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	345333	A. BUILDING _____ B. WING _____	C 11/02/2020

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E 000	Initial Comments An unannounced COVID-19 Focused Survey and complaint investigation survey were conducted on 10/13/2020 through 11/02/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# KSF811.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 10/13/2020 through 10/21/2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 3 of the 5 complaint allegations were substantiated resulting in a deficiency. Substandard Quality of Care was idenitified at: CFR 483.12 at tag F600 at scope and severity H. A partial extended survey was conducted on 11/02/20 and the survey's exit date was changed to 11/02/20.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		11/10/20

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

Electronically Signed | 11/09/2020

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physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 2 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, family, staff, outpatient Physician ' s Assistant (PA), and facility Medical Director, the facility failed to notify the physician, outpatient medical provider, or the resident ' s representative when Resident #2 ' s lumbar (lower back) surgical incision re-opened during care. Resident #2 ' s surgical incision was open for greater than 10 days with no medical treatment which resulted in an infection in the incision site requiring hospitalization and surgical debridement. This was for 1 of 3 residents reviewed for wound care (Resident #2). The findings included: Resident #2 was admitted to the facility on 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system. Resident #2 ' s demographic sheet in the medical record indicated emergency contact #1 was a family member. A nursing note dated 9/10/20 completed by Nurse #14 (the Nurse Supervisor) indicated Resident #2 was admitted to the facility following a laminectomy (a major spine surgery that removes a portion of the vertebral bone called the lamina). This note made no mention of Resident #2 ' s lumbar (lower back) surgical incision. Physician treatment orders from 9/10/20 to 9/28/20 for Resident #2 were reviewed and	F 580	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Abbotts Creek Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F580 CFR(s): 483.10(g)(14)(i)-(iv)(15) (1) Resident #2 was discharged 9/28/2020. (2) The Center Nurse Executive (CNE) and designee audited on 11/3/2020 the last thirty days of change in conditions to ensure that notifications to the physician, resident representatives, and if necessary the outpatient medical provider have been completed. No discrepancies were found upon discovery with the audit. The Center Nurse Executive, Registered Nurse (RN) supervisor or designee, audited on 11/3/2020 all current residents admitted in the last thirty days to review orders and ensure appropriate treatments are in place. No discrepancies were found upon discovery with the audit. The Center Nurse Executive, Registered Nurse (RN)	

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revealed no physician ' s orders related to Resident #2 ' s lumbar surgical incision.

A history a physical dated 9/12/20 completed by Resident #2 ' s physician (the facility ' s Medical Director) indicated Resident #2 was in the hospital from 8/22/20 through 9/10/20. He had a laminectomy on 8/25/20 due to spinal stenosis causing leg weakness.

On 9/14/20 the physician completed an addendum to the history and physical conducted for Resident #2 on 9/12/20. The addendum indicated Resident #2 ' s lumbar surgical incision was healing well.

The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. Resident #2 was dependent on 2 or more staff for bed mobility, transfers, toileting, personal hygiene and bathing. He required the extensive assistance of 2 or more for dressing. Resident #2 had an indwelling urinary catheter, was assessed as always incontinent of bowel, and he had a surgical wound.

On 9/28/20 Resident #2 attended a postoperative (post-op) outpatient follow up appointment for his lumbar laminectomy. The outpatient Physician ' s Assistant ' s (PA) progress note, completed 9/28/20 at 10:40 AM, indicated Resident #2 had breakdown of the inferior (lower) portion of his surgical incision. His staples were intact to superior (upper) portion of incision. There was malodorous (foul smelling) drainage from the inferior portion of the incision and breakdown of the incision was assessed as at least 2 to 3 cm deep with erythema (redness of the skin) of the

supervisor or designee performed a skin check on all residents from 11/5/2020 through 11/7/2020 to ensure that all skin concerns have been addressed with appropriate wound care orders in place, and appropriate notification completed and documented. Eight corrections were made for any discrepancies found upon discovery with audits.

(3) The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency, on facility Change of Condition Policy by 11/10/20. All staff not in serviced by 11/10/2020, will be required to complete in-service prior to working. The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee will educate all licensed nurses on obtaining wound care orders for all wounds, completing a change of condition, completing an incident in the Risk Management System (RMS),where incident and accident reports are created by the nursing staff, and notification to physician and resident representative by 11/10/20.

(4) Within 24 hours of admission, a complete skin assessment will be performed by the Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee. Orders will be reviewed to ensure appropriate treatments are in place, including pain evaluation and monitoring the wound for infection, and dehiscence. Surgical wounds will be

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F 580	Continued From page 4 surrounding tissue. The PA indicated she was concerned the surgical incision was infected and she sent Resident #2 to the Emergency Department (ED) for evaluation, imaging, and further management. A general note dated 9/28/20 at 5:03 PM completed by Nurse #7 indicated she was notified by Resident #2 ' s emergency contact #1 that he was sent to the hospital from his post-op outpatient follow up appointment due to his lumbar surgical incision being infected. A review of Resident #2 ' s facility medical record from his admission on 9/10/20 through discharge on 9/28/20 included no measurements, nursing assessments, monitoring or treatments of his lumbar surgical incision. There were also no physician ' s orders related to the surgical incision. Resident #2 ' s lumbar surgical incision was mentioned only twice in the facility medical record: 1) the 9/14/20 physician ' s addendum to his 9/12/20 note in which he indicated the incision was healing well on 9/12/20 and 2) the 9/28/20 general note completed by Nurse #14 that indicated she received a call from Resident #2 ' s family member reporting that the resident was sent to the hospital from his outpatient follow up appointment due to his surgical incision being infected. The hospital record included an ED skin assessment that indicated Resident #2 had a midline lumbar surgical site wound, inferior portion of the wound was dehisced (opened up) with drainage noted and surrounding erythema. A CT scan of the lumbar spine was obtained which showed superficial dehiscence of the inferior portion of the lumbar wound and cellulitis (skin	F 580	entered into the wound portal in Point Click Care system and assessed by nursing administration weekly. The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee, will review five times weekly for three months in the morning clinical meeting. The review will include RMS for any new incidents, and new orders for wound care to ensure appropriate treatments are in place, and ensure that notifications were made to the resident representative, physician and outside provider if necessary. The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee, will review all change in conditions five times weekly for three months in the morning clinical meeting, to ensure that notifications were made to the resident representative, physician and outside provider if necessary. All findings will be brought to the Quality Assurance Performance Improvement Committee on a monthly basis for ongoing compliance. The Center Nurse Executive is responsible for implementing the acceptable plan of correction. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020.	

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infection). He was seen for a neurosurgery consult and was admitted to the Neurosurgery Unit (NSU) on 9/28/20. The neurosurgery physician indicated plans were made with Infectious Disease (ID) specialists to attempt primary closure of the wound. Antibiotic therapy was pending intraoperative cultures. On 9/30/20 Resident #2 underwent surgical irrigation and debridement (removal of unhealthy tissue) and primary closure of his lumbar surgical wound. Wound cultures tested positive for E. Coli and intravenous (IV) antibiotics were initiated. ID specialists recommended to continue antibiotic therapy until at least 11/13/20.

A review of Resident #2 ' s medical record from his 9/10/20 admission through 9/28/20 discharge indicated his emergency contact #1 was notified by staff of changes in condition as well as weekly phone calls with status updates.

A phone interview was conducted with Resident #2 on 10/16/20 at 9:49 AM. Resident #2 stated that he depended on staff to provide assistance with all ADLs, he was incontinent of bowel, was on a laxative that caused runny/loose stools, and he needed 2 staff ' s assistance for incontinent care. He reported that during his stay at the facility as he was receiving care, one of the Nursing Assistants (NAs) told him that a couple of his staples came out, but not to worry about it. He was unable to recall the NAs name or the specific date, but he knew it occurred during the 1st shift (7:00 AM to 3:00 PM) and that this specific NA had worked with him on multiple occasions during the first shift. He reported that it was at least a week prior to his discharge from the facility to the hospital on 9/28/20. He stated that he told his family member (emergency

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contact #1) by phone about incident.

A phone interview was conducted with Resident #2 ' s family member (emergency contact #1) on 10/16/20 at 8:30 AM. She stated that she spoke with Resident #2 frequently by phone during his stay at the facility. She indicated that on 9/19/20 Resident #2 called her and said that sometime during that week one of the NAs told him a couple of his staples "popped out" when they were turning him. She reported that she spoke with the DON several times during Resident #2 ' s facility stay, and she asked how his surgical incision was healing, and she was told it was healing well. She revealed she was never informed the surgical incision had opened. She indicated that the PA from Resident #2 ' s post-op follow up appointment called her on 9/28/20 and told her the surgical wound was infected and that she was sending him to the hospital.

A review of the staff schedule with assignments from Resident #2 ' s 9/10/20 admission through 9/28/20 discharge revealed Resident #2 ' s first shift NAs were most frequently NA #1 and NA #2.

A phone interview was conducted with NA #1 on 10/16/20 at 11:53 AM. NA #1 stated she was an agency NA and she worked on Resident #2 ' s unit (200 hall) on the first shift on 9/16/20, 9/17/20, 9/19/20 through 9/21/20, 9/23/20 through 9/25/20, and 9/28/20. She indicated she was familiar with Resident #2 stating that he required the assistance of 2 or more staff for most ADLs, he was always incontinent of bowel, and he required frequent repositioning in bed as he was unable to turn himself. She stated that 2 NAs were normally working on the 200 hall unit and they worked together to provide assistance to

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Resident #2. NA #1 revealed she was providing care to Resident #2 at the time that a couple of his staples came out of his lumbar surgical incision. She stated that she was turning Resident #2 in bed with another NA when the staples came out. She was unable to recall the exact date, but she believed she was working with NA #2 at the time. She reported that she informed the Nurse on duty right after the staples came out, but she was unable to recall who the nurse was. NA #1 indicated that after the staples came out a dressing was placed on the surgical incision by the nurse.

During a phone interview with NA #2 she stated that she was familiar with Resident #2, but she had no recollection of working with him at the time a couple of his staples came out.

A phone interview was conducted with Nurse #2 on 10/16/20 at 12:24 PM. Nurse #2 revealed she recalled Resident #2 having a dressing on his surgical incision on 9/18/20. This was 10 days prior to Resident #2 ' s post-op follow up appointment (9/28/20). Nurse #2 explained that she remembered seeing the dressing and noticing that there were no physician ' s orders for it. She stated that she asked the day shift nurse before she left that day (Nurse #3) why there was a dressing on Resident #2 ' s surgical incision and she stated that she had not known why the dressing was in place and that it was on when she began her shift that morning 9/18/20. Nurse #2 stated that she had not removed or replaced the dressing as there was no physician ' s order for this. She revealed she made no notifications to the physician or resident ' s representative regarding the dressing that was in place to Resident #2 ' s surgical incision. Nurse #2

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explained that at the time, she thought that the nurse who first applied the dressing to Resident #2 ' s surgical incision must have made the required notifications to the physician and resident representative. Nurse #2 indicated that looking back on the situation she should have assessed the surgical incision and notified the physician to determine why a dressing was in place with no physician ' s order. She further indicated that she should have notified Resident #2 ' s representative (emergency contact #1) as well.

