STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 9/20/16 through 9/23/16. Immediate Jeopardy was identified at: CFR 483.25 at tag F309 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tags F490 and F520 at a scope and severity (J) The tags F309 and F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/10/16 and was removed on 9/23/16. An extended survey was conducted. On 10/26/16, the 2567 was amended. A new tag was added at F282 E. The scope and severity of F314 and F353 was changed from D to E. tags F224, F314, F353, F490 and F520 were amended.	F 000		
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		11/14/16

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

Electronically Signed | 10/14/2016

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F 224	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observation and physician, resident and staff interview, the facility neglected to provide wound treatment as ordered by the physician for 4 (Residents #9, # 10, #11 and #13) of 6 sampled residents reviewed for wound treatment. Findings included: 1. Resident #10 was admitted to the facility on 4/12/16. The Minimum Data Set (MDS) dated 7/11/16 revealed he had a mild memory problem, and an indwelling catheter. His current diagnoses were in part, chronic urinary tract infection, urinary tract disease and dementia. Review of the care plan initiated 7/21/16 and updated on 7/19/16 revealed in part, for the nursing staff to provide suprapubic catheter care every shift and as needed. Review of the physician order dated 7/27/16, revealed to clean the surgical incision with warm soapy water and apply dry dressing every day and as needed. Review of the physician order dated 8/17/16, revealed to clean the right suprapubic catheter site with normal saline and apply Mipirocin 2% (an antibiotic) ointment and Santyl (a debridement agent) gauze every day . Review of Resident #10's August 2016 treatment administration record (TAR) revealed, suprapubic catheter documentation revealed the suprapubic catheter was not cleaned and changed on 8/6/16 (Saturday), 8/7/16 (Sunday), 8/13/16 (Saturday), 8/14/16 (Sunday), 8/15/16 (Monday), 8/20/16 (Saturday) or 8/21/16 (Sunday). Additionally, suprapubic catheter documentation revealed the suprapubic catheter was not cleaned	F 224	F 224 1. Resident #9 sacrum treatment was performed per physician order by the wound nurse on 9/21/16. Resident #10 suprapubic catheter treatment was performed per physician order by the wound nurse on 9/22/16. Resident #11 lesion on back treatment was performed per physician order by the wound nurse on 9/22/16. Resident #13 bilateral toes and left heel treatment was performed per physician orders by wound nurse on 9/21/16. Physician was notified on 9/28/16. Education of staff assigned to these shifts began on 9/22/16. 2. Licensed Nursing staff were re-educated on performing treatments per physician□s orders by the Director of Nursing and or Staff Development Coordinator on 9/23/16 and prior to next shift worked. Any new licensed employee will receive this education upon orientation. Every licensed nurse will be observed during treatment round(performing treatment)and skills checklist will be completed by Certified wound care nurse and or supervisor by 11 -14-16 or prior to next shift. Every new licensed nurse will be observed during treatment round(performing treatments) and skills checklist will be completed by certified Wound Care nurse and or supervisor.	

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F 224	Continued From page 2 and changed on 8/20/16 (Saturday) and 8/21/16 (Sunday), with Santyl and Mipirocin 2% ointment. Review of Resident #10's September 2016 TAR revealed the suprapubic catheter dressing change was not administered on 9/10/16 (Saturday) or 9/11/16 (Sunday). During an interview via telephone on 9/22/16 at 10:00am, Nurse #4 indicated she had not performed any dressing changes for Resident #10 until 8/20/16. Nurse #4 stated she was assigned to do Resident #10's suprapubic dressing change on 8/15/16, but did not perform this dressing change as ordered, because she didn't know she was supposed to. During an interview via telephone on 9/22/16 at 2:22pm, Nurse #9 (weekend supervisor), revealed she was responsible to complete the weekend treatments. When she worked on the hall with a resident assignment the treatments were delegated to the nurses who had the assigned residents. She stated she had elected which treatments to do and chose not to do the suprapubic dressing change when she worked on the weekends. The schedule revealed she was assigned to do Resident #10 suprapubic treatment on 8/6/16 (Saturday). She stated there wasn't enough time to do everything and she had informed the Director of Nursing (DON). During an interview via telephone on 9/22/16 at 4:48pm, Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medications. She had not done any treatments. Nurse #12 specified she did not perform Resident #10's suprapubic dressing changes as ordered when she worked. She was assigned to do the suprapubic dressing changes for Resident #10 on 8/7 (Sunday), 8/14 (Sunday), 8/20 (Saturday) and 8/21 (Sunday). During an observation on 9/22/16 at 8:43pm,	F 224	3. An audit of treatment administration records was performed by the ward clerk on 10/4/16. All incidences of omission was discussed with the Medical Director on 9/28/16 and was taken to QA meeting on 10/22/16. Any licensed nurse not completing treatments as ordered will receive disciplinary action per policy up to and including termination of employment. 4. Residents with treatments ordered by the physician have the potential to be affected. 5. An audit of treatment administration records will be conducted every day for completeness by the wound nurse and or the floor nurse for two months. Then the audit will be conducted three times per week for one month, then monthly for eleven months. The results of audits will be discussed by Director of Nursing during the monthly QA meeting monthly for twelve consecutive months and then periodically to ensure compliance is met.	

