted the resident was status | F 157 | F157<br>The Resident Representative Bobby Barber and physician for Resident #45 was notified of the Resident sustaining a fall and bruises on 09/22/2017 by Director of Nursing, with documentation of the notification in the clinical record. Nurse #4 is no longer employed at the facility.<br>On 9/26/2017 Nurse's Progress Notes and Risk Management Reports from 9/1/2017 to 9/25/2017 were reviewed for All Residents to include Resident #45 to ensure the physician and Resident Representative had been notified of all documented changes in condition, to include falls and bruises. All identified areas of concern were addressed by the facility Nurse Consultant on 9/26/17with notification to the physician and Resident representative and documentation of the | |

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| F 157 | Continued From page 2<br>post hospitalization and was found to have an acute inferior MI. The CAA revealed the resident was started on antiplatelet therapy at that time. Antiplatelet medications are a class of drugs that decrease the clumping of platelets in the blood and inhibit the formation of blood clots.<br><br>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 7/17/17 revealed Resident #45 had severe cognitive impairment, was independent with transfers and toileting and required limited assistance with ambulation.<br><br>a. On 9/22/17 at 9:30 AM, Resident #21 (roommate of Resident #45) stated Resident #45 had fallen the Thursday before Labor Day (8/31/17) and the Thursday after Labor Day (9/7/17). The Roommate stated when Resident #45 fell she rang her call bell to notify the staff who came in and got her up.<br><br>Review of the nurse ' s notes for Resident #45 from 8/24/17 through 9/22/17 revealed no documentation of falls or bruises.<br><br>On 9/22/17 at 10:49 AM, NA (nursing assistant) #7 stated in an interview she was not aware of a fall but the resident ' s roommate said Resident #45 had fallen. The NA stated Resident #21 was alert, oriented and reliable.<br><br>On 9/22/17 at 10:59 AM, NA #5 stated in an interview about 2 weeks ago a nurse told her Resident #45 had a fall when trying to get up to go to the bathroom and identified Nurse #4 as the nurse who assisted the resident to get up after the fall. The NA further stated the resident had bruises which she had reported to a nurse but could not recall the name of the nurse she told. | F 157 | notification in the clinical record. 100% of all license nurses and Nursing assistants (NAs) to include NA #7 and NA #5, will be interviewed by the Staff Facilitator by 10/25/2017 with questions to include: 1. Are you aware of any residents' falling within the past 3 months? If yes, who, when, and who did you report it to? An assessment will be completed and notification to the physician and Resident Representative with documentation in the clinical record by the Director of Nursing by 11/05/2017, for any identified unreported resident falls. A 100% head to toe assessment was completed on 9/21/2017 by the Treatment nurse and Treatment Aide to identify any bruises and ensure that the physician and Resident Representative had been notified of the bruise. Notification to the physician and Resident Representative with documentation in the clinical record will be completed by the Director of Nursing by 11/05/2017, for any identified unreported bruises.<br>100% in-servicing was initiated on 10/4/2017 and will be completed by 11/05/2017 by Staff Facilitator with all Nursing assistants to include NA #7 and NA #5, regarding immediately reporting acute changes in condition to include falls and bruises to the nurse. All newly hired nursing assistants will receive the in service during orientation by the Staff Facilitator.<br>100% In-servicing was initiated on 9/252017 and will be completed by 11/05/2017 by Staff Facilitator with all license nurses to include the nursing | |

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| F 157 | Continued From page 3<br><br>On 9/22/17 at 11:15 AM an observation was made of the resident ' s bruises with NA #5. The resident was observed to have a pale blue bruise that mostly covered the right knee cap and a quarter sized bruise just below the left knee, a round bluish colored bruise approximately 1.5 inches in diameter on the right lower buttock and a purple bruise at the base of the right little toe that was approximately 2.5 inches long and 1.5 inches wide with slight swelling.<br><br>On 9/22/17 at 12:14 PM the Administrator stated there had been no reports of a fall or of bruises for Resident #45. The Administrator further stated they discussed falls in their morning meetings and there had been no reports of falls for this resident.<br><br>On 9/22/17 at 3:40 PM an interview was conducted with the nursing supervisor that worked Monday through Friday on the 7 AM to 3 PM shift. The Supervisor stated none of the staff had told her Resident #45 had a fall or bruises. The Supervisor stated if the roommate told a staff member that Resident #45 had fallen the staff member should have reported it immediately. The Supervisor further stated the nurse should have done an assessment, initiated the QI (Quality Improvement) document related to falls in the progress notes and notified the physician and the family.<br><br>On 9/22/17 at 4:01 PM an interview was conducted with the administrator and Nurse Consultant #2. The Administrator stated the NAs were supposed to report any bruises to the nurse. The Administrator further stated if someone told a nurse a resident had fallen but did not know | F 157 | supervisor regarding notification of the physician and Resident Representative for acute changes in condition to include falls and bruises with documentation of the notification in the clinical records. All newly hired License Nurses will receive the in service during orientation by the Staff Facilitator.<br>Nurse's Progress Notes and Risk Management Reports will be reviewed for All Residents to include Resident #45, weekly x 8 weeks then monthly x 1 month to ensure that the physician and resident representative was notified immediately of all identified acute changes in condition to include falls and bruises utilizing an Acute Change Notification QI Audit Tool by Staff Facilitator. Notification to the physician and Resident Representative with documentation in the clinical record and re training with the license nurse, will be completed by the Staff Facilitator/Quality Improvement Nurse during the audit, for any identified areas of concern. The Director of Nursing will review and initial the Acute Change Notification QI Audit Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern are addressed.<br>The Director of Nursing will forward the results of the Acute Change notification QI Audit Tools to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Acute Change Notification QI Audit Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of | |

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| F 157 | Continued From page 4<br>when, the nurse should report it to administration so it could be investigated.<br><br>On 9/22/17 at 4:20 PM, Nurse Consultant #2 and the physician were observed to do an assessment for Resident #45. The Physician stated he did not find any major injury but would get an X-ray of the right foot.<br><br>On 9/22/17 at 5:55 PM, Nurse #4 stated in an interview that Resident #45 did have a fall about 2-2 ½ weeks ago. The Nurse stated the resident told her she did not hit her head and she checked the resident ' s vital signs which were OK and did an assessment and the only injury was a skin tear to the right arm that she cleaned and put a clear dressing on it. The nurse stated she did not document the fall as she was in a hurry to leave and had planned to document it the next day but must have forgotten. The Nurse stated she did not report the fall to the on-coming nurse but thought she told the nurse practitioner.<br><br>On 9/22/17 at 6:23 PM, the resident ' s Physician stated in an interview the nurse practitioner did not say anything to him about the resident having a fall. After examining the resident on 09/22/17, the Physician stated the resident did have bruises and was on Plavix (antiplatelet medication), Eliquis (blood thinner) and Aspirin.<br><br>On 9/22/17 6:30 PM the Nurse Practitioner stated in an interview that none of the staff had reported to her that Resident #45 had fallen.<br><br>Review of an X-ray report of the right foot for Resident #45 dated 9/22/17 was negative for fracture or dislocation. | F 157 | monitoring. | |

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| F 157 | Continued From page 5 | F 157 | | |

On 9/25/17 at 10:36 PM the Nurse Practitioner stated in an interview if the facility had notified her about the fall she would have seen the resident if she was in the building and if not her course of action would depend on what the nurse told her, whether the fall was witnessed or not and whether or not the resident hit her head. The Nurse Practitioner further stated if the fall was unwitnessed they would do neuro (neurological) checks and monitor closely in house if no injuries found but she might send the resident to the hospital depending on what the nurse told her.

b. On 9/22/17 at 12:45 PM an interview was conducted with a family member listed on the resident ' s clinical record as contact #2. The Family Member stated in an interview that she and the resident ' s Responsible Party (RP) were in the facility last Saturday (9/16/17) and the roommate told her the resident had fallen and hit her head. The family member stated she saw the resident had a lot of bruises. The Family Member stated no one from the facility notified her of a fall or bruises.

On 9/22/17 at 1:02 PM an interview was conducted with the resident ' s responsible party. The RP stated he and another family member were in the facility last Saturday and the roommate told them the resident had fallen twice and hit her head. The RP stated no one from the facility called to notify him of a fall or bruises.

On 9/22/17 at 3:40 PM an interview was conducted with the nursing supervisor that worked Monday through Friday on the 7 AM to 3 PM shift. The Supervisor stated none of the staff had told her the resident had a fall or bruises. The

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| F 157 | Continued From page 6<br>Supervisor stated if the roommate told a staff member that Resident #45 had a fall, the staff member should have reported it immediately. The Supervisor further stated the nurse should do an assessment, initiate the QI (Quality Improvement) document related to falls in the progress notes and notify the physician and the family.<br><br>On 9/22/17 at 5:55 PM, Nurse #4 stated in an interview that Resident #45 did have a fall 2-2 ½ weeks ago. The Nurse stated the resident told her she did not hit her head and she did an assessment and took her vital signs which were okay and the only injury was a skin tear to the right arm that she cleaned and put a clear dressing on it. The Nurse stated she did not document the fall because she was in a hurry to leave that day and had planned to document it the next day but must have forgotten. The Nurse stated she heard Resident #45 on the phone with a family member and the resident told the family member she had fallen and was not hurt. The Nurse stated she did not call and report the fall to the RP. | F 157 | | |
| F 166 SS=D | 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances | F 166 | | 11/5/17 |

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| F 166 | Continued From page 7 | F 166 | | |

regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being

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| F 166 | Continued From page 8<br>investigated;<br><br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br><br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br><br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, resident interview, and staff interviews the facility failed to follow facility procedures to resolve grievances related to | F 166 | F166<br>A resident concern form was completed for resident # 175 grievance related to | |

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| F 166 | Continued From page 9<br>medication concerns for one (Residents # 175 ) out of six residents reviewed for grievances. The findings included:<br><br>1. Record review revealed Resident # 175 was admitted to the facility on 7/12/17. The resident had diagnoses of cerebrovascular accident, chronic pain, diabetes, and hypertensive disorder.<br><br>Review of the resident's admission minimum data set (MDS) assessment, dated 7/19/17, revealed the resident was cognitively intact.<br><br>On 9/20/17 a review of grievances revealed two forms had been completed for Resident # 175. The first was dated as received on 9/18/17. The summary of the concern noted the resident had received his medications late on 9/17/17. There was no further information in regards to the late medications. The second form was dated as received on 9/19/17. The summary of the concern was listed as "didn't receive his 8 PM Insulin on 9-19."<br><br>On each form there were different steps noted which could be taken during the investigative process. As of 9/20/17 resident interview and staff interview had not been checked on either form. The two steps noted to be checked as of 9/20/17 were "staffing review" and "other-MAR review."<br><br>The resident was interviewed on 9/20/17 at 1:50 PM and stated he had concerns about not receiving medications on Sunday, 9/17/17. The resident stated he routinely received OxyContin for pain. The resident stated on Sunday evening he had gone in search of a nurse and could not find one on the hall. The resident stated he | F 166 | medication concern on 9/18/2017 by Social Worker. The Director of Nursing initiated an investigation on 9/20/2017 related to the medication concern to include resident and staff interview to include Medication Aide #2 (MA) and Nurse #6). The grievance related to the medication concern for resident #175 was addressed with a resolution on 9/21/2017 by Director of Nursing with complete documentation on the resident concern form. The Director of Nursing discussed the resolution for the medication concern with resident #175 on 9/21/2017. A copy of the completed resident concern form with documented resolution was provided to resident #175 on 9/21/2017 by Social worker.<br>100% interview of all alert and oriented residents to include resident # 175 will be completed on 9/26/2017 by Facility Consultant to assure all grievances have been resolved. These interview questions include: Have you voiced any concerns recently to staff? Do you feel your concerns were resolved? If no, give brief explanation, and Do you have any new concerns? Social Worker will address all areas of new and unresolved concerns voiced during the interviews by completing a resident concern form and forwarding to the appropriate personnel for proper resolution by 9/29/2017.<br>100% audit of all resident concerns from 9/1/2017 to 9/25/2017, to include any for resident #175, was reviewed by the Facility Consultant on 9/26/2017 to ensure all resident concerns were completed and resolved timely with follow up discussion | |

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| F 166 | Continued From page 10<br>should not have had to struggle to get his medications. The resident stated one of his missed medications was his seven units of nightly insulin and another medication was his narcotic pain medication. The resident stated he had filed a formal complaint with the social worker letting him know that he had missed some of his medications on Sunday.<br><br>On 9/20/17 at 3 PM the administrator was interviewed and stated she had not been made aware that any residents had voiced concerns that they had not received medications.<br><br>The administrator and the director of nursing (DON) were interviewed on 9/20/17 at 4:15 PM. The administrator stated she had talked to staff since her 3 PM interview and she had found there had been grievances related to medications. According to the administrator the social worker had given the grievances to the facility's newly hired DON who had started employment the previous week. The administrator stated she had not been informed there had been medication issues in the grievances.<br><br>According to the DON on 9/20/17 at 4:15 PM she was in training on 9/18/17 and 9/19/17. The DON stated the social worker had brought her a grievance for Resident # 175 on 9/19/17 related to late medications. The DON stated she had found another grievance for Resident # 175 on her desk the morning of 9/20/17 related to medication. The DON stated she had looked at the resident's MAR which showed the medications had been administered, and she had talked to Nurse # 2 who had been the nursing supervisor beginning at 11 PM on 9/17/17. The DON clarified that as of 9/20/17 at 4:15 PM an | F 166 | of the concern with the resident. Any concerns identified will be corrected with follow up resolution by the Social Worker and oversite by the Facility Consultant.<br>100% audit of the last 30 days of resident concern forms will be completed on 9/26/2017 by the Facility Consultant to assure appropriate investigation, follow up, resolution and notification of appropriate persons. Any area of concerns noted during the audit will be given to the Administrator for further investigation, follow up and resolution by 9/29/2017.<br>The Facility Consultant initiated in-service on 10/11/2017 for the Administrator, Director of Nursing, Social Worker, Dietary manager, Maintenance director and Activities Director on proper grievance resolution to include investigating grievances in a prompt manner, initiating corrective measures and timely follow up with resident and\or family member to be completed by 11/05/2017.<br>The Social worker will review and provide a copy of the resident\family grievance policy to all alert and oriented residents to include resident number # 175 by 10/17/2017. The Social worker will mail a copy of the resident\ family grievance policy to the responsible party by 11/05/2017 for all none alert and oriented residents.<br>The Social worker will interview 10% of alert and oriented residents to include resident# 175 for new concerns and to ensure concerns have been resolved utilizing a Resident Concern Interview QI tool. The Resident Concern Interview QI | |

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| F 166 | Continued From page 11<br>administrative staff member had not talked to the staff members (MA # 2 or Nurse # 6) who had been responsible for Resident # 175's medications on 9/17/17.<br><br>During an interview with the social worker (SW) on 9/21/17 at 11:18 AM it was confirmed that the resident's 9/19/17 grievance regarding missed Insulin on 9/19/17 had not been recorded accurately. The SW acknowledged he was the administrative person who received the 9/19/17 grievance. The SW stated he did not know when the Insulin dose was allegedly missed, and it would need to be clarified with the resident.<br><br>Interview with the administrator on 9/21/17 at 11:26 AM revealed it was the facility's administrative process to discuss grievances in a morning clinical meeting with department heads. The administrator verified that Resident # 175's grievance should have been discussed at the 9/19/17 morning clinical meeting when administrative department heads met, and then she would have been made aware there were problems voiced that medications had not being administered correctly on a day when residents also complained about staffing issues. The administrator stated the facility had started their morning clinical meeting on 9/20/17 but did not complete the meeting when the state surveyor entered. The administrator stated Resident # 175's grievance had not been discussed or brought to her attention on that morning before the meeting was dismissed. | F 166 | tool will be completed weekly for 8 weeks and monthly for 1 month. Any new or unresolved concerns made during the interviews will be placed on a Resident concern form by the Social Worker and forwarded to appropriate personnel for proper investigation, follow up and resolution. The Administrator will review and initial the Resident Concern Interview QI tool and resident concern forms weekly for 8 weeks and monthly for 1 month for completion and to ensure all areas of concerns have been addressed with proper resolution.<br>The Administrator will forward the results of the Resident Concern Interview Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Resident Concern Interview Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. | |
| F 224 SS=E | 483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br><br>§483.12 The resident has the right to be free from | F 224 | | 11/5/17 |

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| F 224 | Continued From page 12<br>abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.<br><br>483.12(b) The facility must develop and implement written policies and procedures that:<br><br>(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interviews, family interview, and staff interviews, for one (Resident # 135) out of three sampled residents with wounds the facility neglected to perform dressing changes to the resident's vascular and Stage III pressure ulcers. The findings included:<br><br>1. Record review revealed Resident # 135 was initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial fibrillation, and severe peripheral vascular disease.<br><br>Review of the resident's last quarterly minimum data set (MDS) assessment, dated 8/13/17, | F 224 | F 224<br><br>On 9/21/17, a Head to Toe Skin Assessment was completed on Resident # 135 to include her coccyx ulcer with no new skin issues identified or changes to coccygeal wound. On 9/22/17, the coccyx wound was cleansed, Santyl ointment and dressing applied by the Treatment Nurse per the physician's orders. On 9/25/17, The Director of Nursing (DON) was made aware that Resident #135 failed to receive dressing changes as ordered for 8/5/17, 8/6/17, 8/12/17, 8/13/17, 8/19/17, 8/20/17, 8/26/17, 8/27/17, 9/2/17, 9/3/17, 9/9/17, and 9/10/17 by licensed nurses. On 9/28/17, Resident #135 was seen by the | |

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| F 224 | Continued From page 13<br>revealed the resident was cognitively intact. The resident was also coded as having 7 vascular ulcers and a Stage III pressure ulcer.<br><br>According to August 2017 wound ulcer flow records Resident #135's vascular ulcers were located on her left lower leg, right lower leg, left heel, left great toe, left outer great toe, right great toe, and right heel. The pressure ulcer was located on the resident's Coccyx.<br><br>Review of the resident's care plan, last updated on 8/17/17, revealed the staff had identified the resident had skin ulceration caused by diabetes and peripheral vascular disease and a pressure ulcer. The goal for the resident was that she would show positive healing of her ulcers and not develop further ones. Staff were directed on the care plan to provide treatment as ordered.<br><br>Review of physician orders revealed a current order, originating on 5/31/17, for daily dressing changes to the coccyx pressure ulcer. The order directed staff to cleanse the ulcer and apply Santyl ointment and a dry dressing daily.<br><br>On 9/23/17 the facility was asked to provide the treatment orders from the resident's thinned medical record which would have been in effect for August and September, 2017 for the resident's vascular ulcers.<br><br>On 9/25/17 at 5:13 PM, the DON (director of nursing) provided a physician's order, dated 7/25/17, for the ulcers located on the resident's right and left lower legs. This order specified the resident was to have daily dressing changes to these areas. The staff were to cleanse these ulcers with saline and apply Santyl and a dry | F 224 | Wound Physician and returned to the facility with new orders for treatment of Coccyx wound: Cleanse with soap and water, apply crushed Flagyl 500 milligrams, cover with Aquacel Silver and a foam dressing to be changed every other day and as needed. Resident #135 had follow up appointment with the Wound Physician on 10/5/17 with no change in orders for treatment to the coccyx and another appointment scheduled for October 19, 2017.<br><br>On 10/12/17, A 24 hour report was sent to the Health Care Registry regarding the allegation of neglect and an investigation was initiated by the Administrator.<br>On 10/17/2017, a 100% audit of all Treatment Administration Records (TARs) from 8/1/2017-9/30/2017 was initiated by the Facility Nurse Consultant/Director of nursing to ensure all dressing changes were performed as ordered by the physician to include Resident #135. The 100% audit of all TARs will be completed by 11/05/2017. Any areas of concern identified during the audit to include missing documentation will be immediately addressed by the Facility Nurse Consultant/Director of Nursing to include additional retraining, physician notification, and/ or initiating the protocol for neglect if indicated.<br>This protocol includes reporting to the administrator, filing of a 24 hour report, and contacting the police if a reasonable suspicion of a crime has occurred, drug testing and suspending the employee suspected of neglect pending outcome of | |