A phone interview was conducted with Nurse #3 on 10/19/20 at 12:09 PM. Nurse #3 reported that she had not known when Resident #2 ' s surgical incision first opened, but that she had seen it with a dressing in place when she was working with him. She stated that she had not made any notifications to the physician or Resident #2 ' s representative about the surgical incision as she assumed the nurse who implemented the dressing made the required notifications.

A phone interview was conducted with Nurse #5 on 10/16/20 at 11:40 AM. Nurse #5 reported that one day right before the end of her shift she noticed that Resident #2 had dressing with some "yellowish" drainage on it over his surgical incision. She reported that she took the dressing off and it looked like 1 or 2 staples were missing and she approximated there to be about 1 cm opening of the lower part of the incision. She indicated that this was just an approximation as she had not taken any measurements or completed any assessments of the surgical incision. Nurse #5 revealed that she had not looked for any physician ' s orders for a dressing as it was already time for her to leave, but she

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had changed the dressing to a new dry dressing since there was some drainage on the previous dressing. She further revealed she had not made any notifications to the physician or Resident #2 ' s representative about the surgical incision being open and a dressing in place. She explained that she assumed another nurse had informed the physician of the surgical incision opening since there was already a dressing on it. Nurse #5 indicated that Resident #2 was incontinent of bowel and frequently had loose stools as he was on a laxative (lactulose) which may have contributed to the surgical incision becoming infected.

A phone interview was conducted on 10/16/20 at 12:54 PM with Resident #2 ' s outpatient PA who conducted the post-op follow up appointment on 9/28/20. The PA indicated that she was familiar with Resident #2 and recalled his 9/28/20 follow up appointment. She stated that based on her assessment of the lumbar surgical wound she believed it was infected. She explained that there was drainage on the dressing which had a foul odor indicative of an infection, the inferior portion of the incision was open with erythema of the surrounding tissue, and the upper portion of the incision still had staples intact. She indicated that she sent Resident #2 straight to the ED for further evaluation and treatment. She stated that Resident #2 required hospitalization, surgical debridement of the wound, and IV antibiotic therapy. The PA reported that she believed this was preventable explaining that if she had been notified by facility staff when the surgical wound opened that she or the physician could ' ve ordered treatment and an antibiotic which most likely would have kept Resident #2 out of the hospital and from having another surgery. She

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added that Resident #2 ' s immobility, incontinence of bowel, and total dependence on staff increased his risk for infection in an open surgical wound which made it even more important to notify herself or the physician as soon as the wound was identified to be open.

An interview was conducted with the DON on 10/19/20 at 3:32 PM. The DON reported that she first learned of Resident #2 ' s surgical wound opening and the wound infection on 9/28/20 when emergency contact #1 phoned the facility after the resident had been sent to the ED. She indicated she completed an investigation and was unable to determine the exact date the surgical wound opened, but she had determined that the wound opened prior to 9/18/20 as Nurse #2 saw a dressing on the wound on that date. The DON reported that she expected the nurse who first identified that the surgical incision was open to notify the physician to obtain treatment orders and notify the resident ' s representative. She indicated that emergency contact #1 was Resident #2 ' s representative.

A phone interview was conducted with the facility ' s Medical Director on 10/19/20 at 11:56 AM. He stated that he observed Resident #2 ' s surgical incision on 9/12/20 and that it was healing well at that time. He reported that he had not seen the surgical incision after 9/12/20. He indicated that he depended on the nursing staff who look at the wounds to let him, the resident ' s surgeon, or the surgeon ' s PA know if there was a problem. The Medical Director explained that he normally deferred treatment decisions related to surgical incisions to the treating surgeon. He reported that if staff were unable to get a hold of the surgeon that staff were to call him to obtain

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F 580	Continued From page 11 treatment orders. The Medical Director revealed that he had not been informed by staff that Resident #2 ' s surgical incision opened during his stay at the facility (9/10/20 through 9/28/20) and he had not given any treatment orders related to the surgical incision. He also revealed that he was unaware that the surgical incision was open for greater than 10 days. He stated that for a resident with immobility and multiple medical issues who had back surgery, it was not uncommon for an infection to develop and it was pertinent for staff to report any changes in wound condition as soon as they were identified to prevent further complications.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(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. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		11/10/20

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§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances 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 585	Continued From page 13 investigated; (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; (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; (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 (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. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, the facility failed to resolve a grievance and failed to provide a written grievance decision for 1 of 1 residents reviewed for grievances (Resident #2). The findings included:	F 585	F585 CFR(s): 483.10(j)(1)-(4) (1) Resident #2 was discharged 9/28/20. (2) An audit was completed by the Center Executive Director (CED) , for the past 30 days to assure that all grievances were	

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F 585	Continued From page 14 A review of the facility ' s grievance policy (last revised on 7/1/19) included, in part, the right to file grievances orally or in writing, the right to obtain a written decision regarding his/her grievance, and notification to the person filing the grievance of the resolution within 72 hours. Resident #2 was admitted to the facility on 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system. The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. A grievance form dated 9/28/20 indicated Resident #2 ' s family member reported a concern to the Business Office Manager (BOM) by phone on 9/28/20. The grievance indicated Resident #2 had a postoperative (post-op) follow up appointment on this date and his surgical incision was found to be infected. The grievance also indicated that no documentation was sent to the outpatient provider by the facility on Resident #2 ' s condition and medical treatment. This form indicated the grievance was assigned to the Director of Nursing (DON) on 9/29/20 and was to be resolved by 10/1/20. The bottom section of the form was titled, "Resolution of grievance/concern". This section required documentation on if the grievance was resolved, a description of the resolution, date of written notification, and signature of the staff member who completed the documentation on this section of the form. This entire section was blank. Attached to the form was an undated typed investigation about when Resident #2 ' s surgical	F 585	resolved with written notification per facility grievance policy on 11/4/20. Audit revealed all grievances were resolved with written notification provided. (3) The Center Executive Director or designee will educate staff on the grievance policy and procedures by 11/10/20. (4) The Center Executive Director and Social Services Director will be responsible for timey review of all grievances, resolutions and written notifications. The Center Executive Director will be responsible for auditing grievances 5x weekly for 1 month, then 3x weekly for 1 month, then weekly for 3 months. The Center Executive Director will review the audits, and results will be reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020	

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incision opened. The investigational summary, undated, indicated the DON was unable to pinpoint the date the surgical incision opened. The DON reported that an inservice was to be conducted with nursing staff related to documentation of wounds and physician/family notification. There was no information on this investigation related to Resident #2 being sent to his outpatient follow up appointment without any documentation from the facility.

A phone interview was conducted on 10/16/20 at 8:30 AM with Resident #2 ' s family member. She stated that she never received a written summary of the grievance resolution from the 9/28/20 grievance. She indicated she spoke with the DON by phone about a week after she reported her concerns to the BOM and the DON informed her that she was unable to determine when Resident #2 ' s surgical incision first opened, but that she was implementing a correction plan, so the error would not be repeated. The family member reported that she never received any information on why Resident #2 was sent to his outpatient appointment without any documentation from the facility.

A phone interview was conducted with the DON on 10/16/20 at 4:40 PM. She revealed she was unaware that written notice of the grievance decision was required to be provided to the reporting party for all grievances. The 9/28/20 grievance reported by Resident #2 ' s family member was reviewed with the DON. The DON acknowledged that the section of the grievance form titled, "Resolution of grievance/concern" was blank. She stated that she forgot to fill out this section of the grievance form. She explained that she investigated the grievance, but was unable to

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F 585	Continued From page 16 determine when Resident #2 ' s incision opened and that she informed Resident #2 ' s family member of this information by phone. She revealed she had not provided any information related to this grievance to the family member in writing. The DON further revealed she had not looked into the portion of the grievance that indicated Resident #2 was sent to his outpatient appointment with no documentation from the facility. She was unable to explain why this had not been addressed.	F 585		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, family, staff, outpatient Physician ' s Assistant, and facility Medical Director, the facility neglected to assess, monitor, document, communicate and provide medical treatment to a lumbar (lower back) surgical incision to promote healing and prevent complications. Resident #2 '	F 600	F600 CFR(s): 483.12(a)(1) (1) Resident #2 was discharged 9/28/2020. (2) The Center Nurse Executive (CNE) and designee will audit the last thirty days	11/10/20

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F 600	Continued From page 17 s lumbar surgical incision was not treated for 18 days which resulted in an infection in the incision site requiring hospitalization. Resident #2 was admitted to the hospital and was diagnosed with lumbar surgical wound dehiscence (reopening of the wound) with infection and a surgical debridement of the lumbar incision was performed. The facility also neglected to implement preventative measures for Resident #2, who was at high risk for pressure ulcers, to prevent the development of an ankle pressure ulcer. This was for 1 of 3 residents (Resident #2) reviewed for wound care. The findings included: 1. Resident #2 was admitted to the facility on 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system, spinal stenosis (a narrowing of the spaces within your spine, which can put pressure on the nerves that travel through the spine), and sepsis. A nursing note dated 9/10/20 completed by Nurse #14 (the Nurse Supervisor) indicated Resident #2 was admitted to the facility following a laminectomy (a major spine surgery that removes a portion of the vertebral bone called the lamina). Resident #2 was alert and oriented to person, place, time, and situation. Nurse #14 indicated he had soiled dressings to his left buttock, inner fold of buttocks and coccyx (commonly referred to as the tailbone). The dressings were removed and revealed Moisture Associated Skin Damage (MASD) to these areas. This note made no mention of Resident #2 ' s lumbar (lower back) surgical incision.	F 600	of change in conditions, to ensure that notifications to the physician, resident representative□s, and if necessary the outpatient medical provider have been completed. No discrepancies were found upon discovery with audits. The Center Nurse Executive, Registered Nurse (RN) supervisor and designee performed a skin check on all residents from 11/5/2020 through 11/7/2020 to ensure that all skin concerns have been addressed with appropriate wound care orders in place, and appropriate notification completed and documented. No discrepancies were found upon discovery with the audit. Nurse #14 was educated 1:1 by Corporate nurse consultant on skin inspection and skin checks. On 11/8/2020, the Center Nurse Executive performed an audit of current residents to review their Braden Scale, and identify residents that are at risk for pressure ulcers, and ensure that preventative measures are in place. Two corrections were made for discrepancies found upon discovery with audits. (3) Abuse and neglect for all staff started on 10/30/20 and completed 11/6/2020. Education for all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency on skin inspection and skin checks was started on 10/30/20. All licensed nurses including fulltime (FT), part time (PT), per diem (PRN)and agency will complete a course in vital learn on pressure ulcer prevention and management. All staff that have not completed the course by 11/10/2020, will be required to complete the course prior	