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| F 224 | Continued From page 14<br>dressing.<br><br>On 9/26/17 at 4:46 PM, the facility administrator provided the facility's wound protocol as the treatment modality being used for Resident #135's left great toe, left outer great toe, left heel, right great toe, and right heel during the months of August, 2017 and September, 2017. The wound protocol directed that betadine should be applied to the ulcers every day or every other day and the affected areas checked daily.<br><br>Review of the August 2017 TAR and September 2017 TAR revealed no documentation on the following weekend dates Resident # 135's dressings were checked or changed to any of her vascular ulcers or her Stage III pressure ulcer: 8/5/17, 8/6/17, 8/12/17, 8/13/17, 8/19/17, 8/20/17, 8/26/17, 8/27/17, 9/2/17, 9/3/17, 9/9/17, and 9/10/17.<br><br>On 9/22/17 at 3:14 PM Facility Nurse Consultant # 1 provided a list of nurses who had been responsible for Resident # 135's dressing changes during the September, 2017 weekends. On 9/26/17 at 10:55 AM the director of nursing (DON) provided a list of nurses who had been responsible for weekend dressing changes in August, 2017 for Resident # 135. According to the nurse consultant and DON one of the hall nurses for the dayshift and evening shifts on the lists should have done the dressing changes. The nurses identified as responsible and the dates and shifts on which they were identified to be responsible are as follows:<br>8/5/17- 7:00 AM to 3:00 PM -Nurse # 4<br>8/5/17- 3:00 PM to 11:00 PM- Nurse # 4<br>8/6/17- 7:00 AM to 3:00 PM- Nurse # 4<br>8/6/17- 3:00 PM to 11:00 PM- Nurse # 4 | F 224 | investigation, and interviews of staff and residents. Any concerns will be immediately addressed by the Director of Nursing by completing a skin referral, initiating a treatment, documenting observations in the clinical record, and notifying the administrator, physician, and RP for any allegations/observations of neglect.<br>On 10/12/2017, a 100% inservice was initiated by the Staff Facilitator for all staff to include Certified Nursing Assistants (CNAs), licensed nurses, social workers, dietary, maintenance, activities, therapy, managerial staff, and agency staff regarding neglect. No staff will be allowed to work until completion of the inservice. The neglect in service advised that all alleged violations involving mistreatment, misappropriation of resident property, neglect, or abuse are reported as soon as possible to the Administrator. Any employee who witnesses abuse/neglect or suspects abuse/neglect, must first protect the resident and immediately report the alleged abuse/neglect to his/her supervisor, who will then report the incident to the Administrator and/or DON. The inservice further advises that failure to report any concern related to abuse/neglect will result in disciplinary action and possible termination of employment.<br>All new hired licensed nurses, CNAs, Dietary staff, therapy staff, managerial staff or agency staff will be inserviced during orientation by the Staff Facilitator regarding the neglect in service including that all alleged violations involving | |

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| F 224 | Continued From page 15<br>8/12/17- 7:00 AM to 3:00 PM-Nurse # 1<br>8/12/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/13/17-7:00 AM to 3:00 PM -Nurse # 7<br>8/13/17-3:00 PM to 11:00 PM- Nurse # 1<br>8/19/17-7:00 AM to 3:00 PM-Nurse # 8<br>8/19/17-3:00 PM to 11:00 PM-Nurse # 8<br>8/20/17-7:00 AM to 3:00 PM-Nurse # 1<br>8/20/17-3:00 PM to 11:00 PM -Nurse # 1<br>8/26/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/26/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/27/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/27/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/2/17-7:00 AM to 3:00 PM-Nurse # 3<br>9/2/17-3:00 PM to 11:00 PM-Nurse # 2<br>9/3/17-7:00 AM to 3:00 PM-Nurse # 3/or Nurse # 1<br>9/3/17-3:00 PM to 11:00 PM-Nurse # 2/ or Nurse # 1<br>9/9/17-7:00 AM to 3:00 PM-Nurse # 4<br>9/9/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/10/17-7:00 AM to 3:00 PM-Nurse # 4<br>9/10/17-3:00 PM to 11:00 PM-Nurse # 1<br><br>Nurse # 3, who had been identified as responsible on one day and had shared responsibility on another day, was interviewed on 9/22/17 at 5:15 PM. The nurse stated she had not done the dressing changes. The nurse was not aware it was her responsibility.<br><br>Nurse # 4, who had been identified as responsible on six of the week-end days as either solely or partially responsible, was interviewed on 9/22/17 at 6 PM. Nurse # 4 stated she had not done any dressing changes for Resident # 135 during the August and September week-end days she worked. The nurse stated she was charge nurse with other responsibilities, and she was not aware it had been her responsibility to change the | F 224 | mistreatment, misappropriation of resident property, neglect, or abuse are reported as soon as possible to the Administrator.<br>On 10/3/2017, a 100% inservice was initiated by the Director of Nursing for all licensed nurses that when the treatment nurse is off on the weekends nurses are to complete their own treatments. 7-3 complete odd number rooms and 3-11 complete even number rooms this is not optional. Document by initialing on MAR immediately after completing treatment. If treatments cannot be completed hall nurse must notify nursing supervisor and/or Director of Nursing. All Refusal of treatments must be documented on Treatment Administration Record and in a nursing progress note to include notifications of Medical Director and Resident Representative of treatment refusal. No licensed nurse will be allowed to work until completing this inservice. All newly hired and agency licensed nurses will be inserviced on orientation by the Staff Facilitator regarding missed dressing changes and the expectation that all treatments ordered by the physician will be completed as ordered and documented on the TAR in the absence of a treatment nurse or other designated nurse to include on the weekends.<br>The Assistant Director of Nursing/Nursing supervisor will conduct audits of 10% of TARs utilizing the TAR audit tool for documentation weekly for twelve weeks to include Resident # 135 to ensure dressing changes are completed as ordered by the physician. Any areas of | |

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| F 224 | Continued From page 16<br>dressings.<br><br>Nurse # 2, who had been identified as responsible or partially responsible on two days, was interviewed on 9/25/17 at 9:25 AM. The nurse stated she had not done the dressing changes. The nurse stated she had just started near the end of August, 2017 and she had not been made aware dressing changes were one of her responsibilities.<br><br>Nurse # 8, who had been identified as responsible for one day, was interviewed on 9/26/17 at 1:29 PM. The nurse stated she did not recall whether she had or had not done the dressing changes.<br><br>Nurse # 7, who had been identified as responsible on one day for the dressing changes, was interviewed on 9/26/17 at 4:42 PM. The nurse stated she had not done the dressing changes. The nurse stated there was not enough time to do it. The nurse stated the facility used to have a treatment nurse on the week-ends, and when the treatment nurse quit during the summer months the facility management staff left a paper schedule for the hall nurses to do dressing changes. The nurse stated the paper schedule directed that dayshift nurses were responsible for either the odd number rooms or even number rooms, and the evening shift nurses were responsible for the ones the dayshift nurses did not do. The nurse stated management never went over the new responsibility or gave directions. They just left the paper schedule at the desk. The nurse stated it was an impossible task given the other responsibilities which were placed on the hall nurses. The nurse stated she often had to administer medications for two halls, be | F 224 | concern noted during the audits will be immediately addressed by the DON to include additional training, physician notification, and/ or initiating the protocol for neglect if indicated.<br>The DON will forward the results of TAR audit tool for documentation theto the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months to review the audit results of the TAR audit tool for documentation. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. | |

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| F 224 | Continued From page 17 | F 224 | | |

responsible for medication assistants on other halls, deal with family concerns, deal with issues/events that came up with residents, deal with week-end housekeeping issues, and answer the phone.

Nurse # 1, who had been identified as solely or partially responsible on 8 days, was interviewed on 9/27/17 at 9:20 AM. The nurse stated she had only done the dressing changes one time during August and September for Resident # 135, and that was when the resident's family member had approached her and requested it. The nurse stated she had not charted the one day she had done it. The nurse stated on the other days, she had not done the resident's dressing changes. The nurse stated there was not enough time to do the dressing changes given her other responsibilities. The nurse stated she often had to work double shifts and she often had her own medication cart responsibilities as well as cover for medication technicians who could not give intravenous fluids, Insulin, or tube feedings. The nurse stated she had talked to the previous DON, who had worked in August 2017, about the dressing changes not being done on the week-end but then the DON had left. The nurse stated the new DON had not been at the facility long enough for her to talk to her about the problem.

Interview with the DON on 9/25/17 at 9:19 AM revealed she had just been employed the previous week and she had not been made aware of the lack of dressing changes for Resident # 135.

Interview with the administrator on 9/26/17 at 12:15 PM revealed the missed dressing changes

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| F 224 | Continued From page 18<br>had not been brought to her attention and that the staff had probably told the previous DON, who was no longer employed.<br><br>The resident's vascular physician was interviewed on 9/25/17 at 11:15 AM. According to the vascular physician Resident # 135's vascular ulcer dressings should have been checked or changed daily as a standard of good practice. According to the physician, when he initially saw the resident in July 2017, her vascular disease was severe to the point that the family knew the resident would probably need bilateral amputations at some point. | F 224 | | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews the facility failed to promote a resident ' s dignity when staff allowed the resident to wait while 2 other residents at the same table were being fed and staff pulled the resident ' s Geri-chair backwards without telling the resident for 1 of 8 residents reviewed for dignity (Resident #29).<br><br>The findings included:<br><br>Resident #29 was admitted to the facility on 12/26/13 and had a diagnosis of adult failure to | F 241 | F 241<br><br>Nursing Assistant # 5 failed to promote dignity when resident # 29 was allowed to wait to be fed while two other residents at resident # 29 table were being fed. Nursing # 5 failed to promote dignity when resident # 29 Geri-chair was pulled backwards. Nursing assistant # 5 was re-educated on 10/4/2017 by Director of Nursing.<br>Meals observed to include breakfast, lunch and dinner initiated on 10/3/2017 by | 11/5/17 |

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| F 241 | Continued From page 19<br>thrive, anxiety and dementia.<br><br>The resident ' s Care Plan dated 5/13/16 noted the resident was at risk for aspiration related to dysphagia and dementia, was dependent on staff for feeding and to feed resident slowly. The Care Plan directed staff to sit resident upright when feeding and giving fluids.<br><br>The Annual Minimum Data Set (MDS) Assessment dated 8/15/17 revealed the resident had short and long term memory loss and severe cognitive impairment and was totally dependent on staff for all activities of daily living.<br><br>The Care Area Assessment for Cognitive Loss dated 8/24/17 noted the resident was alert and nonverbal and unable to state her basic needs.<br><br>a. On 9/21/17 at 12:15 PM Resident #29 was observed to be reclined in a Geri-chair in the main dining room at a table with 2 other residents. NA #5 was observed to feed one of the residents at the table who was also sitting in a Geri-chair and the central supply manager was feeding another resident who was sitting in a wheelchair at the same table. Resident #29 was observed sitting in the Geri-chair beside the table looking around the dining room and waiting to be fed. When NA #5 finished feeding the resident she went to the meal cart and removed the meal tray for Resident #29 to feed the resident.<br><br>On 9/21/17 at 12:50 PM the Central Supply Manager stated in an interview the social worker came in to feed Resident #29 and NA #5 told the social worker she would feed the resident.<br><br>On 9/21/17 at 1:02 PM NA #5 stated in an | F 241 | Facility Nurse Consultant to ensure that residents were being provide meals at the same time to include resident # 29 and that no resident was pulled backwards. Any identified areas of concerns were addressed with re-education during the audit by Director of Nursing to be completed by 11/05/2017.<br>All alert and oriented resident were interviewed on 10/3/2017 by the Social Worker utilizing a Dignity Interview Tool. A resident concern form was completed by 10/3/2017 and forwarded to the Administrator for any identified areas of concerns.<br>100% in-servicing was initiated on 10/4/2017 by Facility Nurse Consultant with all nursing assistants to include nursing assistant # 5 in regards to helping to take residents to eat and to participate in various activities. Serve the residents meals and in some cases, to help them eat if they cannot do it for themselves. Residents must be feed in a manner that is not too fast for meal intake. Ensure all residents in room and dining room have their trays passed out and residents needing assistance are being fed at the same time. No resident should be sitting at table while other residents have their trays and are eating. All residents at one table should eat at the same time. Always make resident aware before you provide any care to be completed by 11/05/2017.<br>Meals to be observed to include breakfast, lunch and dinner by Administrative Staff member from Team A or B to ensure that residents were being provide meals at the same time to include | |

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| F 241 | Continued From page 20<br>interview she had to feed the residents one on one and pay attention to the resident she was feeding. The NA stated the social worker came in to feed Resident #29 but had to leave to deliver meal trays on the 400 hall.<br><br>On 9/22/17 at 8:05 AM the Administrator stated in an interview that all three residents at the table should have been fed at the same time and the NA should have let the social worker feed Resident #29 and other staff could have passed out trays on the 400 Hall. The Administrator stated she routinely observed meals in the dining room and she had not observed this to happen.<br><br>b. On 9/21/17 at 12:31 PM Resident #29 was observed to be reclined in a Geri-chair beside a table in the main dining room. NA #5 finished feeding one of the 3 residents at the table and went to the meal cart and removed a meal tray. The NA was observed to walk behind Resident #29 ' s Geri-chair and in a rushed manner pulled the Geri-chair backwards to the next table. When the NA moved the chair, Resident #29 was observed to throw up her hands and make a sound as if she was startled. The NA was then observed to sit down beside the resident to feed her.<br><br>On 9/21/17 at 1:02 PM NA #5 stated in an interview she told the resident it was time to eat but did not tell the resident she was going to move her chair.<br><br>On 9/22/17 at 8:05 AM the Administrator stated in an interview NA #5 should have told the resident she was going to move her chair. | F 241 | resident # 29 and that no resident was pulled backwards utilizing a Resident Care Audit- Meal Observations 3 X a week for 4 weeks, weekly for 4 weeks and then monthly for 1 month. Any areas of concerns will be addressed by Director of Nursing/Assistant Director of Nursing during the audit. The Director of Nursing will review and initial the Resident Care Audit- Meal Observations for completion weekly X 8 weeks and monthly X 1 month.<br>10 % of alert and oriented resident will be interviewed by the Social Worker utilizing a Dignity Interview Tool weekly X 8 weeks and monthly X 1 month. A resident concern form will completed by the Social Worker and forwarded to the Administrator for any identified areas of concerns. The Administrator will review and initial the Dignity Interview tool for completion weekly X 8 weeks and monthly X 1 month.<br><br>The Director of Nursing will forward the results of the Resident Care Audit-Meal Observation and the Dignity Interview Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Resident Care Audit- Meal Observation and Dignity Interview Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring | |

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| F 242 | Continued From page 21 | F 242 | | |
| F 242 SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(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.<br><br>(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.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and family interviews, and record review, the facility failed to offer showers as scheduled for 1 of 3 sampled residents (Resident #44).<br><br>Findings included:<br><br>Resident #44 was admitted to the facility initially on 7/27/2014, he was last readmitted on 8/29/2017 after a hospitalization. His diagnoses included Non-Alzheimer's Dementia, Parkinson's Disease and Depression.<br><br>The Annual Minimum Data Set (MDS) dated 5/30/2017 indicated Resident #44 was severely cognitively impaired with behaviors. He was coded totally dependent for hygiene and bathing.<br><br>His Care Area Assessment dated 5/30/2017 | F 242 | F 242<br><br>Resident # 44 was offered and given a shower on 10/16/2017 by assigned nursing assistant with oversight by hall nurse.<br>All alert and oriented resident were interviewed on 10/3/2017 by the Social Worker utilizing a Dignity Interview Tool. A resident concern form was completed by 10/3/2017 and forwarded to the Administrator for any identified areas of concerns.<br>A 100% audit will be completed by Facility wound Consultant on 10/5/2017 to include resident # 44 to ensure residents receive a shower according to choice and shower schedule. Any negative findings will be addressed immediately by the Director of | 11/5/17 |

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| F 242 | Continued From page 22<br>revealed Resident #44 required extensive assistance for bed mobility, transfers, toileting, personal hygiene, bathing, dressing, eating and locomotion on the unit.<br><br>His most recent care plan revised 8/31/2017 indicated he required total assistance with toileting and dressing related to his cognitive deficit and impaired mobility.<br><br>The Quarterly MDS dated 9/05/2017 indicated Resident #44 was totally dependent for bathing, toileting, and personal hygiene with one person physical assist.<br><br>Review of Hallway 300's Shower Book indicated Resident #44 was to receive showers every Tuesday on second shift.<br><br>Review of the Activities of Daily Living (ADL) records for bathing from 8/01/2017 to 9/12/2017 revealed Resident #44 did not receive a shower on any shift. It indicated he received full or partial bed baths. There were no documented refusals of showers from 8/01/2017 to present in the ADL records.<br><br>Review of the nursing notes from 8/01/2017 to 9/12/2017 made no mention of Resident #44 refusing his showers.<br><br>An interview on 9/10/2017 at 6:10 PM, a Family Member stated Resident #44 was frequently visited by the family (more than two times) each week. The Family Member had requested to the Administrative Staff for Resident #44 to have a shower at least once a week and the remainder of the week could be bed baths. | F 242 | Nursing during the time of the audit to be completed by 11/05/2017.<br>100% in-servicing initiated by Facility Consultant on 9/25/2017 for all nursing assistants to include agency staff, related to Cleaning and bathing your residents. Both of these task are a daily requirement unless resident prefers otherwise. Showers to be given by shower schedule unless resident prefers otherwise. If care cannot be performed for any reason or performed timely, the nurse must be notified. The nurse must ensure that the care needed is provided for the resident in a timely and accurate manner. Nursing assistants must notify the nurse about all refusals of care so that nurse can document in progress note to include notification of Resident Representative of the care being refused to be completed by 11/05/2017. All newly hires nursing assistants, to include agency staff will be in-serviced on Cleaning and bathing your residents. Both of these task are a daily requirement unless resident prefers otherwise. Showers to be given by shower schedule unless resident prefers otherwise. If care cannot be performed for any reason or performed timely, the nurse must be notified. The nurse must ensure that the care needed is provided for the resident in a timely and accurate manner. Nursing assistants must notify the nurse about all refusals of care so that nurse can document in progress note to include notification of Resident Representative of the care being refused during orientation by Staff Facilitator.<br>Nursing Supervisor will monitor 10% of all | |

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| F 242 | Continued From page 23<br>An interview on 9/10/2017 at 6:40 PM, Nursing Assistant (NA) #3 stated Resident #44 was kept clean and toileted as needed. She explained she tried to toilet every two hours but it can be impossible because if she is the only aide on Hallway 300 then showers cannot be given because there would be no one to watch the other residents. She added sometimes the nursing assistants are pulled to other units and that leaves Hallway 300 short of staff on the Dementia Unit.<br><br>An interview on 9/11/2017 at 4:05 PM, Nursing Assistant (NA) #2 stated Resident #44 was assigned a shower every Tuesday on second shift. She explained he was to get a shower unless he refused or if he was combative. She added she would report to the nurse in charge if Resident #44 refused his shower or if he became combative. She continued to say it is hard to get him up for showers if there is only one NA scheduled for Hallway 300 or if the second scheduled NA had to go to another hall to share staffing assignments.<br><br>An interview on 9/12/2017 at 12:45 PM, the Interim Director of Nursing (DON) revealed her expectations were residents are given their showers as scheduled and as their care plan indicated. She also stated the nursing staff should offer the showers and if residents refused then the refusals should be documented in the resident's record.<br><br>An interview on 9/12/2017 at 3:40 PM, the Administrator revealed it was an expectation that residents received their showers as care planned on their shower days or at their request. She continued by stating if the residents refused the | F 242 | residents to include resident # 44 to ensure showers are being provide per the shower schedule or resident preference utilizing a Shower audit tool weekly for 8 weeks and monthly for 1 month. The assigned nursing assistant will be immediately retrained during the audit by Nursing Supervisor for any identified areas of concern. The DON will review and initial the Shower audit tools weekly for 8 weeks and monthly for 1 month for completion and to ensure all areas of concerns were addressed.<br>10 % of alert and oriented resident will be interviewed by the Social Worker utilizing a Dignity/ Choices Interview Tool weekly X 8 weeks and monthly X 1 month. A resident concern form will completed by the Social Worker and forwarded to the Administrator for any identified areas of concerns. The Administrator will review and initial the Dignity/Choices Interview tool for completion weekly X 8 weeks and monthly X 1 month.<br>The Director of Nursing will forward the results of the Resident Care Audit-Meal Observation and the Dignity/ Choices Interview Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Resident Care Audit- Meal Observation and Dignity/ Choices Interview Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring | |

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| F 242 | Continued From page 24<br>shower, then it needed to be documented in the medical record and the Responsible Party (RP) should be notified. | F 242 | | |
| F 248 SS=D | 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>(c) Activities.<br><br>(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and family and staff interviews, the facility failed to provide an on-going activity program designed to allow the resident to participate in one on one activities and to have supervised activity outdoors for one of one sampled resident (Resident #44).<br><br>Findings included:<br><br>Resident #44 was admitted to the facility initially on 7/27/2014. His diagnoses included Hypertension, Non-Alzheimer's Dementia, Depression, Schizophrenia, Chronic Kidney Disease, Dysphagia and Vascular Dementia.<br><br>An activity assessment dated 5/24/2017 documented resident interests as outside, family and friend visits, Spanish music and one on one | F 248 | F 248<br><br>Resident # 44 was provided 1:1 in room activities on 10/5/2017 by Activity aide with documentation in the electronic medical record. Resident # 44 was provided a supervised activity outdoors by activity aide on 10/18/2017 with documentation in the electronic medical record.<br>100% audit will be completed on 11/05/2017 by the Social Worker with a 7 day look back to ensure all residents are being provided ongoing Activities that are of interest to the residents in an effort to meet each resident's needs. Activities that engage the resident as evidenced by the facility Activity calendar, in room documentation or group participation | 11/5/17 |

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| F 248 | Continued From page 25<br>visits. It noted Resident #44 refused group activities.<br><br>The Care Area Assessment Worksheet dated 5/30/2017 indicated Resident #44 made poor decisions and required monitoring and redirecting. The worksheet also indicated Resident #44 had a language barrier. The worksheet indicated Resident #44's primary language is Spanish.<br><br>The most recent care plan created on 08/01/2016 and revised 8/31/2017 indicated he had an alteration in supervised/organized recreation characterized by little or no involvement, lack of attendance related to progressive disease. The goal was for Resident #44 to participate in 2 - 3 activities per week through his next review. His interventions/tasks included "engage resident in group activities."<br><br>The Documentation Survey Report of Activities dated July 2017 to September 2017 revealed no documented activities from 7/01/17 to 7/09/17, from 7/17/17 to 7/28/17, from 8/09/17 to 8/15/17, and from 8/29/17 to 9/08/17.<br><br>No Activities Progress Notes for the months of July 2017 to September 2017 were found in Resident #44's Medical Records. The Activity Director failed to provide any documentation of what and/or when the resident received outside or in-room activities upon request.<br><br>The Quarterly Minimum Data Set (MDS) dated 9/05/2017 indicated Resident #44 was severely cognitively impaired with long and short term memory problems. | F 248 | documentation. The Activity Director will assure activities are immediately provided as appropriate to the resident for any identified areas of concerns during the audit.<br>All Activity Staff were in-serviced by the Facility Consultant on 10/5/2017 related to the requirement to provide Activities that are of interest to the residents in an effort to meet each residents needs and that engage the resident in a group or in room activity with daily documentation in the electronic medical record.<br>10% of residents to include resident #44 activity documentation and visual observation of in room and/or group activity participation will be reviewed/ observed weekly for 8 weeks and monthly for 1 month utilizing a Activity Attendance QI Audit tool to ensure ongoing activities are being offered that engage the resident by Activity Director. The Activity staff member will be retrained during the audit for any identified areas of concern by the Activity Director. The Administrator will review and initial the Activity Attendance QI Audit Tool weekly for 8 weeks and monthly for 1 month for completion and to ensure all areas of concerns are addressed.<br>The Administrator will forward the results of the Activity Attendance QI Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Resident Care Audit- Meal Observation and Dignity/ Choices Interview Tool to determine trends and / or issues that may need further interventions put into place | |

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| F 248 | Continued From page 26<br>An Activity Assessment Form dated 9/05/2017 documented resident interests as watching TV, listening to music, sitting outside and one on one visits. It noted Resident #44 did not attend group activities.<br><br>An observation on 9/10/2017 at 4:30 PM, revealed Resident #44 in his room in his wheelchair watching television.<br><br>During an interview on 9/10/2017 at 6:10 PM, Resident #44's family member reported that he was not receiving any stimulation and activities from staff at the facility. She added she had requested for him to go outside for he liked the outdoors and sunlight. She also stated he enjoyed Spanish movies and/or music.<br><br>In an interview on 9/10/2017 at 6:15 PM, Nurse #1 revealed she had no concerns with Resident #44 refusing care or his activities. She explained she redirected him when he refused care or medications and he usually complied later in the shift. She also explained she had no knowledge of him going outside for any sunlight or any outdoor activities.<br><br>During an interview on 9/10/2017 at 6:23 PM, Nursing Assistant #2 stated she did the best she could, but there were a "lot of times when there was only one Nursing Assistant on the 300 Hallway and many times the second Nursing Assistant (if scheduled) was called to go to another unit to assist with care or to relieve for lunch/dinner. This then left on one Nursing Assistant on the 300 Hallway until someone returned or until the next shift." She continued by stating she had not seen the activities staff take Resident #44 out of the unit to go outside when | F 248 | and to determine the need for further and / or frequency of monitoring. | |

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| F 248 | Continued From page 27 | F 248 | | |

she worked the 300 Hallway.

On 9/11/2017 at 8:50 AM, Resident #44 was observed sitting up in bed eating breakfast. Later that same day at 1:10 PM he was observed in bed resting quietly.

In an interview on 9/13/2017 at 11:35 AM, the Activities Director revealed there had been an Activity Aide for the 300 Hallway but she was no longer at the facility. She explained she was trying to replace the vacant staff positions. She acknowledged Resident #44 preferred Spanish music and movies. She also acknowledged he liked to go outside. She stated the prior staff had provided the services but it just was not documented.

An interview was conducted on 9/13/2017 at 12:05 PM with Nursing Assistant #1 revealed she had not seen Resident #44 taken outside in months.

During an interview on 9/13/2017 at 1:50 PM with Nursing Assistant #4, she explained she had not seen him go outside in a very long time. She explained her usual assignment is the 300 Hallway. She continued by saying there were few to no activities being done on the 300 Hallway.

During an interview on 9/13/2017 at 2:10 PM, the Administrator indicated her expectation was for the residents to receive the care and activities as indicated in their care plans. She expressed the facility would focus on providing one on one activities for Resident #44, take him outside and documenting his attendance in activities and/or his refusals.

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| F 250 | Continued From page 28 | F 250 | | |
| F 250 SS=D | 483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, family interview, staff interview, and physician interview the facility failed to coordinate care with a consulting vascular physician to assure a vascular procedure was done for one (Resident # 135) out of one resident with vascular ulcers. The findings included:<br><br>1. Record review revealed Resident # 135 was initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial fibrillation, severe peripheral vascular disease.<br><br>Review of the resident's last quarterly minimum data set (MDS) assessment, dated 8/13/17, revealed the resident was cognitively intact. The resident was also coded as having 7 vascular ulcers.<br><br>Review of a vascular physician's consult follow up note, dated 7/27/17, revealed the physician had identified through testing that the resident had bilateral chronic total occlusion of the superficial femoral arteries. The vascular physician's plan was to place a femoral artery balloon and a patch and stent to help with blood supply for her vascular ulcers. The physician noted he planned | F 250 | F 250<br><br>Resident # 135 had a follow-up appointment scheduled on 9/26/2017 by Ward Clerk with the vascular surgeon. Resident # 135 attended scheduled appointment on 9/26/2017. Resident Representative made aware of the appointment results on 9/27/2017 by Director of Nursing.<br>100% of all residents to include resident # 135 telephone orders and discharge summaries were audited for any request appointments on 10/6/2017 by Facility Consultant. Any identified areas of concern noted during the audit were immediately addressed by Director of Nursing/Facility Consultant. All residents with requested appointments from telephone orders or discharge summary have been made.<br>100% audit of all residents to include resident # 135 for NPO orders completed by Facility Nurse Consultant on 10/6/2017. Any identified areas of concern noted during the audit were addressed by Director of Nursing on 10/6/2017.<br>100% in-servicing with all licensed nurses to include agency nurses was initiated on 10/3/2017 by Director of Nursing | 11/5/17 |

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| F 250 | Continued From page 29<br>to do the left leg first and then at a later time do the right leg.<br><br>There was no notation in the resident's facility progress notes when the vascular procedure was to take place.<br>On 9/11/17 the first documentation appeared in the nursing notes in regards to the facility's efforts to schedule an appointment with the vascular physician. Nurse # 6 documented on 9/11/17 at 11:44 AM that a call had been placed to the vascular physician's office to make an appointment, and that the resident's left lower extremity continued to worsen because of no circulation. The nurse noted the resident had refused to go to previous appointments per the resident's responsible party.<br><br>Interview with the resident's responsible party on 9/20/17 at 12 noon revealed the resident was scheduled to undergo the vascular procedure on 8/8/17, but never had the procedure because the resident was given a breakfast tray and not kept NPO (nothing by mouth) by facility staff. The RP stated it was rescheduled for a second time, and the resident was nauseated and did not feel up to going to the hospital. The RP stated the resident's left leg continued to get worse and she felt the facility was not communicating well with the vascular physician in order to get the procedure done. The RP stated one day she was present when the resident's dressing changes were being done, and she saw that the resident's left leg ulcer had worsened to the point that the tendon was exposed. The RP stated she demanded that the facility call and get the resident back to the vascular physician.<br><br>Interview with the wound care nurse and | F 250 | regarding appointments: Nurses must check daily prior to the start of medication pass to see if any of their assigned residents have MD appointments to include time. Nurse must to ensure that resident is up, dressed and ready for the appointment. Nurse should try and encourage resident to go to their appointment for any refusals. If resident continues to refuses, nurse must notify attending MD and Resident Representative with documentation in a nursing progress note. Once a resident returns from appointment: Check paperwork for new orders, next appointment, dressing changes etc. Make sure that Resident Representative is aware of any new orders and follow up appointments. Make sure document medication changes, adding a medication, NPO orders, treatment changes and notification of Resident Representative in a nursing progress note to be completed on 11/05/2017. All newly hired nurses to include agency will be in-serviced during orientation by the Staff Facilitator regarding Nurses must check daily prior to the start of medication pass to see if any of their assigned residents have MD appointments to include time. Nurse must to ensure that resident is up, dressed and ready for the appointment. Nurse should try and encourage resident to go to their appointment for any refusals. If resident continues to refuses, nurse must notify attending MD and Resident Representative with documentation in a nursing progress note. Once a resident returns from appointment: Check | |

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| F 250 | Continued From page 30<br>administrator on 9/21/17 at 2:40 PM revealed the facility's ward clerk had been working with the vascular physician's office to get Resident # 135's procedure scheduled with the vascular physician.<br><br>The ward clerk was interviewed on 9/22/17 at 10 AM. The ward clerk referenced her appointment book and verified the resident was first scheduled for the vascular procedure on 8/8/17, but had not had the procedure completed because the resident had not been kept NPO.<br><br>The ward clerk continued and said the procedure was next scheduled for 8/21/17. The ward clerk said the resident did not go to that appointment either, and it was her understanding the resident had been nauseated. The ward clerk stated she had been off work on 8/21/17, and it was "probably" 8/25/17 or the following week before she was made aware she was supposed to be working on rescheduling the procedure. The ward clerk stated on the day she was made aware, she called the vascular physician's office and was told she needed to speak to a specific person. The ward clerk stated she left a message for the person. The ward clerk stated the person called back and said that they would talk to the vascular physician regarding the resident since she had missed two appointments.<br><br>The ward clerk stated she never heard back and the wound care nurse called on 9/11/17 to talk to the office.<br>On 9/25/17 at 10:49 AM a staff member at the vascular physician's office was interviewed. The staff member confirmed the resident's vascular procedure was not done on 8/8/17 because the resident was not kept NPO. The staff member confirmed the resident did not show up for the | F 250 | paperwork for new orders, next appointment, dressing changes etc. Make sure that Resident Representative is aware of any new orders and follow up appointments. Make sure document medication changes, adding a medication, NPO orders, treatment changes and notification of Resident Representative in a nursing progress note<br>100% in-servicing with all nursing assistants was initiated on 10/3/2017 by Facility Nurse Consultant regarding Please check appointment list located on glass case in break room for any assigned residents that may be NPO for that day. All care provided and refusals must be documented on the shift that task is performed to be completed by 11/05/2017. All newly hired nursing assistants will be in-serviced during orientation by the Staff Facilitator regarding Please check appointment list located on glass case in break room for any assigned residents that may be NPO for that day. All care provided and refusals must be documented on the shift that task is performed.<br>Ward clerk in-serviced on 10/17/2017 by Administrator on the importance of scheduling appointments per telephone order request, discharge summary and in a timely manner. This includes documenting after scheduling appointment and notifying the responsible representative. If ward clerk unable to get appointment schedule for any reason ward clerk is to notify Director of Nursing immediately. | |

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| F 250 | Continued From page 31<br>second procedure which had been scheduled for 8/21/17.<br>Interview with the resident's RP on 9/20/17 at 12 noon revealed when she accompanied the resident to the 9/12/17 appointment, the vascular physician immediately decided to admit the resident to the hospital the next day for a planned amputation of the resident's left leg.<br><br>Record review revealed the resident was hospitalized on 9/13/17 and underwent a left above the knee amputation. During the same hospitalization the resident had a right superficial femoral artery recanalization and endovascular intervention to her right leg. (a procedure to help circulation to her right lower leg).<br><br>The resident's vascular physician was interviewed on 9/25/17 at 11:15 AM and stated when he initially saw the resident her vascular disease was severe to the point that the family knew the resident would probably need bilateral amputations. The vascular physician stated they wanted to first try intravascular procedures. According to the vascular physician, he had not been made aware the resident's leg was declining and the tendon was exposed until the staff made the appointment for 9/12/17. The vascular physician stated it was his understanding that one of the resident's missed procedure appointments was due to the resident not being kept NPO, and the second one was due to the resident being nauseous and not feeling well. The physician stated if he had been alerted that the tendon had been exposed, he then would have tried to admit the resident to the hospital to better manage these problems which had kept her from having the procedures on 8/8/17 and 8/21/17. | F 250 | Treatment Nurse was in-serviced on 10/17/2017 by Corporate Wound Consultant regarding: Treatment nurse must monitor wounded residents Physician appointments to assure that residents attend the scheduled appointments. Treatment nurse need to assure all recommendations are followed through new dressing orders, follow up appointments etc. Treatment nurse must write any telephone orders needed and make resident representative aware of any new orders and follow up appointments with documentation in the electronic medical record. If a wound worsens the treatment nurse must notified the Physician for any new orders and notified resident representative of worsening of wound to include, any changes to dressings with documentation in the electronic medical record.<br>100% in-servicing initiated on 10/17/2017 by the Facility Nurse Consultant with the Director of Nursing, RN Supervisor, Staff Facilitator, Quality Improvement Nurse regarding the admissions checklist to completed after each new admit, to identify any requested appointments from discharge summary. Upon completion of admission checklist the DON, RN Supervisor, Staff Facilitator or QI Nurse is to notify the Ward Clerk of the requested appointment to be completed by 11/05/17<br>100% in-servicing initiated on 10/17/2017 by the Facility Nurse Consultant with the Director of Nursing, RN Supervisor, Staff Facilitator, Quality Improvement Nurse regarding monitoring the pink telephone orders 5 X a week for orders for any | |

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| F 250 | Continued From page 32 | F 250 | requested appointments. Upon review of pink telephone orders the Director of Nursing, RN Supervisor, Staff Facilitator or Quality Improvement Nurse is to make the Ward clerk aware that appointment has been requested.<br>Upon each new admission to the facility the RN Supervisor, Staff Facilitator or Quality Improvement Nurse will review the discharge summary using the Admission checklist 5 X a week X 8 weeks and monthly X 1 month. Once Admission Checklist completed, the Ward Clerk is to be made aware of the requested appointment. The DON will review and initial the Admission Checklist for completion weekly X 8 weeks and monthly X 1 month. Any identified areas of concerns will be corrected during the audit by Assistant Director of Nursing.<br>The pink telephone orders will be reviewed by the RN Supervisor, Staff Facilitator and Quality Improvement Nurse 5 X a week for 8 weeks and monthly X 1 month to assure that Ward clerk is made aware of any requested appointments.<br>The DON will provide oversight in reviewing the pink telephone orders 5 X a week X 8 weeks and monthly X 1 month. Any identified areas of concern will be corrected at the time of review.<br>The Director of Nursing will forward the results of the Admission checklist to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Admission Checklist to determine trends and / or issues that may need further interventions put into place and to | |

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| F 250 | Continued From page 33 | F 250 | determine the need for further and / or frequency of monitoring. | |
| F 281 SS=E | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interviews, and staff interviews the facility failed to administer and document the administration of medications for three (Residents # 135, #97 and # 175) of three sampled residents reviewed for medications. The findings included:<br><br>1. Record review revealed Resident # 97 was last readmitted to the facility on 8/22/17. The resident had a diagnosis of diabetes.<br><br>Review of the resident's care plan, last updated on 8/17/17, revealed the staff had identified the resident was at risk for complications of diabetes. Two of the care plan interventions directed staff to perform finger stick blood sugars as ordered per the facility protocol and administer the resident's medication as ordered.<br><br>Review of Resident # 97's readmission minimum data set (MDS) assessment, dated 9/5/17, revealed the resident was cognitively intact.<br><br>Review of the resident's physician orders | F 281 | F281<br><br>Resident #97 no longer at facility.<br>Resident # 175 was assessed for pain on 10/17/2017 by Director of Nursing.<br>Resident # 175 pain medication was administered per the MAR on 10/17/2017 by Medication Aide. Resident # 135 was assessed for pain on 10/17/2017 by Staff Facilitator. Resident # 135 was administered pain medications per the MAR on 10/17/2017 by medication aide.<br>Nurse #1, Nurse #2, Nurse #6 and Medication aide #2 were in-serviced on 10/4/2017 by Facility Consultant regarding Document medications on the MAR after it has been given to include narcotics and blood sugars. Document narcotics on the narcotic count sheet as soon as you pull it out of the drawer. All refusals should be initialed and circled on the front of the MAR and the reason should be written on the back. Never give any medications from memory to include insulin. Always | 11/5/17 |

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| F 281 | Continued From page 34<br>revealed an order, dated 8/21/17, for the resident to have sliding scale insulin coverage before meals and at bedtime. For blood sugar levels of 150 to 200 the resident was ordered to receive 2 units of Humalog Insulin.<br><br>Interview with the resident on 9/20/17 at 1:20 PM revealed he thought there had been a morning when he was supposed to get sliding scale Insulin coverage recently and he had not received any.<br><br>Review of the resident's September 2017 medication administration record (MAR) revealed the following documentation: On 9/1/17 Nurse # 1 documented the resident's 6:00 AM blood sugar was 154 and she documented she administered zero units of Insulin. On 9/2/17 Nurse # 1 documented the resident's blood sugar at 6:00 AM was 160 and she documented she administered zero units of Insulin. On 9/8/17 Nurse # 1 documented the resident's blood sugar at 6:00 AM was 174 and she documented she administered zero units of insulin.<br><br>On 9/9/17 at 6 AM Medication Aide # 2 documented the resident's blood sugar was 182. There was documentation the resident received zero units of Insulin.<br><br>On 9/14/17 Nurse # 1 documented the resident's blood sugar at 6:00 AM was 164 and she documented she administered zero units of Insulin. Review of the MAR revealed that for each time zero units of Insulin had been given on the above dates, a zero had been placed on the MAR with a line drawn through it.<br><br>Nurse # 1 was interviewed on 9/22/17 and confirmed she had not given Resident # 97 his | F 281 | follow orders on the MAR. Follow physician's order on the MAR to include special instructions when administering insulin to include before or after meals. Also read MAR correctly for correct sliding scale dose of insulin.<br><br>100% audit was completed on 10/5/2017 by Facility Nurse Consultant on all resident's receiving sliding scale insulin from 9/1/17 to 9/30/2017 to ensure that sliding scale insulin was given as ordered. Attending Doctor made aware of any discrepancies during the audit by Facility Consultant on 10/6/2017.<br><br>100 % Medication Pass audits initiated on 9/26/2017 by Facility Nurse Consultant with all licensed nurse and medication aides' to ensure physician orders are being followed to include orders for sliding scale insulin and narcotics and medications administered timely to be completed on 11/05/2017.<br><br>100% of all licensed nurses and medication aides to include Nurse #1, Nurse #2,<br>Nurse #6 and medication Aide # 2 were in-serviced on Medication Administration to include Document medications on the MAR after it has been given to include narcotics and blood sugars. Document narcotics on the narcotic count sheet as soon as you pull it out of the drawer. All refusals should be initialed and circled on the front of the MAR and the reason should be written on the back. Never give any medications from memory to include | |