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F 600	Continued From page 18 A skin assessment dated 9/10/20 completed by Nurse #14 (the Nurse Supervisor) indicated the following skin conditions: - Bruises to left abdomen, left knee - Discoloration to right elbow - Abrasion to left abdomen - MASD to buttocks, between medial buttock fold, and coccyx This skin assessment made no mention of Resident #2 ' s lumbar surgical incision. On 9/10/20 a care plan was initiated for Resident #2 with a focus area related to the risk for skin breakdown and actual skin breakdown. He was noted to have MASD. The goal was for healing of Resident #2 ' s skin impairment. The interventions initiated on 9/10/20 included: - Pat skin when drying, do not rub - Apply barrier cream with each cleansing - Observe skin condition daily with Activities of Daily Living (ADL) care and report abnormalities - Weekly skin check by nurse a. The nursing admission assessment dated 9/10/20 completed by Nurse #14 (the Nurse Supervisor) indicated Resident #2 was admitted for postoperative (post-op) care status post laminectomy. He was assessed with bilateral lower extremity weakness and he had a urinary catheter. She indicated Resident #2 ' s skin was warm and dry, he had bruising to left abdomen and left knee, an abrasion to left abdomen, and MASD to buttocks and coccyx. There were no other wounds or skin conditions noted. She made no mention of Resident #2 ' s lumbar surgical incision. Physician treatment orders from 09/10/20 to	F 600	to working. The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN)and agency, on facility Change of Condition Policy by 11/10/20. All staff not in serviced by 11/10/2020, will be required to complete in-service prior to working. The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee will review all change in conditions 5 times weekly for three months in the morning clinical meeting, to ensure that notifications were made to the resident representative, physician and outside provider if necessary. The Center Nurse Executive (CNE), RN supervisor or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN)and agency on obtaining wound care orders for all wounds, completing a change of condition, completing an incident in RMS, and notification to physician and resident representative by 11/10/20.All staff not in serviced by 11/10/2020, will be required to complete in-service prior to working. Within 24 hours of admission, a complete skin assessment will be performed by the Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee. Orders will be reviewed to ensure appropriate treatments are in place, including pain evaluation and monitoring the wound for infection, and dehiscence. Surgical wounds will be entered into the wound portal in Point Click Care system and assessed by	

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F 600	Continued From page 19 9/28/20 for Resident #2 were reviewed and revealed there were no orders related to Resident #2 ' s lumbar surgical incision. A history and physical dated 9/12/20 completed by Resident #2 ' s physician (the facility ' s Medical Director). He indicated Resident #2 was in the hospital from 8/22/20 through 9/10/20. He had a laminectomy on 8/25/20 due to spinal stenosis causing leg weakness. The Nursing Assistant (NA), no name specified, indicated Resident #2 needed to be turned, he slept a lot, he was incontinent of bowel, and when they sat him up yesterday he was only able to tolerate 5 minutes before needing to lay back down. The physician indicated he woke Resident #2 up for his assessment. He was noted to be alert and oriented to person, place, and time. He was noted to be able to move his arms, but had trouble moving his legs. He was unable to turn by himself. On 9/14/20 the physician completed an addendum to the history and physical conducted for Resident #2 on 9/12/20. The addendum indicated Resident #2 ' s lumbar surgical incision was healing well. On 9/17/20 a weekly skin check was ordered to be completed and documented during the day shift (7A - 7P). Based on the schedule with assignments, Nurse #4 was assigned to Resident #2 during the day shift on 9/17/20. There were no skin assessments dated 9/17/20 and the section of the Treatment Administration Record (TAR) that required the nurse to sign off when the skin assessment and nursing documentation was completed was blank.	F 600	nursing administration weekly. (4) The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee will review five times weekly for three months in the morning clinical meeting. The review will include Risk Management System (RMS) for any new incidents, and new orders for wound care to ensure appropriate treatments are in place and ensure that notifications were made to the resident representative, physician and outside provider if necessary. The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee will review new admissions daily for three months to identify residents at risk for pressure ulcers and ensure preventative measures are in place. The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor, will review in weekly Clinical At Risk meetings (CAR) with the interdisciplinary team any significant changes that identify residents newly at risk for pressure ulcers. All findings will be brought to the Quality Assurance Performance Improvement Committee on a monthly basis for ongoing compliance. The Center Nurse Executive is responsible for implementing the acceptable plan of correction. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020.	

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The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. He had no behaviors and no rejection of care. Resident #2 was dependent on 2 or more staff for bed mobility, transfers, toileting, personal hygiene and bathing. He required the extensive assistance of 2 or more for dressing. Resident #2 had an indwelling urinary catheter and was assessed as always incontinent of bowel. He was administered scheduled pain medications and PRN pain medications and self-reported frequent pain at a 7 on a scale of 0-10. Resident #2 was assessed with surgical wounds and MASD. He had no pressure ulcers.

On 9/22/20 a care plan related to ADL care was initiated for Resident #2. The focus area indicated that he was dependent for ADL care related to hospitalization, sepsis, post-op back surgery, and limited mobility. The goal was for Resident #2 to improve current level of functioning with ADLs. The interventions included, in part:
- Monitor for decline in ADL function
- Provide cueing for safety and sequencing
A skin assessment dated 9/24/20 at 3:00 PM completed by Nurse #1 indicated a new skin injury was identified. Nurse #1 assessed Resident #2 with a pressure ulcer to the left outer ankle, but made no mention of Resident #2 ' s lumbar surgical incision.

On 9/28/20 Resident #2 attended a post-op outpatient follow up appointment for his lumbar laminectomy. The outpatient Physician ' s Assistant ' s (PA) progress note, completed 9/28/20 at 10:40 AM, indicated Resident #2 had breakdown of the inferior (lower) portion of his surgical incision. His staples were intact to

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superior (upper) portion of incision. There was malodorous (foul smelling) drainage from the inferior portion of the incision and breakdown of the incision was assessed as at least 2 to 3 cm deep with erythema (redness of the skin) of the surrounding tissue. The PA indicated she was concerned the surgical incision was infected and she sent Resident #2 to the Emergency Department (ED) for evaluation, imaging, and further management.

A general note dated 9/28/20 at 5:03 PM completed by Nurse #7 indicated she was notified by Resident #2 ' s family member that he was sent to the hospital from his post-op outpatient follow up appointment due to his lumbar surgical incision being infected.

The hospital record included an ED skin assessment that indicated Resident #2 had a midline lumbar surgical site wound, inferior portion of the wound was dehisced (opened up) with drainage noted and surrounding erythema. A CT scan of the lumbar spine was obtained which showed superficial dehiscence of the inferior portion of the lumbar wound and cellulitis (skin infection). He was seen for a neurosurgery consult and was admitted to the Neurosurgery Unit (NSU) on 9/28/20. The neurosurgery physician indicated plans were made with Infectious Disease (ID) specialists to attempt primary closure of the wound. Antibiotic therapy was pending intraoperative cultures. On 9/30/20 Resident #2 underwent surgical irrigation and debridement (removal of unhealthy tissue) and primary closure of his lumbar surgical wound. Wound cultures tested positive for E. Coli and intravenous (IV) antibiotics were initiated. ID specialists recommended to continue antibiotic

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therapy until at least 11/13/20.

A review of Resident #2 ' s facility medical record from his admission on 9/10/20 through discharge on 9/28/20 included no measurements, nursing assessments, monitoring, or treatments of his lumbar surgical incision. There were also no physician ' s orders related to the surgical incision. Resident #2 ' s lumbar surgical incision was mentioned only twice in the facility medical record: 1) the 9/14/20 physician ' s addendum to his 9/12/20 note in which he indicated the incision was healing well on 9/12/20 and 2) the 9/28/20 general note completed by Nurse #14 that indicated she received a call from Resident #2 ' s family member reporting that the resident was sent to the hospital from his outpatient follow up appointment due to his surgical incision being infected.

A grievance form dated 9/28/20 filed by Resident #2 ' s family member on 9/28/20 indicated Resident #2 had a post-op follow up appointment on this date and his surgical incision was found to be infected. The grievance indicated it was assigned to the Director of Nursing (DON) for investigation on 9/29/20 and the investigation was to be completed by 10/1/20. A review of the investigation completed by the DON, undated, indicated:
- 9/10/20 admission skin check indicated no openings to the surgical incision
- 9/12/20 physician note indicated the surgical incision was healing
- 9/24/20 skin check note by Nurse #1 noted no openings to the surgical incision
- Daily nursing notes had no documentation of the surgical incision opening
- The DON spoke with Nurse #10 (no date

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provided). She worked with Resident #2 on 9/27/20 and she indicated she had not known the surgical incision was open nor had she observed the surgical incision.
- The DON spoke with Nurse #9 (no date provided). She worked with Resident #2 on 9/26/20 and she indicated she had not observed the surgical incision.
- The DON spoke with Nurse #5 (no date provided). This investigation indicated that she worked with Resident #2 during the night shift on 9/25/20 and she stated the surgical incision was open and draining and she covered it with a dry dressing. (Based on the staff schedule with assignments and nursing notes, Nurse #5 last worked with Resident #2 on 9/23/20 during the night shift. She had not worked on 9/25/20 as indicated in this investigation).
The summary of the investigation indicated that the DON was unable to pinpoint the date the surgical incision opened.

On 10/15/20 at 1:06 PM via email correspondence with the DON, all wound assessment and monitoring information was requested for Resident #2 ' s surgical incision. On 10/15/20 at 1:27 PM the DON responded that there was no wound assessment or monitoring for Resident #2 as his wound was surgical and was not a pressure ulcer.

A phone interview was conducted with Resident #2 on 10/16/20 at 9:49 AM. Resident #2 stated that he depended on staff to provide assistance with all ADLs with the exception of eating. He explained that he was incontinent of bowel, was on a laxative that caused runny/loose stools, and he needed 2 staff ' s assistance for incontinent

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care. He further explained that he frequently needed to be turned and repositioned as he had difficulty finding a position that was comfortable. Resident #2 reported that during his stay at the facility as he was receiving care, one of the NAs told him that a couple of his staples came out, but not to worry about it. He was unable to recall the NAs name or the specific date, but he knew it occurred during the 1st shift (7:00 AM to 3:00 PM) and that this specific NA had worked with him on multiple occasions during the first shift. He reported that it was at least a week prior to his discharge from the facility to the hospital on 9/28/20. He stated that he told his family member by phone about incident. Resident #2 indicated that he had pain from admission through discharge from his legs and his back and he was unable to determine if there was a change in pain level after the surgical incision site opened.

A phone interview was conducted with Resident #2 ' s family member on 10/16/20 at 8:30 AM. She stated that she spoke with Resident #2 frequently by phone during his stay at the facility. She indicated that on 9/19/20 Resident #2 called her and said that sometime during that week one of the NAs told him a couple of his staples "popped out" when they were turning him. She reported that she spoke with the DON several times during Resident #2 ' s facility stay, and she asked how his surgical incision was healing, and she was told it was healing well. She indicated that the PA from Resident #2 ' s post-op follow up appointment called her on 9/28/20 and told her the surgical wound was infected and that she was sending him to the hospital.

A phone interview was conducted with Nurse #14 (the Nurse Supervisor) on 10/15/20 at 2:30 PM.

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Nurse #14 stated that she assisted Nurse #1 with completing the admission for Resident #2 as he required 2 staff ' s assistance with care. She reported that she and Nurse #1 turned Resident #2 onto his side and viewed his lumbar surgical incision (9/10/20). She stated the incision was open to air (no dressing in place) and appeared to be healing nicely. Nurse #14 reviewed her admission assessment, skin assessment, and nursing note for 9/10/20 and revealed that she had not documented any information on Resident #2 ' s lumbar surgical incision. She reported there was no indication of the length of the incision, the number of staples, and/or the condition of the surgical incision. She stated that normally she would have put in her note the measurements and condition of the surgical incision. The Nurse Supervisor indicated she must have forgotten to enter this information. She reported that she recalled Resident #2 had MASD on his buttocks which was treated each shift with physician ordered Z-guard (skin paste protectant). Nurse #14 stated that she had not observed Resident #2 ' s surgical incision after his admission on 9/10/20.

A phone interview was conducted with Nurse #1 on 10/16/20 at 2:55 PM. She stated that she and Nurse #14 (the Nurse Supervisor) completed the admission for Resident #2. She indicated she recalled Resident #2 ' s surgical incision was open to air and appeared to be healing with no signs of infection on the date of his admission (9/10/20). She reported that he had a number of staples in the incision, but she had not known how many as she had not counted or documented this information. The nursing schedule with assignments that indicated Nurse #1 had worked with Resident #2 on 4 dates after

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admission (9/11/20, 9/20/20, 9/24/20, and 9/25/20) was reviewed with Nurse #1. Nurse #1 revealed that on either 9/20/20 or 9/24/20 she observed a dressing on Resident #2 ' s surgical incision. She stated that she had not recalled the exact date she observed the dressing or what condition the dressing was in. She indicated that she remembered wondering why the dressing was on his surgical incision and asking the NA who was working with her (unable to recall a name) and they had not known why the dressing was on the surgical incision. Nurse #1 revealed she had not asked anyone else about the dressing and she had not completed any changes of the dressing as she reviewed the physician ' s orders and there were no orders for it. She further revealed that after she saw the dressing she just continued on with her work. She explained that she gave no further thought to figuring out why the dressing was in place, assessing the condition underneath the dressing, and/or notifying the physician of the dressing that was in place without a physician ' s order. Nurse #1 stated that she was so busy when she was working that she moved from one thing to the next and that since she had not initiated the dressing to the surgical incision and she had no orders change the dressing that this surgical incision was not her focus.

This interview with Nurse #1 continued. The skin assessment and SBAR dated 9/24/20 completed by Nurse #1 that indicated a new skin condition of a pressure ulcer to Resident #2 ' s left outer ankle were reviewed with Nurse #1. Nurse #1 stated that 9/24/20 was when she first identified the pressure ulcer on the left outer ankle of Resident #2. She was asked if she had observed the dressing on the surgical incision prior to, at the

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time of, or after this 9/24/20 identification of the left ankle pressure ulcer. She stated that she was not certain about this. Nurse #1 explained that she would not have completed a skin assessment or SBAR for the surgical incision because these were only completed for newly identified skin conditions and since someone else had placed a dressing on the surgical incision, that this person should have completed the appropriate documentation and notified the physician.

A review of the staff schedule with assignments from Resident #2 ' s 9/10/20 admission through 9/28/20 discharge revealed Resident #2 ' s first shift NAs were most frequently NA #1 and NA #2.

A phone interview was conducted with NA #1 on 10/16/20 at 11:53 AM. NA #1 stated she was an agency NA and she worked on Resident #2 ' s unit (200 hall) on the first shift on 9/16/20, 9/17/20, 9/19/20 through 9/21/20, 9/23/20 through 9/25/20, and 9/28/20. She indicated she was familiar with Resident #2 stating that he required the assistance of 2 or more staff for most ADLs, he was always incontinent of bowel, and he required frequent repositioning in bed as he was unable to turn himself. She stated that 2 NAs were normally working on the 200 hall unit and they worked together to provide assistance to Resident #2. NA #1 revealed she was providing care to Resident #2 at the time that a couple of his staples came out of his lumbar surgical incision. She stated that she was turning Resident #2 in bed with another NA when the staples came out. She was unable to recall the exact date, but she believed she was working with NA #2 at the time. She reported that she

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informed the Nurse on duty right after the staples came out, but she was unable to recall who the nurse was. NA #1 indicated that after the staples came out a dressing was placed on the surgical incision by the nurse.

A phone interview was conducted with NA #2 on 10/16/20 at 10:50 AM. NA #2 stated she worked on Resident #2 ' s unit (200 hall) on the first shift on 9/10/20 through 9/13/20, 9/15/20 through 9/18/20, 9/21/20 through 9/24/20, 9/26/20, and 9/27/20. She indicated she was familiar with Resident #2 stating that he required the assistance of 2 or more staff for most ADLs, he was always incontinent of bowel, and he required frequent repositioning in bed as he was unable to turn himself. She confirmed NA #1 ' s statement that the NAs assigned to the 200 hall worked together to provide care to Resident #2. NA #2 stated that she had no recollection of working with Resident #2 at the time a couple of his staples came out. She indicated she had cooperatively worked with NA #1 on multiple dates to provide care to Resident #2. NA #2 reported that she remembered Resident #2 having a dressing on his surgical incision when she worked with him, but she was unable to recall when she first saw the dressing.

A phone interview was conducted with Nurse #2 on 10/16/20 at 12:24 PM. Nurse #2 stated she was an agency nurse and she began working at the facility in September 2020. Based on the staff schedule with assignments and nursing documentation, Nurse #2 was assigned to Resident #2 during the night shift on 9/11/20 and 9/18/20. Nurse #2 revealed she recalled Resident #2 having a dressing on his surgical incision on 9/18/20. This was 10 days prior to

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Resident #2 ' s post op follow up appointment (9/28/20). Nurse #2 explained that she remembered seeing the dressing and noticing that there were no physician ' s orders for it. She stated that she asked the day shift nurse before she left that day (Nurse #3) why there was a dressing on Resident #2 ' s surgical incision and she stated that she had not known why the dressing was in place and that it was on when she began her shift that morning 9/18/20. Nurse #2 reported that she had not recalled if there was any drainage on the dressing. She stated that she had not removed or replaced the dressing as there was no physician ' s order for this. She revealed that she took no further action to figure out why the dressing was in place, she had not assessed the condition of the surgical incision underneath the dressing, and she had not notified the physician of the dressing that was in place without a physician ' s order. Nurse #2 indicated that looking back on the situation she should have assessed the surgical incision and notified the physician to determine why a dressing was in place with no physician ' s order. Nurse #2 revealed that the DON had asked her several days ago about Resident #2 ' s surgical incision, unable to recall the date, and she told her that she saw the dressing in place to Resident #2 ' s surgical incision when she worked with him on 9/18/20.

A phone interview was conducted with Nurse #5 on 10/16/20 at 11:40 AM. Based on the staff schedule with assignments and nursing documentation, Nurse #5 was assigned to Resident #2 during the night shift on 9/14/20, 9/15/20, 9/16/20, 9/20/20, and 9/23/20. She verified that she had not worked with Resident #2 on 9/25/20 as indicated in the grievance

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investigation. Nurse #5 stated that on one of these dates that she worked with Resident #2, unable to recall the exact date, she was going to complete the treatment of Z-guard to his buttocks right before change of shift. She indicated she had 2 NAs (unable to recall the NAs) assist her with turning the resident and that was when she noticed that there was dressing on Resident #2 ' s lumbar surgical incision. She reported that recalled the dressing had some "yellowish" drainage on it. Nurse #5 stated that she remembered thinking that the last time she saw the surgical incision there was not a dressing on it. Nurse #5 reported that she took the dressing off of the surgical incision and it looked like 1 or 2 staples were missing and she approximated there to be about 1 cm opening of the lower part of the incision. She indicated that this was just an approximation as she had not taken any measurements or completed any assessments of the surgical incision. Nurse #5 revealed that she had not looked for any physician ' s orders for a dressing as it was already time for her to leave, but she had changed the dressing to a new dry dressing since there was some drainage on the previous dressing. She stated that she reported off to the oncoming nurse (unable to recall who the oncoming nurse was) that Resident #2 ' s surgical incision was open and that she should have the physician look at it if he came into the building that day. Nurse #5 explained that she assumed another nurse had informed the physician of the surgical incision opening since there was already a dressing on it, so she simply replaced the dressing, reported off to the oncoming nurse, and left when her shift was over. She was asked if she always observed Resident #2 ' s surgical incision site when she was assigned to him and she stated that although he

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required treatment to his buttocks every shift that it was possible she worked with him and had not made an observation of the surgical incision. Nurse #5 indicated that Resident #2 was incontinent of bowel and frequently had loose stools as he was on a laxative (lactulose). She stated that this may have contributed to the surgical incision becoming infected.

A phone interview was conducted with Nurse #13 on 10/16/20 at 8:00 AM. Nurse #13 indicated she was an agency nurse and she worked at the facility 36 hours per week. Based on the staff schedule with assignments and nursing documentation, Nurse #13 worked with Resident #2 on 9/22/20 and 9/23/20 during the day shift. She stated that she was unable to recall if Resident #2 had a dressing on his surgical incision when she worked with him. She reported that she would not have assessed or treated the surgical incision without a physician ' s order.

A phone interview was conducted with Nurse #4 on 10/16/20 at 10:00 AM. Nurse #4 stated he was an agency nurse and he worked at the facility for 4 days in September 2020. Based on the staff schedule with assignments and the nursing documentation, Nurse #4 worked with Resident #2 during the day shift on 9/16/20, 9/17/20, and 9/19/20. The physician ' s order for a skin check on 9/17/20 for Resident #2 was reviewed with Nurse #4. Nurse #4 stated that he had completed the skin check on 9/17/20, but forgot to document it and to sign off on the TAR. He reported that he was unable to recall with certainty what condition Resident #2 ' s surgical incision was in at that time. He explained that he couldn ' t remember if the surgical incision was open to air, was dressed, was open, or was

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closed.