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| F 281 | Continued From page 35<br>ordered sliding scale Insulin coverage on 9/1/17, 9/2/17, 9/8/17, and 9/14/17 at 6:00 AM. Nurse # 1 stated Resident # 97 used to have different sliding scale orders prior to his readmission on 8/21/17. Nurse # 1 stated according to the old order the resident used to get sliding scale coverage for blood sugar readings above 200 only. The nurse stated she therefore was going by what she remembered the sliding scale coverage to be for the resident per his previous residency, and she had not referenced the MAR's instructions on 9/1/7, 9/2/17, 9/8/17, and 9/14/17 to note the order had changed.<br><br>On 9/22/17 Nurse Consultant # 1 identified Nurse # 5 as the nurse who would have been responsible for the medication aide and Insulin coverage for 6 AM on 9/9/17 for Resident # 97.<br><br>Nurse # 5 could not be reached during the survey.<br><br>2. Record review revealed Resident # 175 was admitted to the facility on 7/12/17. The resident had diagnoses of cerebrovascular accident, chronic pain, diabetes, and hypertensive disorder.<br><br>Review of the resident's minimum data set (MDS) assessment, dated 7/19/17, revealed the resident was cognitively intact.<br><br>Review of the resident's care plan, dated 7/19/17, revealed the resident had chronic pain, migraines, and diabetic neuropathy.<br><br>Review of Resident #175's September 2017 medication administration record (MAR) reflected the following orders were present for 09/17/17 at 8:00 AM: | F 281 | insulin. Always follow orders on the MAR. Follow physician's order on the MAR to include special instructions when administering insulin to include before or after meals. Also read MAR correctly for correct sliding scale dose of insulin on 10/4/2017 by Facility Nurse Consultant/Director of Nursing. All newly hired license nurses will be in-serviced by the staff facilitator during orientation regarding Medication Administration to include Document medications on the MAR after it has been given to include narcotics and blood sugars. Document narcotics on the narcotic count sheet as soon as you pull it out of the drawer. All refusals should be initialed and circled on the front of the MAR and the reason should be written on the back. Never give any medications from memory to include insulin. Always follow orders on the MAR. Follow physician's order on the MAR to include special instructions when administering insulin to include before or after meals. Also read MAR correctly for correct sliding scale dose of insulin.<br><br>Assistant Director of Nursing/Staff Facilitator will monitor 10% of all licensed nurses and medications aides to include Nurse # 2, Nurse # 5, Nurse # 6 and medication aide # 2 utilizing a Medication Pass audit tool weekly X 8 weeks and monthly X 1 month to ensure that medications to include orders for sliding scale insulin and Narcotics are given per the MAR and timely. The Assistant Director of Nursing/Staff Facilitator will retrain the license nurse and/ or | |

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| F 281 | Continued From page 36<br>Oxycontin 10 milligrams (mg) every 12 hours by mouth - signed "S"<br>Zestril 2.5 mg by mouth daily- signed "S"<br>Aspirin 81 mg by mouth daily- signed "S"<br>Claritin 10 mg by mouth daily- signed "S"<br>Buspirone 5 mg by mouth daily - signed "S"<br><br>Further review of the September 2017 MAR revealed the Oxycontin 10 mg due at 8 PM on 9/17/17 had been signed "SS" and the initials were circled indicating it had not been given. There was no explanation on the back of the MAR.<br><br>A review of the Controlled Substance Receipt/Count Sheet for the resident's OxyContin revealed there was no documentation the OxyContin had been removed from the resident's OxyContin supply at any time on 9/17/17.<br><br>Nurse # 2 was interviewed on 9/20/17 at 5:30 PM. Nurse # 2 stated she had worked as the night shift supervisor beginning on 9/16/17 and stayed over until 9:30 AM on 9/17/17. Nurse # 2 recalled that MA # 2 was scheduled for 9/17/17 dayshift to give medications on Resident # 175's hall, but had been late for work and she (Nurse # 2) had stayed until the DON had arrived. Nurse # 2 could not recall exactly how medications were given the morning of 09/17/17.<br><br>Nurse # 6 was interviewed on 9/20/17 at 5:35 PM. Nurse # 6 stated she was usually the treatment nurse during the weekdays, but had given medications on Resident # 175's hall during the 3:00 PM to 11:00 PM shift on 9/17/17. Nurse # 6 stated she should have noted a reason on the back of the MAR for holding Resident # 175's scheduled OxyContin at 8:00 PM on 9/17/17. | F 281 | medication aide for all identified areas of concern during the audit. The DON will review and initial the Medication Pass Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern are addressed.<br><br>The Director of Nursing will forward the results of the Medication Pass Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Medication Pass Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. | |

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| F 281 | Continued From page 37 | F 281 | | |

Nurse # 6 stated the resident did not want the OxyContin and she had not given it, and she should have documented this on the back of the MAR.

MA # 2 was interviewed on 9/21/17 at 6:50 AM and again on 9/22/17 at 3:40 PM. MA # 2 stated she had not been late on the morning of 9/17/17. MA # 2 stated she had worked the previous night shift (11:00 PM on 09/16/17 until 7 AM on 09/17/17.) MA # 2 stated at 7:00 AM on 9/17/17 there was no staff member to replace her, and she could not go home. MA # 2 confirmed she had not given Resident # 175 his 8:00 AM medications of OxyContin, Zestril, Aspirin, Claritin, or Buspirone on 9/17/17. MA # 2 stated she signed her initials with two letters, and the single "S" was not the initial she used on the MAR. MA # 2 did not know how the "S" had been documented on Resident # 175's MAR by the resident's morning medications.

Interview on 9/22/17 at 3:45 PM with the DON and the administrator revealed they had no explanation for the "S" which appeared by Resident # 7's OxyContin, Zestril, Aspirin, and Claritin. The DON stated she had been in the facility on 9/17/17 and it was her understanding that MA # 2 was giving medications and would have been responsible for them.

3. Record review revealed Resident # 135 was initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial fibrillation, severe peripheral vascular disease, history of bowel resection with colostomy

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formation, and both vascular and pressure ulcers.

Review of the resident's last quarterly minimum data set (MDS) assessment, dated 8/13/17, revealed the resident was cognitively intact.

Record review revealed the resident was hospitalized from 9/13/17 until 9/16/17 and underwent a left above the knee amputation.

The resident was readmitted to the facility on 9/16/17 where she was to receive wound care for her left stump, vascular ulcers to her right lower extremity, and also to a Stage III pressure ulcer to her coccyx.

Review of the resident's readmission orders, dated 9/16/17, revealed the resident was to receive Tramadol 50 milligrams (mg) every eight hours.

Review of the resident's September 2017 MAR (medication administration record) revealed the resident's Tramadol was transcribed to the MAR to be given at 8:00 AM; 12:00 PM; and 8:00 PM.

Review of the resident's Tramadol Controlled Substance Receipt/Count Sheet revealed the resident would have had 16 doses available for administration at the administration time of 8:00 AM on 9/17/17. There was no Tramadol signed out for the 8:00 AM dose on 9/17/17.

Review of the September MAR revealed Nurse # 2 had signed she had given the 8:00 AM dose on 9/17/17.
Nurse # 2 was interviewed on 9/21/17 at 4 PM. Nurse # 2 stated she was giving medications on 9/18/17 and the MAR had been blank by the

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9/17/17 Tramadol dose of 8:00 AM, and she inadvertently initialed there instead of on 9/18/17. The nurse confirmed she had not given the resident the 8:00 AM dose of Tramadol she signed as giving on 9/17/17.

Medication Aide (MA) # 2 was interviewed on 9/21/17 at 6:50 AM. MA # 2 stated she had worked the previous night shift (11:00 PM on 9/16/17 to 7:00 AM on 9/17/17). MA # 2 stated at 7:00 AM on 9/17/17 there was no staff member to replace her, and she could not go home. MA # 2 stated she stayed and starting giving medications on a hall other than the one where Resident # 135 resided. MA # 2 stated she tried to administer as many of the medications as she could on Resident # 135's hall after she finished her first hall, but was not able to administer all of them. She was not able to say how medication responsibilities were handled on the resident's hall or verify all of the medications she had not administered.

Review of the resident's Tramadol Controlled Substance Receipt/Count Sheet revealed there was no Tramadol signed out for the 8:00 AM dose on 9/18/17. Review of the September MAR revealed Nurse # 2 had signed she had given a dose at 8 AM on 09/18/17.

Nurse # 2 was interviewed on 9/21/17 at 4 PM. Nurse # 2 confirmed she had signed she gave Tramadol at 8 AM when she had not administered the medication on 9/18/17.

Interview with the resident on 9/22/17 at 9:48 AM revealed she did not recall a time when she ever refused her pain medication.

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| F 309 SS=E | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING | F 309 | | 11/5/17 |

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:

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| F 309 | Continued From page 41<br>Based on record review, family interview, and staff interviews the facility failed to provide dressing changes and coordination of care with a consulting vascular physician to assure a vascular procedure was done for one (Resident # 135) out of one resident with vascular ulcers. The findings included:<br><br>1. Record review revealed Resident # 135 was initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial fibrillation, severe peripheral vascular disease.<br><br>Review of the resident's last quarterly minimum data set (MDS) assessment, dated 8/13/17, revealed the resident was cognitively intact. The resident was also coded as having 7 vascular ulcers.<br><br>Review of the resident's care plan, last updated on 8/17/17, revealed the staff had identified the resident had skin ulceration caused by diabetes and peripheral vascular disease. The goal for the resident was that she would show positive healing of her ulcers and not develop further ones. Staff were directed on the care plan to provide treatment as ordered.<br><br>According to August, 2017 wound ulcer flow records the resident had vascular ulcers on her left lower leg, right lower leg, left great toe, left outer great toe, left heel, right heel, and right great toe.<br><br>a. On 9/23/17 the facility was asked to provide the treatment orders from the resident's thinned | F 309 | F 309<br><br>On 9/21/17, a head to toe skin assessment was completed on Resident #135 to include the coccyx ulcer with no new skin issues identified or changes to the coccygeal wound. On 9/22/17, the coccyx wound was cleansed, Santyl ointment and dressing applied by the treatment nurse per the physician's orders. On 9/25/17, The Director of Nursing (DON) was made aware that Resident #135 failed to receive dressing changes as ordered for 8/5/17, 8/6/17, 8/12/17, 8/13/17, 8/19/17, 8/20/17, 8/26/17, 8/27/17, 9/2/17, 9/3/17, 9/9/17, and 9/10/17. On 9/28/17, Resident #135 was seen by the wound physician and returned to the facility with new orders for treatment of the coccyx wound: Cleanse with soap and water, apply crushed Flagyl 500 milligrams, cover with Aquacel Silver and a foam dressing to be changed every other day and as needed. Resident #135 had a follow up appointment with the wound physician on 10/5/17 with no change in orders for treatment to the coccyx and another appointment scheduled for October 19, 2017.<br><br>On 8/8/17, Resident #135 attended the appointment with Carolina Vascular for the vascular procedure, but was unable to undergo the procedure due to eating breakfast prior to arrival. The procedure was cancelled on 8/8/17, and Resident #135 returned to the facility.<br><br>On 8/8/17, Resident #135 was | |

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| F 309 | Continued From page 42<br>medical record which would have been in effect for August and September, 2017 for the resident's vascular ulcers.<br><br>On 9/25/17 at 5:13 PM, the DON (director of nursing) provided a physician's order, dated 7/25/17, for the ulcers located on the resident's right and left lower legs. This order specified the resident was to have daily dressing changes to these areas. The staff were to cleanse these ulcers with saline and apply Santyl and a dry dressing.<br><br>On 9/26/17 at 4:46 PM, the facility administrator provided the facility's wound protocol as the treatment modality being used for Resident #135's left great toe, left outer great toe, left heel, right great toe, and right heel during the months of August, 2017 and September, 2017.<br><br>Review of Resident 135's August, 2107 treatment administration record (TAR) revealed the resident was to have the following dressing changes.<br><br>The right and left lower leg dressings were to be changed daily. Santyl was to be applied with a dry dressing per the August, 2017 TAR.<br><br>The left great toe was to be painted with betadine and a dry dressing applied. The dressing was to be checked and changed daily per the August, 2107 TAR.<br><br>The left outer great toe, left heel, right heel, and right great toe were to be painted with betadine. The dressing was to be checked daily and changed every three days per the August, 2017 TAR. | F 309 | re-scheduled for an appointment with Carolina Vascular on 8/21/17 by the ward clerk.<br><br>On 8/21/17, Resident #135 was scheduled to attend the appointment with Carolina Vascular. Resident # 135 did not go to the appointment due to complaints of nausea.<br><br>On 9/12/17, Resident #135 arrived for appointment at Carolina Vascular for evaluation of bilateral lower extremities. Resident # 135 was transported to Cape Fear Valley Medical Center<br><br>On 9/17/17, Resident #135 returned to the facility from Cape Fear Valley Medical Center.<br><br>On 9/26/17, Resident #135 went to Carolina Vascular for evaluation of bilateral lower extremities.<br><br>On 10/17/2017, a 100% audit of all Treatment Administration Records (TARs) for the 8/1/2017-9/30/2017 was initiated by the Facility Nurse Consultant and Director of Nursing to ensure all dressing changes were performed as ordered by the physician to include Resident #135. The 100% audit of all TARs will be completed by 11/05/2017. Any areas of concern identified during the audit to include missing documentation will be immediately addressed by the Director of Nursing to include additional retraining, physician notification, and/ or any new orders. | |

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| F 309 | Continued From page 43<br>Review of the August 2017 TAR revealed no documentation on the following weekend dates Resident # 135's dressings were checked or changed to any of her vascular ulcers: 8/5/17, 8/6/17, 8/12/17, 8/13/17, 8/19/17, 8/20/17, 8/26/17, 8/27/17.<br><br>Review of the September, 2017 TAR revealed the resident was to have the following dressing changes:<br>The right and left lower leg dressings were to be changed daily. Santyl was to be applied with a dry dressing per the September, 2017 TAR.<br><br>The left great toe, left outer great toe, left heel, right heel, and right great toe were to be painted with betadine. The dressing was to be checked daily and changed every three days per the September, 2017 TAR.<br><br>Review of the September 2017 TAR revealed no documentation on the following weekend dates Resident # 135's dressings were checked or changed to any of her vascular ulcers: 9/2/17, 9/3/17, 9/9/17, and 9/10/17.<br><br>Record review revealed on 9/13/17 Resident # 135 was admitted to the hospital where she underwent amputation of her left leg secondary to the necrotic areas on her left leg not being amenable to debridement and revascularization.<br><br>Interview with the resident's responsible party (RP) on 9/20/17 at 12 noon revealed she was concerned the resident's dressings did not appear to be changed on some days when she visited. The resident's RP stated the dressings appeared old, and there was no date on the dressings. The RP stated she had talked to staff | F 309 | On 10/6/2017, a 100% audit of all charts beginning August 1, 2017 was completed by the facility nurse consultant to ensure all appointments requiring residents to remain with nothing by mouth (NPO) prior to a scheduled appointment was correctly followed and that the procedure was completed. Any areas of concern observed was immediately addressed by the facility nurse consultant and/ or Director of Nursing (DON).<br>On 10/4/2017 a 100% inservice was initiated by the Facility Nurse Consultant/Director of Nursing/Staff Facilitator for all licensed nurses regarding the expectation that dressing changes will be completed by the hall nurses in absence of the treatment nurse, to include on weekends. The 7-3 shift completes odd numbered rooms and 3-11 completes even numbered rooms. This is not an option. Document by initialing the Treatment Administration Record immediately after completing treatment. If treatments cannot be completed the hall nurse must notify nursing supervisor/ of Director of Nursing. All refusals of treatments must be documented on the Treatment Administration Record and in the nursing progress note to include notifications of the physician and the Resident Representative of treatment refusal.<br>No licensed nurse will be allowed to work until completing this inservice. All newly hired and agency licensed nurses will be inserviced on orientation by the Staff | |

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| F 309 | Continued From page 44<br>members regarding her concerns.<br><br>On 9/22/17 at 3:14 PM Facility Nurse Consultant # 1 provided a list of nurses who had been responsible for Resident # 135's dressing changes during the September, 2017 weekends. On 9/26/17 at 10:55 AM the director of nursing (DON) provided a list of nurses who had been responsible for weekend dressing changes in August, 2017 for Resident # 135. According to the nurse consultant and DON one of the hall nurses for the dayshift and evening shifts on the lists should have done the dressing changes. The nurses identified as responsible and the dates and shifts on which they were identified to be responsible are as follows:<br>8/5/17- 7:00 AM to 3:00 PM -Nurse # 4<br>8/5/17- 3:00 PM to 11:00 PM- Nurse # 4<br>8/6/17- 7:00 AM to 3:00 PM- Nurse # 4<br>8/6/17- 3:00 PM to 11:00 PM- Nurse # 4<br>8/12/17- 7:00 AM to 3:00 PM-Nurse # 1<br>8/12/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/13/17-7:00 AM to 3:00 PM -Nurse # 7<br>8/13/17-3:00 PM to 11:00 PM- Nurse # 1<br>8/19/17-7:00 AM to 3:00 PM-Nurse # 8<br>8/19/17-3:00 PM to 11:00 PM-Nurse # 8<br>8/20/17-7:00 AM to 3:00 PM-Nurse # 1<br>8/20/17-3:00 PM to 11:00 PM -Nurse # 1<br>8/26/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/26/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/27/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/27/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/2/17-7:00 AM to 3:00 PM-Nurse # 3<br>9/2/17-3:00 PM to 11:00 PM-Nurse # 2<br>9/3/17-7:00 AM to 3:00 PM-Nurse # 3/or Nurse # 1<br>9/3/17-3:00 PM to 11:00 PM-Nurse # 2/ or Nurse # 1<br>9/9/17-7:00 AM to 3:00 PM-Nurse # 4 | F 309 | Facilitator regarding missed dressing changes and the expectation that all treatments ordered by the physician will be completed as ordered and documented on the TAR in the absence of a treatment nurse or other designated nurse to include on the weekends.<br>On 10/4/2017, a 100% inservice for all licensed nurses was initiated by the Director of Nursing regarding following orders for scheduled appointments to include ensuring the resident remains on NPO status prior to arriving for a procedure. This inservice provides education to the licensed nurses to always document any new orders for NPO status prior to an appointment in the resident's medical record (PCC) and on the Medication Administration Record (MAR) on the scheduled date of appointment. No licensed nurse will be allowed to work until completing this inservice. All newly hired and agency licensed nurses will be inserviced on orientation by the Staff Facilitator regarding following orders for scheduled appointments to include ensuring the resident remains on NPO status prior to arriving for a procedure. This inservice provides education to the licensed nurses to always document any new orders for NPO status prior to an appointment in the resident's medical record (PCC) and on the Medication Administration Record (MAR) on the scheduled date of appointment.<br>The Assistant Director of Nursing/Nurse Supervisor will conduct audits of 10% of TARs utilizing the TAR documentation audit tool weekly for twelve weeks to | |

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| F 309 | Continued From page 45<br>9/9/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/10/17-7:00 AM to 3:00 PM-Nurse # 4<br>9/10/17-3:00 PM to 11:00 PM-Nurse # 1<br><br>Nurse # 3, who had been identified as responsible on one day and had shared responsibility on another day, was interviewed on 9/22/17 at 5:15 PM. The nurse stated she had not done the dressing changes. The nurse was not aware it was her responsibility.<br><br>Nurse # 4, who had been identified as responsible on six of the week-end days as either solely or partially responsible, was interviewed on 9/22/17 at 6 PM. Nurse # 4 stated she had not done any dressing changes for Resident # 135 during the August and September week-end days she worked. The nurse stated she was charge nurse with other responsibilities, and she was not aware it had been her responsibility to change the dressings.<br><br>Nurse # 2, who had been identified as responsible or partially responsible on two days, was interviewed on 9/25/17 at 9:25 AM. The nurse stated she had not done the dressing changes. The nurse stated she had just started near the end of August, 2017 and she had not been made aware dressing changes were one of her responsibilities.<br><br>Nurse # 8, who had been identified as responsible for one day, was interviewed on 9/26/17 at 1:29 PM. The nurse stated she did not recall whether she had or had not done the dressing changes.<br><br>Nurse # 7, who had been identified as responsible on one day for the dressing changes, | F 309 | include Resident #135 to ensure dressing changes are completed as ordered by the physician. Any areas of concern noted during the audits will be immediately addressed by the DON to include additional training, physician notification, and/ or initiating the protocol for neglect if indicated.<br>The Nursing Supervisor will conduct audits of 10% of scheduled appointments utilizing the weekly for twelve weeks including Resident #135 to ensure all appointments requiring residents to remain with nothing by mouth (NPO) prior to a scheduled appointment was correctly followed. The Q.I tool for monitoring appointments will also ensure that documentation in the electronic medical record has occurred regarding the time, date, location, and reason for the scheduled appointment. and that the procedure was completed. Any areas of concern will be immediately addressed by the DON to include additional retraining.<br>The DON will forward the results of the QI Tool for monitoring appointments to the Executive QI Committee monthly for three months. The Executive QI Committee will meet monthly for three months to review the audit results of the Q.I. tool for monitoring appointments. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. | |

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was interviewed on 9/26/17 at 4:42 PM. The nurse stated she had not done the dressing changes. The nurse stated there was not enough time to do it. The nurse stated the facility used to have a treatment nurse on the week-ends, and when the treatment nurse quit during the summer months the facility management staff left a paper schedule for the hall nurses to do dressing changes. The nurse stated the paper schedule directed that dayshift nurses were responsible for either the odd number rooms or even number rooms, and the evening shift nurses were responsible for the ones the dayshift nurses did not do. The nurse stated management never went over the new responsibility or gave directions. They just left the paper schedule at the desk. The nurse stated it was an impossible task given the other responsibilities which were placed on the hall nurses. The nurse stated she often had to administer medications for two halls, be responsible for medication assistants on other halls, deal with family concerns, deal with issues/events that came up with residents, deal with week-end housekeeping issues, and answer the phone.