A phone interview was conducted with Nurse #8 on 10/16/20 at 10:20 AM. Nurse #8 stated she was an agency nurse and she worked at the facility on 1 date only, 9/21/20. Based on the staff scheduled with assignments and nursing documentation she worked with Resident #2 on 9/21/20. Nurse #8 reported that she no recollection of Resident #2, but she was certain that she completed no treatments for any resident on 9/21/20.

A phone interview was conducted with Nurse #11 on 10/16/20 at 12:10 PM. Based on the staff schedule with assignments and nursing documentation, Nurse #11 was assigned to Resident #2 on during the day shift on 9/16/20. Nurse #11 reported she had no recollection of Resident #2.

A phone interview was conducted with Nurse #10 on 10/16/20 at 12:23 PM. Based on the staff schedule with assignments and the nursing documentation, Nurse #10 was assigned to Resident #2 during the day shift on 9/27/20. Nurse #10 stated that she remembered Resident #2, but she was unable to recall what condition his surgical incision was in when she worked with him. She explained she didn ' t know if his surgical incision was open to air, was dressed, was open, or was closed. She stated that she was certain she had not changed a dressing or provided any other type of treatment to Resident #2 ' s surgical incision.

A phone interview was conducted with Nurse #3 on 10/19/20 at 12:09 PM. Based on the staff schedule with assignments and the nursing

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documentation, Nurse #3 worked with Resident #2 on 9/12/20, 9/15/20, 9/18/20, 9/25/20, and 9/28/20. She indicated that she recalled when Resident #2 was first admitted to the facility that his surgical incision was open to air. She revealed that she had not known when the surgical incision first opened, but that she had seen it with a dressing in place when she was working with him. She further revealed that she had never changed the dressing to the surgical incision and she had never provided any other type of assessment, monitoring, or treatment to the surgical incision. Nurse #3 explained that she had not seen any physician ' s orders related to the surgical incision and that it had not occurred to her to figure out why the dressing was in place without an order. She further indicated that she never thought about notifying the physician as she assumed this had been done by whoever initiated the dressing.

A phone interview was attempted with Nurse #6 on 10/16/20 at 8:23 AM but she was unable to reached. Based on the staff schedule with assignments and nursing documentation, Nurse #6 worked with Resident #2 during the night shift on 9/10/20, 9/12/20, 9/13/20, 9/17/20, 9/21/20, 9/22/20, 9/24/20, 9/26/20, and 9/27/20.

A phone interview was attempted with Nurse #9 on 10/16/20 at 11:51 AM but she was unable to be reached. Based on the staff schedule with assignments and nursing documentation, Nurse #9 worked with Resident #2 on 9/12/20, 9/13/20, 9/14/20, 9/25/20, and 9/26/20.

A phone interview was attempted with Nurse #12 on 10/16/20 at 12:46 PM but she was unable to be reached. Based on the staff schedule with

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assignments and nursing documentation, Nurse #12 worked with Resident #2 on 9/13/20 during the day shift.

A phone interview was conducted on 10/16/20 at 12:54 PM with Resident #2 ' s outpatient PA who conducted the post- op follow up appointment on 9/28/20. The PA indicated that she was familiar with Resident #2 and recalled his 9/28/20 follow up appointment. She stated that based on her assessment of the lumbar surgical wound she believed it was infected. She explained that there was drainage on the dressing which had a foul odor indicative of an infection, the inferior portion of the incision was open with erythema of the surrounding tissue, and the upper portion of the incision still had staples intact. She indicated that she sent Resident #2 straight to the ER for further evaluation and treatment. She stated that Resident #2 required hospitalization, surgical debridement of the wound, and IV antibiotic therapy. The PA reported that she believed this was preventable explaining that if the wound breakdown was identified earlier it could ' ve been treated with an antibiotic which most likely would have kept Resident #2 out of the hospital and from having another surgery.

A phone interview was conducted with the DON on 10/19/20 at 3:32 PM. The DON ' s investigation into when Resident #2 ' s surgical incision opened was reviewed. She stated that she was unable to pinpoint the date Resident #2 ' s surgical incision opened as none of the nurses admitted to implementing the dressing. She verified that Nurse #5 had not worked with Resident #2 on 9/25/20 as indicated in the investigation. She revealed that this date should have been 9/23/20. The interview with Nurse #2

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in which she stated she informed the DON that she saw a dressing on Resident #2 ' s surgical incision on 9/18/20 was reviewed with the DON. The DON verified that she had interviewed Nurse #2 and she was aware that she had seen the surgical incision dressed on 9/18/20. The DON was unable to explain why this information was not included in her investigation. NA #1 ' s interview that indicated she was working with Resident #2 when a couple of staples came out and the nurse implemented a dressing was shared with the DON. The staff schedules that indicated NA #1 had worked with Resident #2 on two dates prior to 9/18/20 were reviewed with the DON. These dates were 9/16/20 and 9/17/20. The DON stated that she had not interviewed any of NAs about the investigation and she was unaware of this information prior to this date (10/19/20). She acknowledged that based on Nurse #2 ' s interview that Resident #2 ' s surgical incision had a dressing on it prior to 9/18/20 and NA #1 ' s interview that she was working with Resident #2 when the staples came out and a nurse implemented the dressing, that the surgical incision opened on either 9/16/20 or 9/17/20 as these were the only dates NA #1 worked with Resident #2 prior to 9/18/20 (the date Nurse #2 observed the dressing in place). The DON reported that she expected the nurse who first identified that the surgical incision was open to enter an assessment into the electronic medical record (EMR), notify the physician and obtain treatment orders, enter treatment orders into the EMR, and complete the ordered treatment. The DON was asked what her expectation was for every nurse who worked with Resident #2 and observed the surgical incision with a dressing in place with no physician ' s order. She stated that she expected every nurse who saw the surgical

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incision dressed to figure out when the incision opened and/or why the dressing was in place with no physician ' s order. The DON reported that after she completed her investigation she implemented a new systemic process for all residents admitted with surgical wounds to have the wound assessed and documented in the EMR wound portal within 24 hours of admission, the surgical wound was to be assessed and documented on weekly, and orders were to be in place to monitor the surgical wound for infection/pain/dehiscence every shift. She stated she began educating staff on these systemic processes as well as on the need to obtain a physician ' s order for all treatments after her investigation was completed. She stated that this education had not been fully completed at the start of this survey (10/13/20).

A phone interview was conducted with the facility ' s Medical Director on 10/19/20 at 11:56 AM. He stated that he observed Resident #2 ' s surgical incision on 9/12/20 and that it was healing well at that time. He reported that he had not seen the surgical incision after 9/12/20. He indicated that he depended on the nursing staff who look at the wounds to let him or the resident ' s surgeon know if there was a problem. The Medical Director explained that he normally deferred treatment decisions related to surgical incisions to the treating surgeon. He reported that if staff were unable to get a hold of the surgeon that staff were to call him to obtain treatment orders. The Medical Director revealed that he had not been informed by staff that Resident #2 ' s surgical incision opened during his stay at the facility (9/10/20 through 9/28/20) and he had not given any treatment orders related to the surgical incision. He also revealed that he was unaware

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that the surgical incision was open for greater than 10 days. He stated that for a resident with immobility and multiple medical issues who had back surgery, it was not uncommon for an infection to develop and that regular assessments and monitoring needed to be conducted by the nursing staff so that any complications could be addressed as soon as they were identified. The Medical Director indicated that he expected the nurses to assess and monitor surgical incision sites, notify himself or the surgeon of any complications, and to obtain a physician ' s order for all treatments.

b. Physician ' s orders for Resident #2 dated 9/10/20 indicated a pressure redistribution cushion to chair, a pressure redistribution mattress to bed, and skin check weekly on Thursdays during the 7:00 AM to 7:00 PM shift.

On 9/17/20 a weekly skin check was ordered to be completed and documented during the day shift (7:00 AM - 7:00 PM). Based on the schedule with assignments, Nurse #4 was assigned to Resident #2 during the day shift on 9/17/20. There were no skin assessments dated 9/17/20 and the section of the Treatment Administration Record (TAR) that required the nurse to sign off when the skin assessment and nursing documentation was completed was blank.

The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. He had no behaviors and no rejection of care. Resident #2 was dependent on 2 or more staff for bed mobility, transfers, toileting, personal hygiene and bathing. He

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required the extensive assistance of 2 or more for dressing. Resident #2 had an indwelling urinary catheter and was assessed as always incontinent of bowel. He had no pressure ulcers, but was at risk for pressure ulcers. The Care Area Assessment (CAA) related to pressure ulcers for this 9/18/20 MDS indicated Resident #2 was at risk for pressure ulcers and skin breakdown due to reduced physical mobility and dependence on staff assist for ADLs.

A Braden Scale, an assessment for predicting pressure ulcer risk, completed on 9/20/20 at 10:38 AM by Nurse #9 indicated Resident #2 was at high risk for pressure ulcers. This assessment included the following:

- Sensory Perception: No impairment (Responded to verbal commands. Had no sensory deficit which would limit ability to feel or voice pain or discomfort.)
- Moisture: Constantly moist (Skin is kept moist almost constantly by perspiration, urine, etc. Dampness was detected every time he was moved or turned.)
- Activity: Chairfast (Ability to walk was severely limited to nonexistent. Could not bear weight and/or must be assisted into chair or wheelchair.)
- Mobility: Completely immobile (did not make even slight changes in body or extremity position without assistance.)
- Friction and Shear: Problem (Required moderate to maximum assistance in moving. Complete lifting without sliding against sheets was impossible. Frequently slid down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, and/or agitation led to almost constant friction.

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A skin assessment dated 9/24/20 at 3:00 PM completed by Nurse #1 indicated a new skin injury was identified. Nurse #1 assessed Resident #2 with a pressure ulcer to the left outer ankle.

An SBAR (Situation Background Assessment Recommendation) dated 9/24/20 at 3:07 PM completed by Nurse #1 indicated a pressure ulcer was identified on Resident #2 ' s left outer ankle. It was noted as a 1 centimeter (cm) open area. The physician was notified on 9/24/20 at 3:25 PM and an order to apply Z-guard (skin paste protectant) to the area and apply a bunny boot (a cushion/pillow that wraps around the foot to protect it) to left ankle.

A physician ' s order dated 9/24/20 indicated Z-guard to left outer ankle three times daily and PRN till healed.

On 9/24/20 Resident #2 ' s care plan related to skin breakdown was updated to indicate the interventions of offloading/floating heels while in bed and weekly wound assessment to include measurements and
description of wound status.

A phone interview was conducted with Resident #2 ' s family member on 10/16/20 at 8:30 AM. She stated that she was the person the facility contacted for any changes in condition with the resident. She reported that on 9/24/20 she was contacted by one of the nurses and informed Resident #2 developed a pressure ulcer on his left ankle. The family member indicated that she spoke with the Director of Nursing (DON) by phone about the pressure ulcer ' s development and the DON informed her that there were times

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Resident #2 refused to get out of bed. The family member stated that she asked the DON why other preventative measures were not in place to reduce the risk of pressure ulcer development as Resident #2 was at high risk for skin breakdown. She indicated the DON was unable to explain why other preventative measures had not been implemented prior to the development of the pressure ulcer on Resident #2 ' s left ankle.

A phone interview was conducted with Nurse #4 on 10/16/20 at 10:00 AM. Nurse #4 stated he was an agency nurse and he worked at the facility for 4 days in September 2020. Based on the staff schedule with assignments and the nursing documentation, Nurse #4 worked with Resident #2 during the day shift on 9/17/20. The physician ' s order for a skin check on 9/17/20 for Resident #2 was reviewed with Nurse #4. Nurse #4 stated that he completed the skin check on 9/17/20, but forgot to document it and to sign off on the TAR. He reported that he was unable to recall with certainty if Resident #2 had any new skin conditions during the 9/17/20 skin assessment.

A phone interview was attempted with Nurse #9 on 10/16/20 at 11:51 AM but she was unable to be reached. Nurse #9 completed the Braden Scale, dated 9/20/20, that indicated Resident #2 was at high risk for pressure ulcers.

A phone interview was conducted with Nurse #1 on 10/16/20 at 2:55 PM. The skin assessment and SBAR dated 9/24/20 completed by Nurse #1 that indicated a new skin condition of a pressure ulcer to Resident #2 ' s left outer ankle were reviewed with Nurse #1. Nurse #1 stated that 9/24/20 was when she first identified the pressure ulcer on the left outer ankle of Resident #2. She

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F 600	Continued From page 41 reported that she notified the physician and obtained an order for Z-guard to the left outer ankle three times daily and PRN. She reported that the physician also indicated a bunny boot was to be applied to the resident ' s left ankle. Nurse #1 revealed that these were new interventions for Resident #2. She verified that Resident #2 was at high risk for pressure ulcers and she was unable to explain why a bunny boot or other preventative measures were not in place to Resident #2 ' s ankles until after he developed the pressure ulcer on 9/24/20. A phone interview was conducted on 10/16/20 at 12:54 PM with Resident #2 ' s outpatient PA who conducted the post- op follow up appointment on 9/28/20. The PA indicated that Resident #2 was at high risk for skin breakdown and pressure ulcer development due to his recent back surgery, immobility, and dependence on assistance with ADLs. She stated that preventative measures, such as a bunny boot, should have been implemented for Resident #2 to reduce the risk for pressure ulcer development. A phone interview was conducted with the DON on 10/19/20 at 3:32 PM. The 9/10/20 care plan that indicated Resident #2 was at risk for skin breakdown, the 9/20/20 Braden Scale that indicated he was at high risk for pressure ulcers, and the 9/24/20 skin assessment and SBAR that revealed the resident developed a pressure ulcer on his left ankle were reviewed with the DON. The DON was unable to explain why preventative measures, such as a bunny boot, were not implemented until after Resident #2 developed a pressure ulcer to his left ankle.	F 600		
F 641 SS=D	Accuracy of Assessments	F 641		11/10/20

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F 641	Continued From page 42 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have an accurate Minimum Data Set (MDS) assessment in the area of pressure ulcers for 1 of 3 residents (Resident #2) reviewed for pressure ulcers. The findings included: Resident #2 was admitted to the facility on 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system. A nursing note dated 9/10/20 completed by Nurse #14 (the Nurse Supervisor) indicated Resident #2 had no pressure ulcers. A skin assessment dated 9/10/20 completed by Nurse #14 indicated Resident #2 had no pressure ulcers. The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. He was assessed with no pressure ulcers. The Care Area Assessment (CAA) related to pressure ulcers for Resident #2 ' s 9/18/20 admission MDS assessment provided conflicting information to the MDS coding. This CAA indicated that Resident #2 had a stage 3 pressure ulcer on his left buttock and an unstageable pressure ulcer on outer buttock.	F 641	F641 CFR(s): 483.20(g) (1) Minimum Data Set (MDS), section M and V for resident #2 was corrected and modified by the Clinical Reimbursement Coordinator (CRC) on 10/16/20. (2) Center Nurse Executive will conduct an audit of MDS assessments on all current residents with wounds, to ensure accurate documentation of wounds in section V and section M in the Minimum Data Set (MDS). Any assessment that has not been coded correctly will be modified/significant correction completed by 11/10/20. Audit completed 11/4/2020 by Center Nurse Executive (CNE). Two corrections were made for discrepancies found upon discovery with audits. (3) On 11/9/2020 the Center Nurse Executive educated the Clinical Reimbursement Coordinator (CRC) on accuracy and coding of the Minimum Data Set (MDS), and ensuring proper documentation/accuracy of any wound prior to coding. CRC completed courses in vital learn on coding of section M and V of the MDS on 11/9/2020. (4) Center Nurse Executive or designee	

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F 641	Continued From page 43 On 10/15/20 at 2:21 PM via email correspondence the Director of Nursing (DON) revealed the CAA related to pressure ulcers for Resident #2 ' s 9/18/20 admission MDS assessment was inaccurate as this resident had no pressure ulcers on his buttock. She reported that a modification would be completed. A phone interview was conducted with the MDS Nurse on 10/15/20 at 4:16 PM. She stated that she completed the CAAs for Resident #2 ' s 9/18/20 admission MDS assessment. She verified that the CAA related to pressure ulcers was inaccurate as Resident #2 had no pressure ulcers on his buttock. She stated that she must have documented a different resident ' s information onto Resident #2 ' s pressure ulcer CAA. The MDS Nurse reported that she was new to MDS assessments and to the facility ' s electronic medical records system and was still learning. A phone interview was conducted with the DON on 10/16/20 at 4:40 PM. She stated that she expected the MDS to be completed accurately. She reported that the MDS Nurse was new to MDS coding and that additional training would be conducted for her on MDS accuracy.	F 641	will audit section M and V, of new admission assessments weekly times three months to ensure accurate coding of the assessment, results of these audits will be reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		11/10/20

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F 656	Continued From page 44 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a person centered care plan that was accurate related to the resident ' s condition in the area of skin breakdown for 1 of 3	F 656	F656 CFR(s): 483.21(b)(1) (1) Resident #2 was discharged 9/28/20.	

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F 656	Continued From page 45 residents (Resident #2) reviewed for pressure ulcers. The findings included: Resident #2 was admitted to the facility on 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system. A nursing note dated 9/10/20 completed by Nurse #14 (the Nurse Supervisor) indicated Resident #2 had no pressure ulcers on admission. He was noted with Moisture Associated Skin Damage (MASD) to his left buttock, inner fold of buttocks and coccyx (commonly referred to as the tailbone). A skin assessment dated 9/10/20 completed by the Nurse Supervisor indicated the following skin conditions: - Bruises to left abdomen, left knee - Discoloration to right elbow - Abrasion to left abdomen - MASD to buttocks, between medial buttock fold, and coccyx Resident #2 ' s care plan was initiated on 9/10/20 with a focus area of the resident being at risk for skin breakdown related to actual skin breakdown: MASD, pressure ulcer stage 3 and unstageable to left side of buttocks. The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. He was assessed with no pressure ulcers. On 10/15/20 at 3:59 PM via electronic	F 656	(2) On 11/4/2020 the Center Nurse Executive audited care plans on all current residents with wounds, to ensure care plans reflect the resident□s current condition. No discrepancies were found upon discovery with the audit. (3) On 11/9/2020 the Center Nurse Executive educated the Clinical Reimbursement Coordinator (CRC) on implementing a comprehensive person centered care plan that reflects resident□s wounds. (4) Center Nurse Executive or designee will audit care plans of residents admitted with wounds, weekly times three months to ensure accuracy of wounds. Results of these audits will be reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020.	

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F 656	Continued From page 46 correspondence the Director of Nursing (DON) revealed the care plan for Resident #2 related to skin breakdown was inaccurate as Resident #2 had no pressure ulcers on his buttocks. A phone interview was conducted with the MDS Nurse on 10/15/20 at 4:16 PM. She stated that the care plan related to skin breakdown was inaccurate for Resident #2 as he had no pressure ulcers on his buttocks. She stated that she must have documented a different resident ' s information onto Resident #2 ' s care plan by mistake. The MDS Nurse reported that she was new to care planning and to the facility ' s electronic medical records system and was still learning. A phone interview was conducted with the DON on 10/16/20 at 4:40 PM. She indicated that she expected care plans to be comprehensive, person centered, and an accurate depiction of the resident. She reported that the MDS Nurse was new to her position and additional training would be conducted with her.	F 656		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and Medical Director interview, the facility failed to consistently evaluate and monitor pain levels for a resident who received routine	F 697	F697 CFR(s):483.25(k) (1) Resident #2 was discharged 9/28/20.	11/10/20

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F 697	Continued From page 47 and as needed pain medications and failed to assess a resident ' s pain level prior to the administration of a controlled substance pain medication for 1 of 3 residents (Resident #2) reviewed for pain management. The findings included: 1a. Resident #2 was admitted to the facility on 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system, spinal stenosis (a narrowing of the spaces within your spine, which can put pressure on the nerves that travel through the spine), and sepsis. Resident #2 ' s physician orders, dated 9/10/20, related to pain were as follows: - 10 milligrams (mg) Baclofen (a muscle relaxer) once three times daily for muscle spasms - 600 mg Gabapentin (a medication which may be indicated due to neuropathic or nerve pain) three times daily for pain - 1000 mg Tylenol (an over the counter pain medication) once daily for pain - 5 mg Oxycodone (an opioid pain medication) every 6 hours as needed (PRN) for moderate to severe pain for 5 days (end date of 9/15/20) A physician ' s order for Resident #2 dated 9/10/20 indicated pain monitoring was to be conducted every shift. This order was entered into the Electronic Medical Record (EMR) by Nurse #7. A pain level assessment dated 9/10/20 at 4:44 PM completed by Nurse #14 (the Nurse Supervisor) for Resident #2 indicated a pain level of 0 (on a scale of 0 - 10 with 0 indicating no	F 697	(2) The Center Nurse Executive (CNE) completed an audit on 11/9/2020 of all current residents to ensure each pain monitoring order has the supplemental documentation that includes a pain scale numeric value for the nurses to obtain each shift. Corrections were made for any discrepancies found during the audit. The Center Nurse Executive (CNE) and designee completed a pain assessment on all current residents beginning 11/6/2020 thru 11/8/2020 to ensure that pain needs are being met appropriately. One correction was made for discrepancies found during the audit. (3) The Center Nurse Executive, Registered Nurse (RN) supervisor or designee will educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency, by 11/10/20 on evaluation and monitoring of pain levels for routine and as needed medication, including prior to the administration of a controlled substance, and alternative forms of pain management. All staff not in serviced by 11/10/2020, will be required to complete in-service prior to working. The Center Nurse Executive, Registered Nurse (RN) supervisor or designee will re-educate all licensed nurses including fulltime (FT), part time (PT), per diem (PRN)and agency on the correct way to enter the pain monitoring order in Point Click Care (PCC) by 11/10/2020. The order should be for every shift with documentation of a numeric value. All staff not in serviced by 11/10/2020, will be required to complete in-service prior to	