Nurse # 1, who had been identified as solely or partially responsible on 8 days, was interviewed on 9/27/17 at 9:20 AM. The nurse stated she had only done the dressing changes one time during August and September for Resident # 135, and that was when the resident's family member had approached her and requested it. The nurse stated she had not charted the one day she had done it. The nurse stated on the other days, she had not done the resident's dressing changes. The nurse stated there was not enough time to do the dressing changes given her other responsibilities. The nurse stated she often had to

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work double shifts and she often had her own medication cart responsibilities as well as cover for medication technicians who could not give intravenous fluids, Insulin, or tube feedings. The nurse stated she had talked to the previous DON, who had worked in August 2017, about the dressing changes not being done on the week-end but then the DON had left. The nurse stated the new DON had not been at the facility long enough for her to talk to her about the problem.

Interview with the DON on 9/25/17 at 9:19 AM revealed she had just been employed the previous week and she had not been made aware of the lack of dressing changes for Resident # 135.

Interview with the administrator on 9/26/17 at 12:15 PM revealed the missed dressing changes had not been brought to her attention and that the staff had probably told the previous DON, who was no longer employed.

The resident's vascular physician was interviewed on 9/25/17 at 11:15 AM. According to the vascular physician Resident # 135's vascular ulcer dressings should have been checked or changed daily as a standard of good practice. According to the physician, when he initially saw the resident in July 2017, her vascular disease was severe to the point that the family knew the resident would probably need bilateral amputations at some point.

1 b. Record review revealed a vascular physician initially saw Resident # 135 on 7/11/17. The physician noted the resident had severe ulceration of both lower extremities placing her at

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risk of limb jeopardy. The vascular physician noted he was scheduling noninvasive studies to evaluate the arterial anatomy and determine the arterial perfusion (circulation) to the lower extremities.

Review of the physician's consult follow up note, dated 7/27/17, revealed the physician had identified through testing that the resident had bilateral chronic total occlusion of the superficial femoral arteries. The vascular physician's plan was to place a femoral artery balloon and a patch and stent to help with blood supply for her vascular ulcers. The physician noted he planned to do the left leg first and then at a later time do the right leg. The vascular physician noted the procedure was explained to the resident and she acknowledged she understood and agreed to the procedure.

Review of the nursing progress and social service notes from 7/27/17 through 9/10/17 revealed no notations regarding when the resident went to further vascular consults or procedures.

Review of the resident's wound care notes revealed on 8/7/17 the resident's left leg ulcer was documented as 20 % necrotic; 40 % grey stringy tissue and 40% slough. The measurements were 2.5 cm X 2.0 X 0 centimeters (cm). On 8/21/17, the day on which the resident missed a procedure appointment, there was documentation the tendon was exposed in the resident's left leg ulcer. The measurements were 9.5 X 5.0 X 1.5 cm. On 8/28/17 the tendon was documented to be exposed, and the measurements were 9.5 X 4.5 X 1.2 cm. On 9/4/17 the tendon was documented as exposed, and the measurements were 9.0 X

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3.0 X 0.8 cm. On 9/11/17 the tendon was documented as exposed, and the measurements were 10.4 X 4.5 X 1.5 cm.

There was no notation in the resident's facility progress notes when the vascular procedure was to take place.

On 9/11/17 the first documentation appeared in the nursing notes in regards to the facility's efforts to schedule an appointment with the vascular physician. Nurse # 6 documented on 9/11/17 at 11:44 AM that a call had been placed to the vascular physician's office to make an appointment, and that the resident's left lower extremity continued to worsen because of no circulation. The nurse noted the resident had refused to go to previous appointments per the resident's responsible party.

Interview with the resident's responsible party on 9/20/17 at 12 noon revealed the resident was scheduled to undergo the vascular procedure on 8/8/17, but never had the procedure because the resident was given a breakfast tray and not kept NPO (nothing by mouth) by facility staff. The resident's RP stated the resident actually went to the hospital on 8/8/17 to have the procedure, and when they found she had eaten a piece of sausage they sent her back to the facility without doing the procedure. The RP stated it was rescheduled for a second time, and the resident was nauseated and did not feel up to going to the hospital. The RP stated the resident's left leg continued to get worse and she felt the facility was not communicating well with the vascular physician in order to get the procedure done. The RP stated one day she was present when the resident's dressing changes were being done,

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and she saw that the resident's left leg ulcer had worsened to the point that the tendon was exposed. The RP stated she demanded that the facility call and get the resident back to the vascular physician.

Interview with the wound care nurse and administrator on 9/21/17 at 2:40 PM revealed the facility's ward clerk had been working with the vascular physician's office to get Resident # 135's procedure scheduled with the vascular physician.

The ward clerk was interviewed on 9/22/17 at 10 AM. The ward clerk referenced her appointment book and verified the resident was first scheduled for the vascular procedure on 8/8/17. The ward clerk stated the facility had received instructions for the resident to be NPO, and she had given them to a facility nurse. The ward clerk could not recall to which nurse she had given them.

The ward clerk continued and said the procedure was next scheduled for 8/21/17. The ward clerk said the resident did not go to that either, and it was her understanding the resident had been nauseated. The ward clerk stated she had been off work on 8/21/17, and was not aware the resident had not gone to the procedure until later and that she needed to be following up to reschedule the procedure. The ward clerk stated on the day she was made aware, she called the vascular physician's office and was told she needed to speak to a specific person. The ward clerk stated she left a message for the person. The ward clerk stated the person called back and said that they would talk to the vascular physician regarding the resident since she had missed two appointments. The ward clerk stated she never heard back and the wound care nurse called on

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9/11/17 to talk to the office.

Interview with the dietary manager on 9/22/17 at 12:25 PM revealed the procedure for a resident to be NPO was for the staff to either tell him verbally or provide a note for him. The dietary manger stated he then made sure a tray was not prepared and sent to the hall for a resident who is to be NPO. The dietary manager stated he had not received any note or communication from anyone that the resident was to be NPO on the morning of 8/8/17.

Nurse #4, who was assigned to care for Resident #135 on 8/8/17, was interviewed on 9/22/17 at 6 PM. The nurse stated she arrived at the facility after the resident had already been served the breakfast tray on the morning of 8/8/17. The nurse stated there was confusion to whether the resident had eaten or not, and she was sent to the hospital but the physician did not do the procedure.

Interview with Nurse Aide (Nurse Aide) # 5 on 9/25/17 at 11:45 AM revealed she was the assigned NA for Resident # 135 on 8/8/17. NA # 5 stated she was in the dining room and was not aware the resident had been served a breakfast tray by another staff member on 8/8/17. The NA stated when she got to the resident's room, the resident had her breakfast before her and she told her she was not supposed to eat. The NA was not aware of what the resident had on the tray when it was served to verify if the resident had eaten or not.

On 9/25/17 at 10:49 AM a staff member at the vascular physician's office was interviewed. The staff member confirmed the resident's vascular

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procedure was not done on 8/8/17 because the resident was not kept NPO. The staff member confirmed the resident did not show up for the second procedure which had been scheduled for 8/21/17.

Interview with the resident's RP on 9/20/17 at 12 noon revealed when she accompanied the resident to the 9/12/17 appointment, the vascular physician immediately decided to admit the resident to the hospital the next day for a planned amputation of the resident's left leg.

Record review revealed the resident was hospitalized on 9/13/17 and underwent a left above the knee amputation. During the same hospitalization the resident had a right superficial femoral artery recanalization and endovascular intervention to her right leg.

The resident's vascular physician was interviewed on 9/25/17 at 11:15 AM and stated when he initially saw the resident her vascular disease was severe to the point that the family knew the resident would probably need bilateral amputations. The vascular physician stated they wanted to first try intravascular procedures. According to the vascular physician, he had not been made aware the resident's leg was declining and the tendon was exposed until the staff made the appointment for 9/12/17. The vascular physician stated it was his understanding that one of the resident's missed procedure appointments was due to the resident not being kept NPO, and the second one was due to the resident being nauseous and not feeling well. The physician stated if he had been alerted that the tendon had been exposed, he then would have tried to admit the resident to the hospital to better manage

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| F 309 | Continued From page 53<br>these problems which had kept her from having the procedures on 8/8/17 and 8/21/17.<br><br>During an interview with the administrator on 9/21/17 at 2:40 PM the administrator acknowledged the facility failed to keep the resident NPO on the morning of 8/8/17. The administrator stated although they served the tray, her staff felt that the resident knew she was not supposed to eat. The administrator stated her staff felt the resident was hesitant to have the procedure and therefore ate intentionally to avoid the procedure. The administrator stated on 8/21/17 her staff felt the resident just did not want to go. | F 309 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interview, family interviews, and staff interviews the facility failed to provide assistance with activities of daily living for two (Residents # 175 and # 99) out of nine sampled residents reviewed for care needs. The facility failed to provide feeding and toileting assistance (Resident # 99) and assistance with activities of daily living at bedtime (Resident # 175). The findings included:<br><br>1. Record review revealed Resident # 175 was admitted to the facility on 7/12/17. The resident had diagnoses of cerebrovascular accident, chronic pain, diabetes, and hypertensive disorder. | F 312 | F 312<br>On 10/18/17, Resident # 99 was provided with feeding assistance and received toileting assistance by the assigned hall nursing assistant.<br>Resident # 175 was provided assistance with bedtime activities of daily living (ADLs) on 10/15/2017 by assigned hall nursing assistant. NA #6 and Medication Aide # 3 were in-serviced on 10/3/2017 by Facility Nurse Consultant in regards to helping residents use the toilet and get dressed. Toileting may include to provide total assistance or partial assistance. | 11/5/17 |

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| F 312 | Continued From page 54<br><br>Review of the resident's minimum data set (MDS) assessment, dated 7/19/17, revealed the resident was cognitively intact. The resident was coded as needing extensive assistance from staff with his hygiene, dressing, bathing, and bed mobility needs.<br><br>Review of the resident's care plan, dated 7/19/17, revealed the resident had chronic pain, migraines, and diabetic neuropathy. The care plan also identified the resident was non-ambulatory, used a wheelchair for mobility, and needed assistance with his hygiene, dressing, and transfer needs. The care plan directed staff to transfer the resident with a mechanical lift and assist him with his activities of daily living needs.<br><br>The resident was interviewed on 9/20/17 at 1:50 PM and stated he had a migraine on Sunday (9/17/17) evening and wanted to go to bed but could not find anyone to help him. According to the resident he went on the hall and asked for help but there was not anyone available to assist him. The resident stated he was told the person who needed to help him was "around somewhere," but he could never find them. According to the resident after he tried to find someone to assist him for about two hours, he called his family member. He said his family member arrived around 9 PM and helped him prepare and go to bed because there was no available staff member to assist him.<br><br>According to staffing sheets for 9/17/17 Nurse # 6 was the 3:00 PM to 11:00 PM nurse on Resident # 175's hall. Nurse Aide (nurse aide) # 6 was the 3:00 PM to 11:00 PM shift NA. There were no | F 312 | Residents should be checked for toileting needs no less than every two hours. Turn, transfer, and reposition your residents to include the chair and bed. This task must be performed in a timely manner and based upon the resident's preference. Help to take residents to eat and to participate in various activities. Serve the residents meals and in some cases, assist the residents to eat if necessary. Residents must be fed in a manner that is not too fast for meal intake. Ensure all residents in rooms and in the dining room have trays passed out and residents needing assistance are being fed at the same time and reporting to hall nurse if care cannot be provided timely. Resident # 175 and # 99 continue to receive timely assistance with activities of daily living, feeding assistance and toileting assistance.<br>100% audit of all residents was initiated on 10/3/2017 by the Facility Consultant to include resident # 175 and # 99 to assure timely personal care to include assistance with ADL's, feeding assistance and toileting assistance to be completed on 11/05/2017. Personal care will immediately be provided for the resident and re-training to the nursing assistant for any areas of concern to be addressed by Facility Consultant/Staff Facilitator during audit.<br>100% of nursing assistants were re-educated on helping residents use the toilet and to get dressed. Toileting may include to provide total assistance or partial assistance. Residents should be checked for toileting needs no less than | |

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| F 312 | Continued From page 55<br>other staff members on the staffing sheets for Resident # 175's hall for the 3:00 PM to 11:00 PM shift.<br><br>Review of census information provided for the date of 9/17/17 revealed there were twenty residents on Resident # 175's hall on 9/17/17.<br><br>Nurse # 6 was interviewed on 9/20/17 at 5:35 PM. According to Nurse # 6 she was aware the resident had a headache on 9/17/17 at 4:30 PM and had given him medication. According to Nurse # 6 she did not normally give medications, and was being attentive to her duties on the medication cart and was not aware Resident #175 needed assistance getting ready for bed on Sunday evening (9/17/17). The nurse confirmed she had not assisted the resident to bed. According to Nurse # 6 when she got to his room for bedtime medications he was already in bed.<br><br>NA # 6 was interviewed on 9/21/17 at 4:10 PM. NA # 6 stated she thought she had "about fifteen" residents to care for on the evening shift of 9/17/17. NA # 6 stated she got to Resident # 175's room a little after 9:00 PM to assist him and he was already in bed, but she had not assisted him.<br><br>Interview with the resident's family member on 9/21/17 at 10:45 AM revealed he had received a call around 8 PM on 9/17/17 from Resident # 175. The family member stated Resident # 175 told him he had been to all of the halls and he couldn't find anyone to help him to go to bed. The family member stated he (the family member) then drove to the facility to help the resident. The family member stated when he arrived he only saw one or two people on the hall that evening. | F 312 | every two hours. Turn, transfer and reposition residents to include the chair and bed. This task must be performed in a timely manner and based upon the resident's preference. Help to take residents to eat and to participate in various activities. Serve the residents meals and in some cases, assist with eating if necessary. Residents must be fed in a manner that is not too fast for meal intake. Ensure all residents in room and dining room have trays passed out and residents needing assistance are being fed at the same time, and reporting to hall nurse if care cannot be provided timely on 10/3/2017 to be completed by 11/05/2017. All newly hired nursing assistants will be in-serviced by the Staff Facilitator during orientation on Help your residents use the toilet and to get dressed. Toileting may include to provide total assistance or partial assistance. Residents should be checked for toileting needs no less than every two hours. Turn, transfer and reposition residents to include the chair and bed. This task must be performed in a timely manner and based upon resident's preference. Help to take residents to eat and to participate in various activities. Serve the residents meals and in some cases, assist with eating if necessary. Residents must be fed in a manner that is not too fast for meal intake. Ensure all residents in room and dining room have their trays passed out and residents needing assistance are being fed at the same time, and reporting to hall nurse if care cannot be provided timely. | |

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| F 312 | Continued From page 56<br>The family member confirmed he was the one to help the resident prepare for bed and go to bed on 9/17/17. The family member stated there was not enough staff.<br>2. Record review revealed Resident #99 was admitted to the facility on 11/19/14. The resident had diagnoses of heart disease, acute kidney failure, dementia, and Alzheimer ' s Disease.<br><br>Review of the resident ' s annual minimum data set (MDS) assessment, dated 4/20/17, revealed the resident was severely cognitively impaired. The resident was coded as needing extensive assistance from staff with his hygiene, dressing, bathing, dressing, eating and bed mobility needs. He was assessed with no upper extremity impairments and impairments on both sides of his lower extremities. Resident #99 was also assessed as always incontinent for bowel and bladder.<br><br>Review of the resident ' s care plan, dated 7/26/17, identified the resident was cognitive impaired and needed assistance with bathing, dressing, eating, transferring, and mobility. The care plan directed staff to transfer with a mechanical lift and assist him with his activities of daily living needs.<br><br>According to the staffing sheets for 9/17/17, Medication Aide #3 was the 3:00 PM to 11:00 PM Nurse Assistant on Resident #99 ' s hall. There were no other staff members on the staffing sheets for Resident #99 ' s hall after the 7:00 AM to 3:00 PM Nurse Assistant #8 ended her shift.<br><br>Review of the census information provided for the date of 9/17/17 revealed there were twenty-one residents on Resident #99 ' s hall on 9/17/17. | F 312 | Resident care audit tools will be completed by Assistant Director of Nursing/Nursing supervisor on 10% of residents to include resident # 175 and # 99 to ensure residents received personal care to include assistance with ADL's, feeding assistance and toileting assistance 3 X a week for 4 weeks and weekly X 4 weeks and monthly X 1 month. All nursing assistants will be immediately retrained for any identified areas of concern by Assistant Director of Nursing/Nursing Supervisor during the observation. The Director of Nursing will initial and review the results of the resident care audit tool weekly X 12 weeks for completion and to ensure all areas of concerns have been addressed.<br><br>The Director of Nursing will forward the results of the Resident Care Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Resident Care Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. | |

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| F 312 | Continued From page 57<br><br>Interview with the resident ' s family member on 9/21/17 at 10:00 AM revealed she had been in the facility on 9/17/17 evening shift and no staff came in Resident ' s #99 room after Nurse Assistant #8 left to go home. The family member went to retrieve the dinner tray after no one came to feed Resident #99. She stated she received the tray from the staff and fed him. No one came to provide care for him while she was there. She stated she left about 10:00 PM.<br><br>Nurse Assistant #8 was interviewed on 9/21/17 at 3:14 PM. She stated she left the facility about 5:00 PM on 9/17/17 and she had no idea who took over her assignments. She stated the family was present with Resident #99 when she left.<br><br>Interview with the Scheduler on 9/21/17 at 3:30 PM revealed she was short staffed on 9/17/17. She explained Medication Aide #3 was assigned to Resident #99 for the 3:00 PM to 11:00 PM care. It was her understanding she would complete the Medication Pass for 7:00 AM to 3:00 PM shift and then become the assigned Nurse Assistant for 3:00 PM to 11:00 PM.<br><br>Medication Aide #3 was interviewed on 7/22/17 at 4:00 PM. According to Medication Aide #3, she was not aware she was assigned the front part of the hall. She expressed someone else was responsible for Resident #99 ' s care on the 3:00 PM to 11:00 PM shift. She confirmed she did not provide care to Resident #99 on her shift other than his medications. She did pass his dinner tray to his family and to her knowledge his family fed him dinner. | F 312 | | |
| F 314 | 483.25(b)(1) TREATMENT/SVCS TO | F 314 | | 11/5/17 |