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F 697	Continued From page 48 pain). A pain level assessment dated 9/13/20 at 1:57 PM completed by Nurse #12 for Resident #2 indicated a pain level of 0. The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. He was administered scheduled pain medications and PRN pain medications and self-reported frequent pain at a 7 on a scale of 0-10. Resident #2 received opioid medication on 6 of 7 days. The Care Area Assessment (CAA) related to pain for the 9/18/20 MDS assessment indicated Resident #2 stated he had frequent pain that affected his ability to do activities at times. He recently had back surgery. Resident #2 was to be monitored each shift for pain and as needed. On 9/22/20 a care plan related to Activities of Daily Living (ADL) care was initiated for Resident #2. The focus area indicated that he was dependent for ADL care related to hospitalization, sepsis, post-operative (post-op) back surgery, and limited mobility. The goal was for Resident #2 to improve current level of functioning with ADLs. The interventions included, in part: - Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness, administer pain medication as ordered, and document effectiveness/side effects. - Evaluate and medicate for pain, as appropriate, prior to activity or rehabilitation program. A review of the medical record from Resident #2 ' s 9/10/20 admission through 9/28/20 discharge revealed no pain level assessments were	F 697	working. (4) The Center Nurse Executive (CNE), Registered Nurse (RN) supervisor or designee will review new admissions, and any new orders for pain medication in clinical start up Monday thru Friday, on weekends the Registered Nurse (RN) supervisor will review to ensure order for pain monitoring is correctly entered. The Center Nurse Executive or designee will complete five random pain assessments weekly to ensure that residents pain needs are being met appropriately. The Center Nurse Executive (CNE) will bring the results of the audits to the monthly Quality Assurance and Improvement committee meetings for ongoing compliance. The Center Nurse Executive is responsible for implementing the acceptable plan of correction. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020.	

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completed after 9/13/20.

A review of Resident #2 ' s Medication Administration Record (MAR) from his 9/10/20 admission through 9/28/20 discharge revealed each nurse documented a checkmark once per shift under the pain monitoring section, but there was no indication of whether or not the resident was experiencing pain. Further review of the MAR indicated Resident #2 was administered routine Gabapentin, Tylenol, and Baclofen as ordered and PRN Oxycodone was administered 13 times.

A phone interview was conducted with Resident #2 on 10/16/20 at 9:49 AM. Resident #2 was alert and oriented to person, place, time, and situation. He indicated that he had pain from admission through discharge from his legs and his back. He reported he received routine and PRN pain medications when he was at the facility and that he informed staff when he was experiencing pain.

A phone interview was conducted with Nurse #7 on 10/16/20 at 3:21 PM. Nurse #7 verified she entered Resident #2 ' s 9/10/20 physician ' s order for pain monitoring into the EMR. She reviewed the order and stated that when she entered this order she forgot to include the portion of the order called a "supplemental value" that required the nurse to select a numerical value for pain level when the monitoring was completed. She explained that when this supplemental value was included on the order that the EMR automatically populated a question for the nurse to enter a numerical value for pain level when pain monitoring was checked off on

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the MAR. Nurse #7 acknowledged that the pain monitoring for Resident #2 only showed that monitoring was completed, but not if there was any pain present. She stated that there was no way to evaluate the effectiveness of pain management if there was no indication of pain presence or pain level.

A phone interview was conducted with Nurse #1 on 10/16/20 at 2:55 PM. She stated that she recalled Resident #2 was alert and oriented and was able to voice his needs and report pain levels. When asked about the normal protocol for pain monitoring she stated that this was documented on the MAR and that every shift the nurse was required to document a pain level from 0 to 10 for the resident. Resident #2 ' s MAR that showed a checkmark was documented each shift in the pain monitoring section with no indication of pain level or pain presence was reviewed with Nurse #1. Nurse #1 stated that she had not known why Resident #2 ' s MAR had no place to document the pain level. She reported she had not noticed this before. She acknowledged that since there was just a checkmark on the MAR for pain monitoring, you were unable to tell if pain was present and/or what the pain level was.

A phone interview was conducted with Nurse #3 on 10/19/20 at 12:09 PM. She stated that she recalled Resident #2 and reported that he had routine and PRN pain medication for pain management of leg and back pain. She stated that pain monitoring was completed daily each shift and that the nurse was required to document either a pain level of 0 to 10 or a "Y" (indicating yes pain was present) or "N" (indicating no pain was not present). She reported that if the nurse documented a "Y" that they were then required to

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document a description of the pain in the notes. Resident #2 ' s MAR that showed a checkmark was documented each shift in the pain monitoring section with no indication of pain level or pain presence was reviewed with Nurse #3. Nurse #3 stated that she had not known why Resident #2 ' s MAR had no place to document the pain level or pain presence. She reported she had not noticed this before. She acknowledged that since there was just a checkmark on the MAR for pain monitoring, you were unable to tell if pain was present and/or what the pain level was.

A phone interview was conducted with Resident #2 ' s physician, who also served as the facility ' s Medical Director on 10/19/20 at 1:20 PM. The Medical Director reported that pain monitoring was essential as it was utilized as a tool to measure whether or not the pain management interventions in place were effective. He reported if a physician ' s order was in place for pain monitoring to be conducted daily each shift then he expected this monitoring to include documentation of a numerical pain level or a description of the pain.

An interview was conducted with the Director of Nursing (DON) on 10/16/20 at 4:40 PM. She stated that pain monitoring was completed daily each shift and was documented on the MAR by either a "Y" or "N" which designated a yes or no to pain presence or by a numerical pain scale of 0 - 10. The DON explained that if the nurse documented a "Y" to indicate pain was present then they were to document a description of pain in the nursing notes. She further explained that this pain monitoring was utilized to determine if the resident ' s pain was being managed. Resident #2 ' s MAR that showed a checkmark

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was documented each shift in the pain monitoring section with no indication of pain level or pain presence was reviewed with the DON. She verified there was no indication of pain presence or pain level. The DON acknowledged that there was no way to tell if a Resident #2 ' s pain was being managed by looking at the pain monitoring on the MAR. She revealed that this must have been overlooked when the pain monitoring order was entered into the MAR.

1b. Resident #2 was admitted to the facility on 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system, spinal stenosis (a narrowing of the spaces within your spine, which can put pressure on the nerves that travel through the spine), and sepsis.

A physician ' s order for Resident #2 dated 9/10/20 indicated 5 milligrams (mg) Oxycodone (an opioid pain medication and controlled substance) every 6 hours as needed (PRN) for moderate to severe pain for 5 days (end date of 9/15/20). This order was entered into the electronic medical record (EMR) by Nurse #7.

The following eMAR (electronic Medication Administration Record) notes indicated PRN Oxycodone was administered to Resident #2:
- On 9/11/20 at 10:34 AM Nurse #1 indicated the resident complained of leg pain and PRN Oxycodone was administered. No pain level was noted.
- On 9/12/20 at 3:30 PM Nurse #3 indicated the resident requested PRN Oxycodone for foot pain and this medication was administered. No pain level was noted.

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- On 9/13/20 at 6:23 AM Nurse #6 indicated PRN Oxycodone was administered. There was no description of pain to indicate why this medication was administered.
- On 9/13/20 at 1:07 PM Nurse #12 indicated the resident ' s pain level was a 6 out of 10 and PRN Oxycodone was administered.
- On 9/14/20 at 1:28 PM Nurse #9 indicated PRN Oxycodone was administered for lower back pain. No pain level was noted.
- On 9/14/20 at 7:29 PM Nurse #5 indicated PRN Oxycodone was administered. There was no description of pain to indicate why this medication was administered.
- On 9/15/20 at 9:17 AM Nurse #3 indicated the resident requested PRN Oxycodone for pain and the medication was administered. No pain level was noted.

On 9/15/20 Resident #2 ' s PRN Oxycodone order from 9/10/20 was completed (ordered for 5 days) and a new order for Oxycodone 5 mg every 6 hours PRN for pain was implemented. This 9/15/20 PRN Oxycodone order was entered into the EMR by Nurse #5.

The following eMAR notes indicated PRN Oxycodone was administered to Resident #2:
- On 9/15/20 at 9:41 PM Nurse #5 indicated PRN Oxycodone was administered. There was no description of pain to indicate why this medication was administered.
- On 9/16/20 at 9:54 AM Nurse #4 indicated PRN Oxycodone was administered. There was no description of pain to indicate why this medication was administered.
- On 9/18/20 at 11:12 AM Nurse #3 indicated the resident requested PRN Oxycodone for leg pain and it was administered. No pain level was

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noted.
- On 9/18/20 at 5:47 PM Nurse #3 indicated the resident asked for PRN Oxycodone and it was administered. There was no description of pain to indicate why this medication was administered. The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. He was administered scheduled pain medications and PRN pain medications and self-reported frequent pain at a 7 on a scale of 0-10. Resident #2 received opioid medication on 6 of 7 days. The Care Area Assessment (CAA) related to pain for the 9/18/20 MDS assessment indicated Resident #2 stated he had frequent pain that affected his ability to do activities at times. He recently had back surgery. Resident #2 was to be monitored each shift for pain and as needed.

On 9/22/20 a care plan related to Activities of Daily Living (ADL) care was initiated for Resident #2. The focus area indicated that he was dependent for ADL care related to hospitalization, sepsis, postoperative (post-op) back surgery, and limited mobility. The goal was for Resident #2 to improve current level of functioning with ADLs. The interventions included, in part:
- Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness, administer pain medication as ordered, and document effectiveness/side effects.
- Evaluate and medicate for pain, as appropriate, prior to activity or rehabilitation program.

The following eMAR (electronic Medication Administration Record) notes indicated PRN Oxycodone was administered to Resident #2:
- On 9/22/20 at 8:59 PM Nurse #6 indicated PRN

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Oxycodone was administered. There was no description of pain to indicate why this medication was administered.
- On 9/23/20 at 11:12 AM Nurse #13 indicated PRN Oxycodone was administered. There was no description of pain to indicate why this medication was administered.

A phone interview was conducted with Resident #2 on 10/16/20 at 9:49 AM. Resident #2 was alert and oriented to person, place, time, and situation. He indicated that he had pain from admission through discharge from his legs and his back. He reported he received routine and PRN pain medications when he was at the facility and that he informed staff when he was experiencing pain.

A phone interview was conducted with Nurse #7 on 10/16/20 at 3:21 PM. Nurse #7 verified she entered Resident #2 ' s 9/10/20 physician ' s order for PRN Oxycodone into the EMR. She reviewed the order and stated that when she entered this order she had forgotten to include the portion of the order called a "supplemental value" that required the nurse to select a numerical value for pain level prior to the administration of the PRN Oxycodone. Nurse #7 explained that when this supplemental value was included on the order that the EMR automatically popped up a question for the nurse to enter a numerical value for pain level when PRN Oxycodone was selected for administration. She further explained this numerical value populated onto the resident ' s MAR.

A phone interview was conducted with Nurse #3 on 10/19/20 at 12:09 PM. Nurse #3 stated that she recalled Resident #2 and reported that he

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had routine and PRN pain medication for pain management of leg and back pain. When asked about the normal protocol for administration of a PRN pain medication she stated that prior to administration the nurse had to assess the resident ' s pain on a numerical scale of 0 to 10. She reported that this number was documented on the MAR. Resident #2 ' s MAR that showed no indication an assessment of pain level was conducted prior to the administration of PRN Oxycodone was reviewed with Nurse #3. The following eMAR notes of Nurse #3 ' s administrations of PRN Oxycodone to Resident #2 were reviewed: 1) 9/12/20 at 3:30 PM for foot pain with no assessment of pain level; 2) 9/15/20 at 9:17 AM for resident request with no assessment of pain level; 3) 9/18/20 at 11:12 AM for leg pain with no assessment of pain level; 4) 9/18/20 at 5:47 PM with no description of pain presence or assessment of pain level. Nurse #3 stated that she documented a pain level prior to every administration of PRN pain medication and she was unable to explain why this information was not in the medical record. She reported that she needed to speak with the Director of Nursing (DON).

On 10/19/20 at 12:54 PM the DON provided a report by email correspondence that showed documentation of assessed pain levels for Resident #2 prior to the administration of PRN Oxycodone from 9/15/20 at 9:41 PM to through 9/23/20 at 11:12 AM. This report revealed the following information:
- On 9/15/20 at 9:41 PM Nurse #5 indicated a pain level of 0 prior to the administration of PRN Oxycodone
- On 9/16/20 at 9:54 AM Nurse #4 indicated a pain level of 0 prior to the administration of PRN

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Oxycodone
- On 9/18/20 at 11:12 AM Nurse #3 indicated a pain level of 0 prior to the administration of PRN Oxycodone
- On 9/18/20 at 5:47 PM Nurse #3 indicated a pain level of 0 prior to the administration of PRN Oxycodone
- On 9/22/20 at 8:59 PM Nurse #6 indicated a pain level of 0 prior to the administration of PRN Oxycodone
- On 9/23/20 at 11:12 AM Nurse #13 indicated a pain level of 0 prior to the administration of PRN Oxycodone

On 10/19/20 at 12:55 PM the above report was reviewed with the DON by phone. The DON stated that she was only able to pull the above report back to the evening of 9/15/20. She was unable to explain why she was unable to retrieve any documentation prior to 9/15/20 related to assessed pain levels for Resident #2 prior to the administration of PRN Oxycodone. The DON was asked if she believed administering PRN Oxycodone for a pain level of 0 was appropriate. She stated that she believed pain was subjective and that she had to depend on her nurse ' s decision making skills on whether or not a pain medication was needed. The DON further stated that if the resident indicated they were not having any pain, but requested the PRN Oxycodone anyway, that the nurse may have administered the medication based on the resident ' s request.

A follow up phone interview was conducted with Nurse #3 on 10/19/20 at 1:00 PM. The DON ' s report of assessed pain levels for Resident #2 prior to the administration of PRN Oxycodone that showed Nurse #3 administered the medication for a pain level of 0 on 9/18/20 at 11:12 AM and

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9/18/20 at 5:47 PM were reviewed. Nurse #3 was unable to explain why she documented a pain level of 0 prior to the administration of PRN Oxycodone. She stated that she would never administer PRN Oxycodone for a pain level of 0 as it was a narcotic medication and the orders indicated it was as needed for pain. Nurse #3 explained that if there was no pain then the medication was not being administered as ordered.

A phone interview was conducted with Nurse #4 on 10/19/20 at 4:05 PM. Nurse #4 documented a 0 as the assessed pain level for Resident #2 prior to him administering the resident PRN Oxycodone on 9/16/20 at 9:54 AM. He stated that this must have been an error as he would not have administered PRN Oxycodone for a pain level of 0. Nurse #4 explained that a pain level of 0 meant that the resident was in no pain, so an as needed pain medication would not have been needed.

A phone interview was attempted with Nurse #6 on 10/16/20 at 8:23 AM but she was unable to reached. Nurse #6 documented a 0 as the assessed pain level for Resident #2 prior to administering the resident PRN Oxycodone on 9/22/20 at 8:59 PM.

A phone interview was attempted with Nurse #13 on 10/19/20 at 1:17 PM but she was unable to be reached. Nurse #13 documented a 0 as the assessed pain level for Resident #2 prior to her administering the resident PRN Oxycodone on 9/23/20 at 11:12 AM.

A phone interview was attempted with Nurse #5 on 10/19/20 at 3:01 PM but she was unable to be

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 59 reached. Nurse #5 documented a 0 as the assessed pain level for Resident #2 prior to her administering the resident PRN Oxycodone on 9/15/20 at 9:41 PM. A phone interview was conducted with Resident #2 ' s physician, who also served as the facility ' s Medical Director on 10/19/20 at 1:20 PM. He stated that he expected the nurses to complete a pain assessment using a numerical pain scale prior to the administration of PRN pain medication. He reported that PRN Oxycodone was not to be administered for a pain level of 0. The Medical Director stated that Oxycodone was a strong narcotic with potential side effects and addiction risks and it should not be utilized unless it was medically necessary to control pain.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(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. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, staff, and outpatient Physician ' s Assistant, the facility failed to coordinate care with the outpatient medical provider when no medical records were sent with Resident #2 to his postoperative (post-op) follow up appointment. This was for 1 of 3 residents (Resident #2) reviewed for professional standards. The findings included: Resident #2 was admitted to the facility on	F 745	F745 CFR(s): 483.40(d) (1) Resident #2 was discharged 9/28/20. (2) All residents with follow up appointments and post op needs have the potential to be affected. The Medical record coordinator, and transportation driver will audit all new admissions in the last 30 days for follow up appointments to ensure that this care was coordinated as necessary. Audit completed 11/06/2020.	11/10/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 11/02/2020

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F 745	Continued From page 60 9/10/20 with diagnoses that included surgical aftercare following surgery on the nervous system. A nursing note dated 9/10/20 at 11:01 AM completed by Nurse #14 (the Nurse Supervisor) indicated Resident #2 was admitted to the facility following a laminectomy (a major spine surgery that removes a portion of the vertebral bone called the lamina). The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2 ' s cognition was intact. On 9/28/20 Resident #2 attended a postoperative (post-op) outpatient follow up appointment for his lumbar laminectomy. The outpatient Physician ' s Assistant ' s (PA) progress note dated 9/28/20 indicated Resident #2 was a resident at a facility and had come to the appointment without any medications or documentation. A grievance form dated 9/28/20 filed by Resident #2 ' s family member on 9/28/20 indicated the resident had a post-op follow up appointment on this date and no medical information was sent to the outpatient provider on his condition. A phone interview was conducted on 10/16/20 at 8:30 AM with Resident #2 ' s family member. She stated on 9/28/20 Resident #2 ' s outpatient PA contacted her to report on his status. She revealed that the PA informed her that Resident #2 was sent to the appointment without any documentation from the facility. The family member stated that she phoned the facility on 9/28/20 and reported this issue.	F 745	Three corrections were made for discrepancies found upon discovery with audit. (3) All licensed nurses including fulltime (FT), part time (PT), per diem (PRN) , agency and all transportation drivers will be educated on required medical records needed for outpatient medical provider appointments by 11/10/2020 by Center Executive Director (CED) and Center Nurse Executive (CNE). A daily appointment sheet has been created, with a sign off section to ensure medical records were sent and received by outside providers. (4) Daily appointment sheets will be audited weekly by the Center Executive Director times three months to ensure compliance. The Center Nurse Executive (CNE), RN supervisor or designee will review new admissions, and any follow up needs and appointments in clinical start up five times weekly for three months. All findings will be brought to the Quality Assurance Performance Improvement Committee on a monthly basis for ongoing compliance. The Center Executive Director is responsible for implementing the acceptable plan of correction. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020	

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F 745	Continued From page 61	F 745		

A phone interview was conducted on 10/16/20 at 12:54 PM with Resident #2 ' s outpatient PA who conducted the post-op follow up appointment on 9/28/20. The PA indicated that she was familiar with Resident #2 and recalled his 9/28/20 follow up appointment. She stated that he came to the outpatient appointment with no paperwork from the facility. She explained that this was unusual as normally the physician ' s orders, wound assessments/measurements, and any other related progress notes were sent to the appointment with the resident, so she was able to see what medical treatment he had been receiving.

A phone interview was conducted with the Director of Nursing (DON) on 10/16/20 at 4:40 PM. She stated that the normal protocol for when a resident went to an outpatient follow up appointment was for the nurse on duty to send the following documents with the transportation driver for the provider: face sheet, medication list, relevant progress notes, and a consult form for the outpatient provider to document any necessary information on about the resident to send back to the facility. The DON indicated that this paperwork was provided to coordinate care and to allow the outpatient provider to know what medical treatment the resident was receiving.

A phone interview was conducted with Nurse #3 on 10/19/20 at 12:09 PM. Nurse #3 stated that the normal protocol for when a resident was sent to an out of facility appointment was to send the face sheet, physician ' s orders, any relevant progress notes, and a form for the outpatient provider to document any information the facility needed, such as, follow up appointments or new/revised orders. Nurse #3 stated that if this

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F 745	Continued From page 62	F 745		

documentation was not sent to the outpatient provider then they wouldn ' t know what was going on with the resident. She confirmed that she was assigned to Resident #3 on 9/28/20 during the time that he left for his post-op follow up appointment. She reported that she recalled that the nurse from the previous shift, Nurse #6, put all of the necessary paperwork into an envelope and put Resident #2 ' s name on it. Nurse #3 stated that she normally put the envelope with the paperwork on the resident ' s wheelchair, stretcher, or handed it to the transportation driver when the resident was leaving. She was unable to recall what she did with Resident #2 ' s paperwork when he left for his appointment on 9/28/20. She was also unable to recall who transported him to his appointment as the facility utilized a multiple transportation companies. Nurse #3 was unable to explain why Resident #2 ' s outpatient provider had received no documentation from the facility on 9/28/20.