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| F 314 SS=E | Continued From page 58<br>PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(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<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, family interview, and staff interviews the facility failed to assure one (Resident # 135) out of three sampled residents with pressures ulcers received dressing changes for a Stage III pressure ulcer as ordered. The findings included:<br><br>Record review revealed Resident # 135 was initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial fibrillation, severe peripheral vascular disease, and history of bowel resection with colostomy formation.<br><br>Review of the resident's quarterly minimum data | F 314 | F 314 Treatment and Services to Prevent/Heal Pressure Sores<br>On 9/21/17, a Head to Toe Skin Assessment was completed on Resident # 135 to include her coccyx ulcer with no new skin issues identified or changes to coccygeal wound by Treatment Nurse.<br>On 9/22/17, the coccyx wound was cleansed, Santyl ointment and dressing applied by the Treatment Nurse per the physician's orders. On 9/28/17, Resident #135 was seen by the Wound Physician and returned to the facility with new orders for treatment of Coccyx wound: Cleanse with soap and water, apply crushed Flagyl 500 milligrams, cover with Aquacel Silver and a foam dressing to be changed every other day and as needed. Resident | |

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| F 314 | Continued From page 59<br>set (MDS) assessment, dated 8/3/17, revealed the resident had one Stage III pressure ulcer.<br><br>Review of the resident's care plan revealed it was initiated on 5/14/17 and last updated on 8/17/17 to address the resident's pressure ulcer. A problem noted on the resident's care plan was that the resident had a wound to her coccyx. The facility's goal for the resident was that the coccyx wound would show healing.<br><br>Review of physician orders revealed an order dated 5/31/17 for daily dressing changes to the coccyx pressure ulcer. The order directed staff to cleanse the ulcer and apply Santyl ointment and a dry dressing daily.<br><br>August 2017 and September 2017 pressure ulcer measurements were reviewed revealing the following: On 8/7/17 the coccyx pressure ulcer measured 3.0 X 6.0 X 0.2 centimeters (cm) and was documented as granulating with yellow slough. On 9/11/17 the Coccyx pressure ulcer measured 6.0 X 4.5 X 0.1 cm and was documented as having red/pink granulating tissue with areas of red/pink non-granulating tissue.<br><br>The resident's pressure ulcer was observed on 9/21/17 at 10:10 AM as Nurse # 6 provided care. The pressure ulcer was observed to have both granulating tissue and slough.<br><br>Review of the resident's August 2017 and September 2017 treatment administration records (TARS) and nursing notes revealed on the following weekend dates there was no documentation the resident's coccyx pressure sore dressing had been changed. The dates were: 8/5/17; 8/6/17, 8/12/17, 8/13/17, 8/19/17, | F 314 | Representative made aware of the new wound orders by Director of Nursing on 9/28/2017. Resident #135 had follow up appointment with the Wound Physician on 10/5/17 with no change in orders for treatment to the coccyx, Resident Representative made aware of no new orders by Treatment Nurse on 10/5/2017. Resident # 135 another appointment scheduled for October 19, 2017. Resident Representative made aware of follow-up appointment by Facility Nurse Consultant on 10/10/2017.<br><br>100 % audit of all residents head to toe skin assessments for any changes in skin abnormalities was completed by the Treatment Nurse and Treatment Medication Nurse Aide on 9/21/17 with Physician and Resident Representative Notification of any identified changes. These assessments were documented utilizing a census sheet.<br>All current wounded residents were assessed by the facility Treatment Nurse initiated on 9/25/17 and completed on 9/27/17 with verification by the Facility Nurse Consultant for an assessment, dressing change per the physician order, physician notified of worsening of wound. No identified areas of concerns.<br>Facility Treatment Nurse was In-Serviced by the Facility Nurse Consultant: Do not backstage pressure ulcers, example: Stage 3 on one week then to a Stage 2 the next week. Unstageable wounds must be staged accurately when the wound bed is visible. The nurse must write a physician’s order for a Wound Vac to | |

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| F 314 | Continued From page 60<br>8/20/17, 8/26/17, 8/27/17, 9/2/17, 9/3/17, 9/9/17, and 9/10/17. The TAR was blank where nurses were to initial when the treatment was done.<br><br>On 9/22/17 at 3:14 PM Facility Nurse Consultant (FNC) # 1 provided a list of nurses who had been responsible for Resident # 135's dressing changes during the September, 2017 weekends. On 9/26/17 at 10:55 AM the director of nursing (DON) provided a list of nurses who had been responsible for weekend dressing changes in August, 2017 for Resident # 135. According to FNC# 1 and the DON one of the hall nurses for the dayshift and evening shifts on the lists should have done the dressing changes. The nurses identified as responsible and the dates and shifts on which they were identified to be responsible are as follows:<br>8/5/17- 7:00 AM to 3:00 PM -Nurse # 4<br>8/5/17- 3:00 PM to 11:00 PM- Nurse # 4<br>8/6/17- 7:00 AM to 3:00 PM- Nurse # 4<br>8/6/17- 3:00 PM to 11:00 PM- Nurse # 4<br>8/12/17- 7:00 AM to 3:00 PM-Nurse # 1<br>8/12/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/13/17-7:00 AM to 3:00 PM -Nurse # 7<br>8/13/17-3:00 PM to 11:00 PM- Nurse # 1<br>8/19/17-7:00 AM to 3:00 PM-Nurse # 8<br>8/19/17-3:00 PM to 11:00 PM-Nurse # 8<br>8/20/17-7:00 AM to 3:00 PM-Nurse # 1<br>8/20/17-3:00 PM to 11:00 PM -Nurse # 1<br>8/26/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/26/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/27/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/27/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/2/17-7:00 AM to 3:00 PM-Nurse # 3<br>9/2/17-3:00 PM to 11:00 PM-Nurse # 2<br>9/3/17-7:00 AM to 3:00 PM-Nurse # 3/or Nurse # 1<br>9/3/17-3:00 PM to 11:00 PM-Nurse # 2/ or Nurse | F 314 | include: location, pressure, frequency of change, intermittent or continuous pressure. If placed on hold, the nurse must write a physician order to discontinue and physician order for current treatment. If the wound vac is off greater than 2 hours, apply a wet to dry dressing and documented on the Treatment Administration Record completed on 10-4-2017.<br>100% In- Service was initiated by Director of Nursing to all Licensed Nurses, to be completed by 11/05/2017: When the treatment nurse is off or on the weekend, the nurses are to complete their own treatments.7-3 shift completes odd numbered rooms and 3-11 completes even numbered rooms. This is not an option. Document by initialing the Treatment Administration Record immediately after completing treatment. If treatments cannot be completed the hall nurse must notify nursing supervisor/ of Director of Nursing. All refusals of treatments must be documented on the Treatment Administration Record and in the nursing progress note to include notifications of the physician and the Resident Representative of treatment refusal.<br>The Director of Nursing will monitor the Treatment Administration Records for complete documentation 3 x week for 4 weeks, weekly x 4 weeks, and then monthly x 1 month utilizing the Treatment Administration Record (TAR) Audit Tool for Documentation to ensure all treatments are being completed per the physician's orders and documented on | |

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| F 314 | Continued From page 61<br># 1<br>9/9/17-7:00 AM to 3:00 PM-Nurse # 4<br>9/9/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/10/17-7:00 AM to 3:00 PM-Nurse # 4<br>9/10/17-3:00 PM to 11:00 PM-Nurse # 1<br><br>Nurse # 1, who had been identified as solely or partially responsible on 8 days, was interviewed on 9/27/17 at 9:20 AM. The nurse stated she had only done the dressing change one time during August and September, and that was when the resident's family member had approached her and requested it. The nurse stated she had not charted the one day she had done it. The nurse stated on the other days, she had not done the resident's dressing changes. The nurse stated there was not enough time to do the dressing change given her other responsibilities. The nurse stated she often had to work double shifts and she often had her own medication cart responsibilities as well as cover for medication technicians who could not give intravenous fluids, Insulin, or tube feedings. The nurse stated she had talked to the previous DON, who had worked in August 2017, about the dressing changes not being done on the weekend but then the DON had left. The nurse stated the new DON had not been at the facility long enough for her to talk to her about the problem.<br><br>Nurse # 4, who had been identified as either solely or partially responsible on six of the weekend days was interviewed on 9/22/17 at 6 PM. Nurse # 4 stated she had not done the dressing change to Resident # 135's Coccyx on the August and September weekend days she worked. The nurse stated she was charge nurse with other responsibilities, and she was not aware it had been her responsibility to change the | F 314 | the treatment record. The Director of Nursing will review and initial the Pressure ulcers utilizing the Quality Improvement (QI) Tool for Monitoring Pressure Ulcers weekly x 8 weeks then monthly x 1 month to ensure dressing changes are per the physician order, wound was assessed, physician notified of any worsening. The Administrator will review all audits and sign.<br>The Director of Nursing will forward the results of the TAR Audit Tool and the QI Tool for Monitoring Pressure Ulcers to the Executive Quality Improvement Committee monthly. The Executive QI Committee will meet monthly x 3 months and review the TAR Audit Toll and the QI Monitoring Pressure Ulcer Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. | |

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| F 314 | Continued From page 62 | F 314 | | |

dressing.

Nurse # 7, who had been identified as responsible on one day for the dressing change, was interviewed on 9/26/17 at 4:42 PM. The nurse stated she had not done the dressing change. The nurse stated there was not enough time to do it. The nurse stated the facility used to have a treatment nurse on the weekends, and when the treatment nurse quit during the summer months the facility management staff left a paper schedule for the hall nurses to do dressing changes. The nurse stated the paper schedule directed that dayshift nurses were responsible for either the odd number rooms or even number rooms, and the evening shift nurses were responsible for the ones the dayshift nurses did not do. The nurse stated management never went over the new responsibility or gave directions. They just left the paper schedule at the desk. The nurse stated it was an impossible task given the other responsibilities which were placed on the hall nurses. Nurse # 7 stated she often had to administer medications for two halls, be responsible for medication assistants on other halls, deal with family concerns, deal with issues/events that came up with residents, deal with weekend housekeeping issues, and answer the phone.

Nurse # 3, who had been identified as responsible on one day and had shared responsibility on another day, was interviewed on 9/22/17 at 5:15 PM. The nurse stated she had not done the dressing change. The nurse was not aware it was her responsibility.

Nurse # 2, who had been identified as responsible or partially responsible on two days,

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| F 314 | Continued From page 63<br>was interviewed on 9/25/17 at 9:25 AM. The nurse stated she had not done the dressing change. The nurse stated she had just started near the end of August, 2017 and she had not been made aware dressing changes were one of her responsibilities.<br><br>Nurse # 8, who had been identified as responsible for one day, was interviewed on 9/26/17 at 1:29 PM. The nurse stated she did not recall whether she had or had not done the dressing change.<br><br>Interview with the resident's responsible party (RP) on 9/20/17 at 12 noon revealed she was concerned the resident's dressing did not appear to be changed on some days when she visited. The RP stated the dressing appeared old, and there was no date on the dressing. The RP stated she had talked to staff members regarding her concerns.<br><br>Interview with the DON on 9/25/27 at 9:19 AM revealed she had just been employed the previous week and she had not been made aware of the lack of pressure sore care for Resident # 135.<br><br>Interview with the administrator on 9/26/17 at 12:15 PM revealed the missed dressing changes had not been brought to her attention and that the staff had probably told the previous DON, who was no longer employed. | F 314 | | |
| F 333 SS=D | 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>483.45(f) Medication Errors. | F 333 | | 11/5/17 |

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| F 333 | Continued From page 64<br>The facility must ensure that its-<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interview, and staff interview the facility failed to assure morning insulin coverage was given per sliding scale order for one of three sampled residents, Resident #97, on five days. The findings included:<br><br>Record review revealed Resident # 97 was last readmitted to the facility on 8/22/17. The resident had a diagnosis of diabetes.<br><br>Review of the resident's care plan, last updated on 8/17/17, revealed the staff had identified the resident was at risk for complications of diabetes. Two of the care plan interventions directed staff to perform finger stick blood sugars as ordered per the facility protocol and administer the resident's medication as ordered.<br><br>Review of Resident # 97's readmission minimum data set (MDS) assessment, dated 9/5/17, revealed the resident was cognitively intact.<br><br>Review of the resident's physician orders revealed an order, dated 8/21/17, for the resident to have sliding scale insulin coverage before meals and at bedtime. For blood sugar levels of 150 to 200 the resident was ordered to receive 2 units of Humalog Insulin.<br><br>Interview with the resident on 9/20/17 at 1:20 PM revealed he thought there had been a morning when he was supposed to get sliding scale Insulin coverage recently and he had not received any. | F 333 | F 333<br><br>Resident #97 no longer at facility.<br>100% audit was completed on 10/5/17by Facility Nurse Consultant on all resident's receiving sliding scale insulin from 9/1/17 to 9/30 ensure that sliding scale insulin was given as ordered. Medical Director made aware of any discrepancies during the audit by Facility Consultant on 10/6/2017.<br>100 % Medication Pass audits initiated on 9/26/2017 by Facility Consultant with all licensed nurse and medication aides' to ensure physician orders are being followed to include orders for sliding scale insulin and narcotics and medications administered timely to be completed on 11/05/2017.<br>100% of all licensed nurses and medication aides to include Nurse #1 and medication Aide # 2 were in-serviced on Medication Administration to include Document medications on the MAR after it has been given to include narcotics and blood sugars. Never give any medications from memory to include insulin. Always follow orders on the MAR. Follow physician's order on the MAR to include special instructions when administering insulin to include before or after meals. Also read MAR correctly for correct sliding scale dose of insulin on 10/4/2017 by | |

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| F 333 | Continued From page 65<br><br>Review of the resident's September 2017 medication administration record (MAR) revealed the following documentation: On 9/1/17 Nurse # 1 documented the resident's 6:00 AM blood sugar was 154 and she documented she administered zero units of Insulin. On 9/2/17 Nurse # 1 documented the resident's blood sugar at 6:00 AM was 160 and she documented she administered zero units of Insulin. On 9/8/17 Nurse # 1 documented the resident's blood sugar at 6:00 AM was 174 and she documented she administered zero units of insulin.<br><br>On 9/9/17 at 6 AM Medication Aide # 2 documented the resident's blood sugar was 182. There was documentation the resident received zero units of Insulin.<br><br>On 9/14/17 Nurse # 1 documented the resident's blood sugar at 6:00 AM was 164 and she documented she administered zero units of Insulin. Review of the MAR revealed that for each time zero units of Insulin had been given on the above dates, a zero had been placed on the MAR with a line drawn through it.<br><br>Nurse # 1 was interviewed on 9/22/17 and confirmed she had not given Resident # 97 his ordered sliding scale Insulin coverage on 9/1/17, 9/2/17, 9/8/17, and 9/14/17 at 6:00 AM. Nurse # 1 stated Resident # 97 used to have different sliding scale orders prior to his readmission on 8/21/17. Nurse # 1 stated according to the old order the resident used to get sliding scale coverage for blood sugar readings above 200 only. The nurse stated she therefore was going by what she remembered the sliding scale coverage to be for the resident per his previous | F 333 | Facility Consultant/Director of Nursing/Staff Facilitator. All newly hired license nurses will be in-serviced by the staff facilitator during orientation regarding Medication Administration to include Document medications on the MAR after it has been given to include narcotics and blood sugars. Never give any medications from memory to include insulin. Always follow orders on the MAR. Follow physician's order on the MAR to include special instructions when administering insulin to include before or after meals. Also read MAR correctly for correct sliding scale dose of insulin.<br>Assistant Director of Nursing/Staff Facilitator will monitor 10% of all licensed nurses and medications aides to include and medication aide # 2 utilizing a Medication Pass audit tool weekly X 8 weeks and monthly X 1 month to ensure that medications to include orders for sliding scale insulin are given per the MAR and timely. The Assistant Director of Nursing will retrain the license nurse and/ or medication aide for all identified areas of concern during the audit. The DON will review and initial the Medication Pass Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern are addressed.<br>The Director of Nursing will forward the results of the Medication Pass Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Medication Pass Audit Tool to determine trends and / or issues that may need further interventions put into place | |

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| F 333 | Continued From page 66<br>residency, and she had not referenced the MAR's instructions on 9/1/7, 9/2/17, 9/8/17, and 9/14/17 to note the order had changed.<br><br>On 9/22/17 Nurse Consultant # 1 identified Nurse # 5 as the nurse who would have been responsible for the medication aide and Insulin coverage for 6 AM on 9/9/17 for Resident # 97.<br><br>Nurse # 5 could not be reached during the survey. | F 333 | and to determine the need for further and / or frequency of monitoring. | |
| F 353 SS=E | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services<br><br>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).<br>[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(a) Sufficient Staff.<br>(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: | F 353 | | 11/5/17 |

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| F 353 | Continued From page 67<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>(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.<br><br>(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident interviews, family interviews, and staff interview, the facility failed to provide sufficient staff for three (Resident # 135, # 175, and 99) out of twenty-one sampled residents. The facility failed to provide sufficient staff for pressure and vascular dressing changes (Resident # 135) and assistance with activities of daily living (Residents # 175 and 99). The findings included:<br><br>1. Record review revealed Resident # 135 was initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial | F 353 | F 353 Sufficient Staff<br>Resident #135 did not receive dressing changes per TAR which revealed no documentation on 8/5/17, 8/6/17, 8/12/17, 8/13/17, 8/19/2017, 8/20/17, 8/26/217, 8/27/17, 9/2/17, 9/3/17, 9/9/17, and 9/10/17 by Nurse #1, Nurse #4, Nurse #8, Nurse #3, and Nurse #2. Director of Nursing aware that resident #135 failed to receive dressing changes. On 9/28/2017 Resident #135 returned to the facility with new orders for treatment of Coccyx wound: Cleanse with soap and water, apply crushed Flagyl 500 milligrams, cover with Aquacel Silver and a foam dressing to be changed every other day | |

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| F 353 | Continued From page 68<br>fibrillation, severe peripheral vascular disease.<br><br>Review of the resident's last quarterly minimum data set (MDS) assessment, dated 8/13/17, revealed the resident was cognitively intact. The resident was also coded as having 7 vascular ulcers and a Stage III pressure ulcer.<br><br>Review of the resident's care plan, last updated on 8/17/17, revealed the staff had identified the resident had skin ulceration caused by diabetes and peripheral vascular disease and a pressure ulcer. The goal for the resident was that she would show positive healing of her ulcers and not develop further ones. Staff were directed on the care plan to provide treatment as ordered.<br><br>Review of August 2017 wound ulcer flow sheets revealed the resident's vascular ulcers were located on her left lower leg, right lower leg, left great toe, left outer great toe, left heel, right heel, and right great toe. The resident's pressure ulcer was located on her Coccyx.<br><br>Review of physician orders revealed a current order, originating on 5/31/17, for daily dressing changes to the coccyx pressure ulcer. The order directed staff to cleanse the ulcer and apply Santyl ointment and a dry dressing daily.<br><br>On 9/23/17 the facility was asked to provide the treatment orders from the resident's thinned medical record which would have been in effect for August and September, 2017 for the resident's vascular ulcers.<br><br>On 9/25/17 at 5:13 PM, the DON (director of nursing) provided a physician's order, dated 7/25/17, for the ulcers located on the resident's | F 353 | and as needed. Resident #135 had follow up appointment with the Wound Physician on 10/5/17 with no change in orders for treatment to the coccyx and another appointment scheduled for October 19, 2017. Resident #175 and 99 facility failed to provide assistance with activities of daily living. NA #6 and Medication Aide #3 were in-serviced on 9/25/17 by Nurse Consultant in regards to helping your residents use the toilet and to get dressed. Residents # 175 and # 99 continue to receive assistance with activities of daily living. Administrator/Director of Nursing/Scheduler reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans.<br><br>On 9/18/2017 the Director of Nursing and Administrator reviewed the clinical staffing schedule to assure the sufficient staff were on duty to meets the care needs of the residents. The Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to assure the clinical staff are on duty to meets the needs of the residents. The Case Mix Index will be reviewed weekly to assure the acuity of the resident is taken in to account with the clinical staffing patterns to meet the needs of the residents.<br><br>On 10/18/2017 the Corporate Consultant in-serviced the Administrator and Director of Nursing regarding Sufficient Staff. The | |

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| F 353 | Continued From page 69<br>right and left lower legs. This order specified the resident was to have daily dressing changes to these areas. The staff were to cleanse these ulcers with saline and apply Santyl and a dry dressing.<br><br>On 9/26/17 at 4:46 PM, the facility administrator provided the facility's wound protocol as the treatment modality being used for Resident #135's left great toe, left outer great toe, left heel, right great toe, and right heel during the months of August, 2017 and September, 2017.<br><br>Review of the August 2017 TAR and September 2017 TAR revealed no documentation on the following weekend dates Resident # 135's dressings were checked or changed to any of her vascular ulcers or her Stage III pressure ulcer: 8/5/17, 8/6/17, 8/12/17, 8/13/17, 8/19/17, 8/20/17, 8/26/17, 8/27/17, 9/2/17, 9/3/17, 9/9/17, and 9/10/17.<br><br>On 9/22/17 at 3:14 PM facility nurse consultant # 1 provided a list of nurses who had been responsible for Resident # 135's dressing changes during the September, 2017 weekends. On 9/26/17 at 10:55 AM the director of nursing (DON) provided a list of nurses who had been responsible for weekend dressing changes in August, 2017 for Resident # 135. According to the nurse consultant and DON one of the hall nurses for the dayshift and evening shifts on the lists should have done the dressing changes. The nurses identified as responsible and the dates and shifts on which they were identified to be responsible are as follows:<br>8/5/17- 7:00 AM to 3:00 PM -Nurse # 4<br>8/5/17- 3:00 PM to 11:00 PM- Nurse # 4<br>8/6/17- 7:00 AM to 3:00 PM- Nurse # 4 | F 353 | Sufficient Staff in-service included the following: A. 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. B. The determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being.<br>The facility has hired a new RN-Assisted Director of Nursing, 4 licensed practical nurses and 8 Certified Nursing Assistants to fill the vacant position in the current schedule. The facility will ensure we have a nurse to provide 8 hrs of RN coverage daily. The Facility will utilize agency staffing to ensure daily staffing is sufficient according to the acuity level of the residents.<br>On 9/18/2017, the Administrator and the DON initiated a QI monitoring tool titled Sufficient Staff tool to meet the needs of the residents based upon the acuity level as identified by the Case Mix Index score. The QI monitoring tool will assist with the facility assuring the residents reach their highest practicable physical, mental and psychosocial well-being. The Administrator and the Director of Nursing will utilize the Sufficient Staff tool daily, at the beginning of each shift to include nights and weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately with assuring the | |

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| F 353 | Continued From page 70<br>8/6/17- 3:00 PM to 11:00 PM- Nurse # 4<br>8/12/17- 7:00 AM to 3:00 PM-Nurse # 1<br>8/12/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/13/17-7:00 AM to 3:00 PM -Nurse # 7<br>8/13/17-3:00 PM to 11:00 PM- Nurse # 1<br>8/19/17-7:00 AM to 3:00 PM-Nurse # 8<br>8/19/17-3:00 PM to 11:00 PM-Nurse # 8<br>8/20/17-7:00 AM to 3:00 PM-Nurse # 1<br>8/20/17-3:00 PM to 11:00 PM -Nurse # 1<br>8/26/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/26/17- 3:00 PM to 11:00 PM-Nurse # 1<br>8/27/17-7:00 AM to 3:00 PM-Nurse # 4<br>8/27/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/2/17-7:00 AM to 3:00 PM-Nurse # 3<br>9/2/17-3:00 PM to 11:00 PM-Nurse # 2<br>9/3/17-7:00 AM to 3:00 PM-Nurse # 3/or Nurse # 1<br>9/3/17-3:00 PM to 11:00 PM-Nurse # 2/ or Nurse # 1<br>9/9/17-7:00 AM to 3:00 PM-Nurse # 4<br>9/9/17-3:00 PM to 11:00 PM-Nurse # 1<br>9/10/17-7:00 AM to 3:00 PM-Nurse # 4<br>9/10/17-3:00 PM to 11:00 PM-Nurse # 1<br><br>Nurse # 1, who had been identified as solely or partially responsible on 8 days, was interviewed on 9/27/17 at 9:20 AM. The nurse stated she had only done the dressing changes one time during August and September for Resident # 135, and that was when the resident's family member had approached her and requested it. The nurse stated she had not charted the one day she had done it. The nurse stated on the other days, she had not done the resident's dressing changes. The nurse stated there was not enough time to do the dressing changes given her other responsibilities. The nurse stated she often had to work double shifts and she often had her own medication cart responsibilities as well as cover | F 353 | proper staff are on duty or the utilization of administrative nurses are pulled to the hall.<br>The Administrator will monitor the Sufficient Staff tool daily to assure the staffing patterns are appropriate to meet the needs of the residents care identified by their acuity level from the Case Mix Index report. The administrator will present findings at the monthly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.<br><br>The scheduling coordinator will be notified of night and weekend call-ins and no shows promptly. The scheduling coordinator will make necessary arrangements to ensure adequate staff are on duty. If the scheduling coordinator is unable to obtain adequate staff or if it is outside of the scheduling coordinator's normal working hours, the director of nursing or assistant director of nursing will be notified promptly. The facility administrator and director of nursing will provide ongoing monitoring daily to ensure that there is adequate clinical staff on duty to provide needed care to residents that enable them to reach their highest practical physical, mental, and psychosocial well-being.<br><br>Current and newly hired staff will be in-serviced that the scheduling coordinator is the first point of contact for any and all scheduling issues that arise | |

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| F 353 | Continued From page 71<br>for medication technicians who could not give intravenous fluids, Insulin, or tube feedings. The nurse stated she had talked to the previous DON, who had worked in August 2017, about the dressing changes not being done on the week-end but then the DON had left. The nurse stated the new DON had not been at the facility long enough for her to talk to her about the problem.<br><br>Nurse # 7, who had been identified as responsible on one day for the dressing changes, was interviewed on 9/26/17 at 4:42 PM. The nurse stated she had not done the dressing changes. The nurse stated there was not enough time to do it. The nurse stated the facility used to have a treatment nurse on the week-ends, and when the treatment nurse quit during the summer months the facility management staff left a paper schedule for the hall nurses to do dressing changes. The nurse stated the paper schedule directed that dayshift nurses were responsible for either the odd number rooms or even number rooms, and the evening shift nurses were responsible for the ones the dayshift nurses did not do. The nurse stated management never went over the new responsibility or gave directions. They just left the paper schedule at the desk. The nurse stated it was an impossible task given the other responsibilities which were placed on the hall nurses. The nurse stated she often had to administer medications for two halls, be responsible for medication assistants on other halls, deal with family concerns, deal with issues/events that came up with residents, deal with week-end housekeeping issues, and answer the phone. The nurse stated she had tried to talk to administrative staff about the problem and was told she needed to delegate some of her | F 353 | while on shift. The scheduling coordinator's contact information will be posted in designated employee areas and will include subsequent points of contact which will be available 24/7, to avoid a single point of failure. | |

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responsibilities. According to the nurse, there were times she could not delegate her responsibilities because there were often medication assistants on the weekends who could not do her responsibilities.

Interview with the DON on 8/25/17 at 9:19 AM revealed she had just been employed the previous week and she had not been made aware of the lack of dressing changes for Resident # 135.

Interview with the administrator on 9/26/17 at 12:15 PM revealed the missed dressing changes had not been brought to her attention and that the staff had probably told the previous DON, who was no longer employed.

2. Record review revealed Resident # 175 was admitted to the facility on 7/12/17. The resident had diagnoses of cerebrovascular accident, chronic pain, diabetes, and hypertensive disorder.

Review of the resident's minimum data set (MDS) assessment, dated 7/19/17, revealed the resident was cognitively intact. The resident was coded as needing extensive assistance from staff with his hygiene, dressing, bathing, and bed mobility needs.

Review of the resident's care plan, dated 7/19/17, revealed the resident had chronic pain, migraines, and diabetic neuropathy. The care plan also identified the resident was non-ambulatory, used a wheelchair for mobility, and needed assistance with his hygiene, dressing, and transfer needs. The care plan directed staff to transfer the resident with a mechanical lift and assist him with his activities of

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daily living needs.

The resident was interviewed on 9/20/17 at 1:50 PM and stated he had a migraine on Sunday (9/17/17) evening and wanted to go to bed but could not find anyone to help him. According to the resident he went on the hall and asked for help but there was not anyone available to assist him. The resident stated he was told the person who needed to help him was "around somewhere," but he could never find them. According to the resident after he tried to find someone to assist him for about two hours, he called his family member. He said his family member arrived around 9 PM and helped him prepare and go to bed because there was no available staff member to assist him.

According to staffing sheets for 9/17/17 Nurse # 6 was the 3:00 PM to 11:00 PM nurse on Resident # 175's hall. Nurse Aide (nurse aide) # 6 was the 3:00 PM to 11:00 PM shift NA. There were no other staff members on the staffing sheets for Resident # 175's hall for the 3:00 PM to 11:00 PM shift.

Review of census information provided for the date of 9/17/17 revealed there were twenty residents on Resident # 175's hall on 9/17/17.

Nurse # 6 was interviewed on 9/20/17 at 5:35 PM. According to Nurse # 6 she was aware the resident had a headache on 9/17/17 at 4:30 PM and had given him medication. According to the hall nurse she did not normally give medications, and was being attentive to her duties on the medication cart and was not aware the resident had difficulties on Sunday evening. The nurse confirmed she had not assisted the resident to

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bed. According to Nurse # 6 when she got to his room for bedtime medications he was already in bed.

NA # 6 was interviewed on 9/21/17 at 4:10 PM. NA # 6 stated she thought she had "about fifteen" residents to care for on the evening shift of 9/17/17. NA # 6 stated she got to Resident # 175's room a little after 9:00 PM to assist him and he was already in bed, but she had not assisted him.

Interview with the resident's family member on 9/21/17 at 10:45 AM revealed he had received a call around 8 PM on 9/17/17 from Resident # 175. The family member stated Resident # 175 told him he had been to all of the halls and he couldn't find anyone to help him to go to bed. The family member stated he (the family member) then drove to the facility to help the resident. The family member stated when he arrived he only saw one or two people on the hall that evening. The family member confirmed he was the one to help the resident prepare for bed and go to bed on 9/17/17. The family member stated staffing was "really scarce."

An interview had been conducted during initial tour of the facility on 9/21/17 at 9:35 AM with a randomly interviewed resident's family which corroborated Resident # 175 and his family member's interview. This family member was the family member of Resident # 25. Resident # 25 was observed to reside on the same hall as Resident # 175 on 9/21/17 at 9:35 AM. During the interview, the family member stated Resident # 25 was not able to go to bed by herself. The family member stated he had been present on 9/17/17 and he had "starting asking" staff to

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assist the resident to bed around 6:00 PM or 6:30 PM that evening. The family member stated it was after 9:00 PM before Resident # 25 received assistance. The family member stated the facility "just didn't have anyone to help" on the hall to assist the resident on Sunday night.

A review of the staffing sheets for the whole facility for the date of 9/17/17 for the 3:00 PM to 11:00 PM shift revealed on two of the facility's four halls there were two NAs. On one of the facility's halls there was one NA and another NA who was scheduled at 6 PM to arrive. On Resident # 175's hall there was one NA on the schedule.

The facility scheduler was interviewed on 9/21/17 at 9 AM. The scheduler stated she routinely tried to schedule two NAs for Resident # 175's hall during the 3:00 PM to 11:00 PM shift, but she did not have a second NA to schedule for that hall on 9/17/17 at 3:00 PM and confirmed that there had been one NA only for Resident # 175's hall for the evening shift of 9/17/17.

3. Record review revealed Resident #99 was admitted to the facility on 11/19/14. The resident had diagnoses of heart disease, acute kidney failure, dementia, and Alzheimer ' s Disease.

Review of the resident ' s annual minimum data set (MDS) assessment, dated 4/20/17, revealed the resident was severely cognitively impaired. The resident was coded as needing extensive assistance from staff with his hygiene, dressing, bathing, dressing, eating and bed mobility needs. He was assessed with no upper extremity impairments and impairments on both sides of his lower extremities. Resident #99 was also

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assessed as always incontinent for bowel and bladder.

Review of the resident ' s care plan, dated 7/26/17, identified the resident was cognitive impaired and needed assistance with bathing, dressing, eating, transferring, and mobility. The care plan directed staff to transfer with a mechanical lift and assist him with his activities of daily living needs.

According to the staffing sheets for 9/17/17, Medication Aide #3 was the 3:00 PM to 11:00 PM Nurse Assistant on Resident #99 ' s hall. There were no other staff members on the staffing sheets for Resident #99 ' s hall after the 7:00 AM to 3:00 PM Nurse Assistant #8 ended her shift.

Review of the census information provided for the date of 9/17/17 revealed there were twenty-one residents on Resident #99 ' s hall on 9/17/17.

Interview with the resident ' s family member on 9/21/17 at 10:00 AM revealed she had been in the facility on 9/17/17 evening shift and no staff came in Resident ' s #99 room after Nurse Assistant #8 left to go home. The family member went to retrieve the dinner tray after no one came to feed Resident #99. She stated she received the tray from the staff and fed him. No one came to provide care for him while she was there. She stated she left about 10:00 PM.

Nurse Assistant #8 was interviewed on 9/21/17 at 3:14 PM. She stated she left the facility about 5:00 PM on 9/17/17 and she had no idea who took over her assignments. She stated the family was present with Resident #99 when she left.

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| F 353 | Continued From page 77<br>Interview with the Scheduler on 9/21/17 at 3:30 PM revealed she was short staffed on 9/17/17. She explained Medication Aide #3 was assigned to Resident #99 for the 3:00 PM to 11:00 PM care. It was her understanding she would complete the Medication Pass for 7:00 AM to 3:00 PM shift and then become the assigned Nurse Assistant for 3:00 PM to 11:00 PM.<br><br>Medication Aide #3 was interviewed on 9/22/17 at 4:00 PM. According to Medication Aide #3, she was not aware she was assigned the front part of the hall. She expressed someone else was responsible for Resident #99 ' s care on the 3:00 PM to 11:00 PM shift. She confirmed she did not provide care to Resident #99 on her shift other than his medications. She did pass his dinner tray to his family and to her knowledge his family fed him dinner. | F 353 | | |
| F 354 SS=D | 483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON<br><br>(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and family | F 354 | F 354 Registered Nursing Coverage | 11/5/17 |

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| F 354 | Continued From page 78<br>interviews the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours per day on two days of five days reviewed. (09/09/2017 and 09/10/2017).<br><br>Findings included:<br><br>Review of time clock punch time for all licensed nursing staffing revealed no RN hours for staffing on 9/9/2017 & 9/10/2017.<br><br>An interview on 9/11/2017 at 10:30 AM with the Interim Director of Nursing (DON) revealed she became interim DON on 9/05/2017. She explained her prior role was the Nursing Supervisor. She also explained there was no additional Registered Nurse to replace a nurse that resigned on 9/08/2017. She explained a new DON had been hired and would be starting on 9/12/2017 and her role would go back to being the Nursing Supervisor.<br><br>During an interview on 9/11/2017 at 12:50 PM, the Administrator revealed her expectation was an RN was to work eight consecutive hours a day, seven days a week. She explained the new Director of Nursing would be starting on 9/12/2017 and then the Interim Director of Nursing would become the Nursing Supervisor.<br><br>During an interview on 9/11/2017 at 3:35 PM with the Facility Scheduler, she verified that no RN worked on 9/09/2017 and 9/10/2017. She explained the scheduled RN resigned on 9/8/2017 at 3:17 PM. She explained she reported the call out to the Administrative Staff. She revealed the facility was trying to hire more nurses. | F 354 | Beginning on 10/5/2017 a registered nurse will provide onsite coverage daily per the Medicare Guideline. In the event of a call out appropriate action will be taken to ensure an RN covers the facility needs either by the Administrative Nurses-RN's or scheduled floor staff registered nurses. All administrative nurses will be educated on 10/19/2017 that upon their role as the RN providing coverage on the floor then they must serve in an administrative capacity/supervisor providing oversight to the patients and clinical staff on duty.<br>On 9/18/2017 the Administrator and the Director of Nursing reviewed the staffing schedule to ensure sufficient numbers of staff and registered nursing coverage to provide nursing care to all residents in accordance with resident care plans.<br>On 9/8/2017 the Director of Nursing and Administrator reviewed the clinical staffing schedule to assure the sufficient staff were on duty to meets the care needs of the residents. The Assistant Director of Nursing was hired 10/17/2017. On 10/18/2017 the scheduler and Director of Nursing were in-serviced by the administrator related to RN coverage in the facility. Director of Nursing will continue to use staff audit tool to ensure a Registered Nurse is scheduled daily. The new Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to assure the clinical staff are on duty to meets the needs of the residents along with assuring the facility residents are provided with 8 consecutive hours of Registered Nursing | |

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| F 354 | Continued From page 79 | F 354 | Coverage.<br>On 10/17/2017 the Corporate Consultant in-serviced the Administrator and Director of Nursing regarding Sufficient Staff and the requirement of the 8 hours of consecutive Registered Nursing Coverage. The Sufficient Staff in-service included the following: A. 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. B. The determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being.<br>On 9/18/2017 the Director of Nursing and Administrator reviewed the clinical staffing schedule to assure the sufficient staff were on duty to meets the care needs of the residents. The Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to assure the clinical staff are on duty to meets the needs of the residents to include the 8 consecutive hours of registered nursing coverage. The Case Mix Index will be reviewed weekly to assure the acuity of the resident is taken in to account with the clinical staffing patters to meet the needs of the residents. The facility has hired a new RN-Assistant Director of Nursing on 10/17/2017, 4 registered nurses, 5 LPNs and 10 Certified Nursing Assistants to fill the vacant position in the current schedule. The open position that remain are 4 full | |

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| F 354 | Continued From page 80 | F 354 | time licensed nurse and 4 certified nurse assistant positions. These positions will be filled by 11/5/17.<br>On 9/18/2017, the Administrator and the DON initiated a QI monitoring tool titled Sufficient Staff tool to meet the needs of the residents based upon the acuity level as identified by the Case Mix Index score. The QI monitoring tool will assist with the facility assuring the residents reach their highest practicable physical, mental and psychosocial well-being. The Administrator and the Director of Nursing will utilize the Sufficient Staff tool daily, at the beginning of each shift to include nights and weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately with assuring the proper staff and RN coverage are on duty or the utilization of administrative nurses are pulled to the hall for appropriate coverage.<br>The Administrator will monitor the Sufficient Staff tool daily to assure the staffing patters are appropriate to meet the needs of the residents care identified by their acuity level from the Case Mix Index report and registered nursing coverage. The administrator will present findings at the monthly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring. | |
| F 490 | 483.70 EFFECTIVE | F 490 | | 11/5/17 |

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| F 490 SS=E | Continued From page 81<br>ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, resident interviews, family interviews, and staff interviews the facility failed to provide leadership to implement effective systems and policies and procedures to assure residents needs were met for four (Residents # 45, # 175 #99, and # 135) out of twenty one sampled residents. The findings included:<br><br>1. Cross Refer to F 166<br>Based on record reviews, resident interview, and staff interviews the facility failed to follow facility procedures to resolve grievances related to medication concerns for one (Residents # 175 ) out of six residents reviewed for grievances.<br><br>2. Cross Refer to F 224<br>Based on record review, resident interviews, family interview, and staff interviews, for one (Resident # 135) out of three sampled residents with wounds the facility neglected to perform dressing changes to the resident's vascular and Stage III pressure ulcers.<br><br>3. Record review revealed Resident # 135 was initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial | F 490 | 483.70 EFFECTIVE ADMINISTRATION / RESIDENT WELL-BEING<br><br>F 490<br><br>On 10/11/17, the Corporate Facility Consultant Registered Nurse (RN) conducted a meeting with the administrator and Director of Nursing (DON) to discuss the areas that the facility failed to provide leadership to implement effective systems and policies and procedures to ensure residents' needs were met to include Residents #45, #175, #99, #135. These areas included following facility procedures to resolve grievances related to medication concerns, neglecting to perform dressing changes, providing sufficient staff for pressure and vascular dressing changes, and assistance with activities of daily living (ADLs). On 10/18/17, the corporate facility consultant RN, the administrator, and the DON initiated a Quality Improvement (QI) action plan to identify and address the root causes of the ineffective systems.<br><br>This plan will ensure that the facility utilized its resources effectively and | |

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| F 490 | Continued From page 82<br>fibrillation, severe peripheral vascular disease.<br><br>Review of the resident's last quarterly minimum data set (MDS) assessment, dated 8/13/17, revealed the resident had 7 vascular ulcers.<br><br>Review of a vascular physician's consult follow up note, dated 7/27/17, revealed the physician had identified through testing that the resident had bilateral chronic total occlusion of the superficial femoral arteries. The vascular physician's plan was to place a femoral artery balloon and a patch and stent to help with blood supply for her vascular ulcers.<br>On 9/25/17 at 10:49 AM a staff member at the vascular physician's office was interviewed. According to the staff member the resident went to the hospital to have the planned procedure on 8/8/17 and was not able to have it because she had not been kept NPO (nothing by mouth). The staff member at the vascular physician's office stated she had been communicating with the ward clerk at the facility prior to the procedure, and the facility had been given verbal and written communication about the resident's NPO orders.<br><br>The ward clerk was interviewed on 9/22/17 at 10 AM. The ward clerk confirmed she had received instructions to keep Resident # 135 NPO prior to the procedure and had given the instructions to a nurse. The ward clerk was not able to state to which nurse she had given the instructions.<br><br>Interview with the dietary manager on 9/22/17 at 12:25 PM revealed the procedure for a resident to be NPO was for the staff to either tell him verbally or provide a note for him. The dietary manger stated he then made sure a tray was not prepared and sent to the hall for a resident who is | F 490 | efficiently to obtain and maintain the highest practical level of wellbeing of each resident. On 10/18/17, the Corporate facility consultant RN, administrator, and DON implemented the plan of action to include investigating the root cause of deficient practice in the areas of grievances, neglecting to perform dressing changes, and failing to provide sufficient staff to perform dressing changes and ADL care.<br><br>On 10/18/17, the corporate facility consultant RN conducted an in-service with the administrator and the DON on performing root cause analysis to determine systemic failure in order that corrections could be implemented to the systems currently identified as ineffective.<br><br>On 10/18/17, the administrator and DON initiated an investigation to determine the root cause of ineffective systems to include deficient practice in the areas of grievances, neglecting to perform dressing changes, and failing to provide sufficient staff to perform dressing changes and ADL care. The investigation will be completed by 11/05/17. The root cause identified for each area will be addressed immediately by the corporate facility consultant RN, administrator, and DON to include corrective action.<br><br>On 10/11/17, a plan of correction was initiated by the corporate facility consultant RN and the administrator for failure to follow facility procedures to resolve grievances related to medication concerns | |

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| F 490 | Continued From page 83<br>to be NPO. The dietary manager stated he had not received any note or communication from anyone that the resident was to be NPO on the morning of 8/8/17.<br><br>Nurse #4, who was assigned to care for Resident #135 on 8/8/17, was interviewed on 9/22/17 at 6 PM. The nurse stated she arrived at the facility after the resident had already been served the breakfast tray on the morning of 8/8/17. The nurse stated there was confusion to whether the resident had eaten or not, and she was sent to the hospital but the physician did not do the procedure.<br><br>Interview with Nurse Aide (Nurse Aide) # 5 on 9/25/17 at 11:45 AM revealed she was the assigned NA for Resident # 135 on 8/8/17. NA # 5 stated she was in the dining room when Resident # 135's breakfast tray was served to her in the room by another staff member who did not know the resident was to be NPO.<br><br>Interview with the administrator on 9/21/17 at 2:40 PM revealed it was the facility's procedure not to serve a resident who was designated NPO a tray and the facility had failed to follow their procedure.<br><br>4. Cross Refer to F 353.<br><br>Based on record review, resident interviews, family interviews, and staff interview, the facility failed to provide sufficient staff for three (Resident # 135, # 175, and 99) out of twenty-one sampled residents. The facility failed to provide sufficient staff for pressure and vascular dressing changes (Resident # 135) and assistance with activities of daily living (Residents # 175 and 99). | F 490 | to include Resident #175. Refer to F 166.<br><br>On 10/12/2017, a plan of correction was initiated by the corporate facility consultant RN and the administrator for neglecting to perform dressing changes to vascular and stage III pressure ulcers to include Resident #135. Refer to F 224.<br><br>On 10/12/2017, a plan of correction was initiated by the corporate facility consultant RN and the administrator for failure to provide sufficient staff for pressure and vascular dressing changes to include Resident #135 and assistance with activities of daily living (ADLs) to include Residents #175 and #99. Refer to F 353. The administrator will review all audit tools for plans of correction to include grievances, neglecting to perform dressing changes, and providing sufficient staff for dressing changes and ADL care weekly for 12 weeks. Any areas of concern will be immediately addressed by the administrator.<br><br>A Plan of Correction was initiated for All Residents to include Resident #45 to ensure the physician and Resident Representative had been notified of all documented changes in condition, to include falls and bruises. Nurse's Progress Notes and Risk Management Reports will be reviewed for All Residents to include Resident #45, weekly x 8 weeks then monthly x 1 month to ensure that the physician and resident representative was notified immediately of all identified acute changes in condition to include falls and | |

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| F 490 | Continued From page 84<br><br>5. Resident #45 was admitted to the facility on 6/30/16 and had a diagnosis of myocardial infarction (MI or heart attack)) atrial fibrillation, pacemaker and dementia.<br><br>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 7/17/17 revealed Resident #45 had severe cognitive impairment, was independent with transfers and toileting and required limited assistance with ambulation.<br><br>On 9/22/17 at 9:30 AM, Resident #21 (roommate of Resident #45) stated Resident #45 had fallen the Thursday before Labor Day (8/31/17) and the Thursday after Labor Day (9/7/17.<br><br>Review of the nurse ' s notes for Resident #45 from 8/24/17 through 9/22/17 revealed no documentation of falls or bruises.<br><br>On 9/22/17 at 11:15 AM an observation was made of the resident with NA #5 revealing that the resident had multiple bruises. The resident was observed to have a pale blue bruise that mostly covered the right knee cap and a quarter sized bruise just below the left knee, a round bluish colored bruise approximately 1.5 inches in diameter on the right lower buttock and a purple bruise at the base of the right little toe that was approximately 2.5 inches long and 1.5 inches wide with slight swelling.<br><br>On 9/22/17 at 5:55 PM it was confirmed with Nurse #4 that the resident had fallen 2-2 ½ weeks ago. The nurse stated she did not document the fall as she was in a hurry to leave and had planned to document it the next day but must | F 490 | bruises utilizing an Acute Change Notification QI Audit Tool by Staff Facilitator. Notification to the physician and Resident Representative with documentation in the clinical record and re training with the license nurse, will be completed by the Staff Facilitator/Quality Improvement Nurse during the audit, for any identified areas of concern. The Director of Nursing will review and initial the Acute Change Notification QI Audit Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern are addressed.<br><br>The administrator will present the findings of the audit tools for the plans of correction and the results of the investigation for root cause analysis for the ineffective systems to the QI committee for review. The QI committee will meet monthly for 3 months to review the audits and ensure that the root cause of ineffective systems has been identified and corrected. Any areas of concern to include identified trends will be review and recommendations for follow up will occur as needed to include increased frequency of monitoring. The Regional Vice president will provide ongoing weekly over sight of the building weekly to ensure the facility is compliance with the plans of corrections and quality assurance processes. | |

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| F 490 | Continued From page 85<br>have forgotten. The Nurse stated she did not report the fall to the on-coming nurse but thought she told the nurse practitioner.<br><br>On 9/22/17 at 6:30 PM it was confirmed with the Nurse Practitioner that she had not been notified the resident had fallen and had bruises.<br><br>During an interview on 9/22/17 at 6:23 PM the resident ' s physician confirmed he had not been made aware of the resident ' s fall and bruises.<br><br>On 9/22/17 at 3:40 PM it was confirmed with a nursing supervisor that worked Monday through Friday on the 7 AM to 3 PM shift that she had not been informed the resident had fallen or had bruises.<br><br>The Administrator was interviewed on 9/22/17 12:14 PM and 4:01 PM. The administrator confirmed she had not been made aware of the resident ' s falls and bruises. According to the administrator it was the facility ' s procedure to discuss falls in morning meetings and Resident # 45 ' s fall had not been discussed. According to the administrator, she should have been made aware of the resident ' s fall so that it could have been investigated. | F 490 | | |
| F 514 SS=D | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- | F 514 | | 11/5/17 |

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| F 514 | Continued From page 86<br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview for two of two sampled residents whose condition warranted a physician notification, the facility failed to assure the medical record was complete. The facility failed to have an accurate medical record in relation to Resident # 45 sustaining bruises and a fall and Resident # 135 missing vascular procedures prior to a leg amputation. The findings included:<br><br>1. Record review revealed Resident # 135 was | F 514 | F 514<br>Resident # 45 attending physician made aware of a fall and bruising on 9/22/17 by Facility Consultant with documentation in the electronic medical record. Resident # 45, Resident Representative made aware of a fall and bruising on 9/22/17 by Facility Consultant with documentation in the electronic medical record. Resident # 135 had a follow-up appointment scheduled on 9/26/17 by Facility Secretary with the | |

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| F 514 | Continued From page 87<br>initially admitted to the facility on 5/6/17. The resident had diagnoses of end stage renal disease with hemodialysis, coronary artery disease, history of coronary artery bypass surgery, hypertension, diabetes, anemia, atrial fibrillation, severe peripheral vascular disease.<br><br>Review of a vascular physician's consult note, dated 7/27/17, revealed the physician had identified through testing that the resident had bilateral chronic total occlusion of the superficial femoral arteries. The vascular physician's plan was to place a femoral artery balloon and a patch and stent to help with blood supply for her vascular ulcers because he had identified she was at risk for losing her limb. The physician noted he planned to do the left leg first and then at a later time do the right leg. The vascular physician noted the procedure was explained to the resident and she acknowledged she understood and agreed to the procedure.<br><br>There was no notation in the resident's medical record when the procedure was to take place, whether it was completed, or facility's efforts to communicate with the vascular physician until 9/11/17 when Nurse # 6 documented she had called the physician's office secondary to the resident's worsening ulcers and obtained an appointment for the vascular physician to see the resident on 9/12/17.<br><br>There was no documentation in the medical record noting why the resident's procedure was not completed.<br><br>There was no documentation in the resident's medical record about the facility's efforts to reschedule the vascular procedure. | F 514 | vascular surgeon. Resident # 135 attended scheduled appointment on 9/26/2017 with documentation in the electronic medical record by Treatment Nurse. Resident Representative made aware of the appointment results with documentation in the electronic medical record on 9/272017 by Treatment Nurse.<br>100% of all residents to include resident # 135 telephone orders and discharge summaries were audited from 8/1/2017 to 10/11/2017 for any request appointments completed on 10/13/2017 by Facility Nurse Consultant. Any identified areas of concern noted during the audit were immediately addressed by Director of Nursing. All residents with requested appointments from telephone orders or discharge summary have been made.<br>100% audit was completed on 9/1/2017 by Facility Consultant on all residents to include resident # 45 to ensure that all incidents to include falls and bruising were appropriately entered into the electronic medical record and that RR and physician had been notified of the incident. For any incidents without documentation in the electronic medical records the Facility Consultant documented the details of the incident on an incident progress note to ensure documentation of the incident with notification of RR and physician is present in the electronic medical record.<br>100 % of all care plans were reviewed by Facility Consultant on 9/1/2017to ensure that the care plans accurately reflect the resident to include history of falls. The care plan was immediately corrected during the audit by Minimum Data Set | |

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| F 514 | Continued From page 88<br><br>Interview with the administrator on 9/22/17 at 10:45 AM revealed the procedure had not been done and the facility staff should have documented in the resident's medical record the circumstances of the resident's canceled vascular appointments, the facility's efforts to reschedule the vascular procedure, and the facility's efforts to communicate with the resident's vascular physician.<br>2. Resident #45 was admitted to the facility on 6/30/16 and had a diagnosis of myocardial infarction (MI or heart attack)) atrial fibrillation, pacemaker and dementia.<br><br>On 9/22/17 at 9:30 AM Resident #21 (roommate of Resident #45) stated in an interview that Resident #45 fell on the Thursday before Labor Day (August 31, 2017) and the Thursday after Labor Day (September 7, 2017). Resident #21 stated when the resident fell, she put on her call light and staff came in and got her up.<br><br>Review of the clinical record dated 8/24/17 through 9/22/17 revealed no documentation of a fall.<br><br>On 9/22/17 at 10:49 AM, NA (nursing assistant) #7 stated in an interview that Resident #21 was alert, oriented and reliable.<br><br>On 9/22/17 at 10:59 AM, NA #5 stated in an interview about 2 weeks ago a nurse told her Resident #45 had a fall when trying to get up to go to the bathroom and identified Nurse #4 as the nurse who assisted the resident to get up after the fall. The NA further stated the resident had bruises which she had reported to a nurse but could not recall the name of the nurse she told. | F 514 | Nurse for any identified areas of concerns.<br>100% in-servicing was initiated on 9/15/2017 by Director of Nursing of all licensed nurses in regards to documentation in the electronic medical record. To include Document after every single Incident to include but not limited to a fall or unsupervised exit under the incident progress note. Assess the resident from head to toe to include vital signs, notify the attending physician, complete an incident report and make the family and/or resident representative aware and document in the medical records. The physician or mid-level provider on call may order x-rays, CT scans or pain medications, so be sure to include any new orders in your nurse’s note and results of any radiology reports with MD and RR notification. Neuro checks must be documented per physician order/facility protocol under the neuro check progress note for all suspected head injury. A nurse’s note must be written regarding bruises that were not previously present. An incident report must be completed and the MD and RR must be notified with documentation in the medical records. Complete a skin referral form. Notify the Don and Administrator immediately of all bruises as this could be considered an “injury of unknown origin” and requires further investigation. Generate a nurse’s note when you schedule an appointment. Example: "Appointment with Dr. Skylar of orthopedics made for Monday, March 3rd at 2:45pm due to leg pain; facility van | |

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| F 514 | Continued From page 89<br><br>On 9/22/17 at 11:15 AM an observation of the resident ' s bruises was made with NA #5. A pale blue bruise was noted on the right knee and just below the left knee. There was a bluish bruise on the right buttock and a purple bruise on the top of the right foot at the base of the right little toe that was approximately 2.5 inches long and 1.5 inches wide with slight swelling of the foot.<br><br>Review of the clinical record dated 8/24/17 through 9/22/17 revealed no documentation of bruises.<br><br>On 9/22/17 at 3:40 PM the Nursing Supervisor that worked Monday through Friday on the 7 AM to 3 PM shift stated in an interview they had a QI (Quality Improvement) document as part of the nurse ' s notes that was supposed to be filled out in the event of a fall. The Nursing Supervisor stated no one had reported a fall or bruises for Resident #45 to her.<br><br>On 9/22/17 at 4:01 PM the Administrator stated in an interview they discussed falls in their morning meeting and there had been no reports of a fall or bruises for Resident #45. The Administrator further stated if a resident had a fall, the nurse should report it. The Administrator stated if a NA saw bruises on a resident she was supposed to notify the nurse and the nurse was supposed to do an assessment and write up an incident report.<br><br>On 9/22/17 at 5:55 PM Nurse #4 stated in an interview Resident #45 had a fall about 2-2 ½ weeks ago and she and another staff member got her up but was unable to recall the name of the staff member that assisted her. The Nurse stated | F 514 | driver will transport to and from doctors office. Resident Representative made aware". If a resident refuses to go to an appointment or the appointment is cancelled for any reason, this must be documented. The MD and RR must be notified of the reasoning for not attending an appointment with documentation in the medical records. When an appointment is rescheduled, this also must be documented in the medical records.<br>In addition, chart when the resident returns to the nursing home. Example: "Resident returned from ortho appointment in no observed acute distress; new orders received for weight bearing as tolerated to both lower extremities and tramadol 50 mg orally q6h PRN pain. Resident Representative Jane Simmons (niece) aware" to be completed by 11/05/2017. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Document after every single Incident to include but not limited to a fall or unsupervised exit under the incident progress note. Assess the resident from head to toe to include vital signs, notify the attending physician, complete an incident report and make the family and/or resident representative aware and document in the medical records. The physician or mid-level provider on call may order x-rays, CT scans or pain medications, so be sure to include any new orders in your nurse's note and results of any radiology reports with MD and RR notification. Neuro checks must be documented per physician order/facility protocol under the | |

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| F 514 | Continued From page 90<br>she did not complete any documentation of the fall because she was in a hurry to leave and had planned to document the fall the next day but must have forgotten. | F 514 | neuro check progress note for all suspected head injury. A nurse's note must be written regarding bruises that were not previously present. An incident report must be completed and the MD and RR must be notified with documentation in the medical records. Complete a skin referral form. Notify the Don and Administrator immediately of all bruises as this could be considered an "injury of unknown origin" and requires further investigation. Generate a nurse's note when you schedule an appointment. Example: "Appointment with Dr. Skylar of orthopedics made for Monday, March 3rd at 2:45pm due to leg pain; facility van driver will transport to and from doctors office. Resident Representative made aware". If a resident refuses to go to an appointment or the appointment is cancelled for any reason, this must be documented. The MD and RR must be notified of the reasoning for not attending an appointment with documentation in the medical records. When an appointment is rescheduled, this also must be documented in the medical records. In addition, chart when the resident returns to the nursing home. Example: "Resident returned from ortho appointment in no observed acute distress; new orders received for weight bearing as tolerated to both lower extremities and tramadol 50 mg orally q6h PRN pain. Resident Representative Jane Simmons (niece) aware."<br>The Quality improvement will audit nursing progress notes and incidents to include falls and bruising utilizing an Audit | |

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| F 514 | Continued From page 91 | F 514 | QI Changes in Condition tool 5 X a week for 8 weeks and monthly X 1 month to ensure that appointments, refusal of appointments, falls and bruising is identified in the electronic medical record with notification of RR and physician. Any identified areas of concern will be immediately corrected and the licensed nurse will be re-trained by Quality Improvement during the audit. The Director of Nursing will review and initial the Audit QI Changes in Condition tool 5 X a week for 8 weeks and monthly X 1 month for completion.<br>The Director of Nursing will forward the results of the Audit QI Changes in Condition tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Audit QI Changes in Condition tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. | |
| F 520 SS=D | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee; | F 520 | | 11/5/17 |

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| F 520 | Continued From page 92<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 7/21/17 recertification survey. This was the recited deficiencies in the areas of Dignity (F241), and Choices (F242). These | F 520 | F520<br>The Administrator, DON and QI Nurse were educated by the Corporate Consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of | |

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| F 520 | Continued From page 93<br>deficiencies were recited again on the revisit survey of 9/27/17. The continued failure of the facility shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program.<br><br>The tag is cross referenced to:<br><br>F241 Dignity: Based on observation, record review and staff interviews the facility failed to promote a resident's dignity when staff allowed the resident to wait while 2 other residents at the same table were being fed and staff pulled the resident ' s Geri-chair backwards without telling the resident for 1 of 8 residents reviewed for dignity (Resident #29).<br><br>During the 7/21/17 recertification survey the facility had a F241 citation for failing to treat residents in a dignified manner when the facility staff allowed a resident who requested incontinent care during a meal to sit in a soiled brief while eating.<br><br>F242 Choices: Based on staff and family interviews, and record review, the facility failed to offer showers as scheduled for 1 of 3 sampled residents (Resident # 44).<br><br>During the 7/21/17 recertification survey the facility had a F242 citation for failing to provide a policy that allows a safe smoker to smoke any time he/she wanted and to smoke unsupervised.<br><br>An interview was conducted with the Administrator on 9/26/17 at 12:15 PM. She stated she attributed the fact that their Quality Assessment and Assurance had not worked because there had been changes in the | F 520 | deficient practice to include promoting dignity and offering showers on 10/4/2017. The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on 10/4/2017.<br>The Facility Consultant completed 100% audit of previous citations and action plans within the past year to include promoting dignity and offering showers to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by the Administrator on 11/05/17 for any concerns identified.<br>All data collected for identified areas of concerns to include promoting dignity and offering showers will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by Administrator.<br>The Corporate Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the | |

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| F 520 | Continued From page 94<br>administrative staff recently. She expressed she had hired new staff and was working on resolving past issues that may not have been addressed by previous QAA efforts. | F 520 | Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include promoting dignity and offering showers and all current citations and QI plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QI nurse for any identified areas of concern.<br>The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring. | |