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Nurse #1 changed the suprapubic dressing. Observation revealed a scant amount of dried exudate and pink tissue from around the incision site. There was no foul odor. The site was cleaned with normal saline on gauze the area was dried and covered with a split gauze and paper tape.
During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.
2. Resident # 11 was admitted to the facility on 3/26/14. The most recent Minimum Data Set (MDS) assessment dated 8/12/16 revealed that she had severe cognitive impairment and a wound. The most recent diagnoses were in part, Alzheimer disease and pyoderma gangrenosum (auto inflammatory disorder)
Review of the most recent wound care plan dated 1/8/16, revealed in part, wound care was to be done as ordered to the lesion on the medial back.
Review of the physician order dated 7/25/16, revealed to apply Clobetasol propionate 0.05% (a corticosteroid) ointment to the ulcer on the back daily and cover with adhesive and collagen powder (sic)(to enhance tissue growth) and calcium alginate (absorbed exudate).
Review of the physician order dated 8/19/16 revealed apply Flagyl (for a bacterial infection) 500 mg tablet crushed and apply to the wound bed medial back then follow current treatment above. A clarification order was added on 8/26/16, to apply the Flagyl for a total of 1 month.
Review of Resident #11's July 2016 treatment administration record (TAR) revealed wound treatment was not documented as being performed as ordered on 7/2/16 (Saturday), 7/3/16 (Sunday) and on 7/24/16 (Sunday).

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Review of Resident #11's August 2016 TAR revealed the wound treatment was not documented as performed on 8/5/16 (Friday), 8/7/16 (Sunday), 8/13/16 (Saturday), 8/14/16 (Sunday), 8/15/16 (Monday) or on 8/21/16 (Sunday). The Flagyl was not documented as being administered to the wound on 8/20/16 (Saturday) and 8/21/16 (Sunday).
Review of Resident #11's September 2016 TAR revealed wound treatment was not documented as as being performed and the Flagyl was not documented as being administered on 9/10/16 (Saturday).
During the observation of the resident's back wound dressing change on 9/22/16 at 8:10am, Nurse #1, the wound care nurse, revealed resident#11's back had a large clean pink wound with dark rolled edges and had no odor. The wound was cleaned with Normal Saline, and Clobetasol, Calcium Alginate and Flagyl were applied and was covered with dressing.
During an interview via telephone on 9/22/16 at 4:48pm, Nurse # 12 said she did not perform Resident #11's dressing changes as ordered when she worked. Nurse #12 was assigned to do the dressing changes for the Resident. She revealed she was not hired to do treatments. She was hired to pass medication. She had not done any treatments. Nurse #12 specified that she did not do the treatment for the resident on 7/24 (Sunday), 8/7 (Sunday), 8/14 (Sunday), and 8/21 (Sunday).
During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.
3. Resident # 9 was admitted to the facility on 4/23/15. The Minimum Data Set (MDS) dated

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6/22/16 revealed she had a memory problem and a stage 3 pressure ulcer. Diagnoses were in part, dementia and encephalopathy. She was discharged on 8/11/16.
Review of the care plan dated 6/25/16, revealed Resident #9 had a stage 3 pressure ulcer sore on her sacrum. The approaches to heal the pressure ulcer were in part, to give medication as ordered, monitor the effectiveness of the treatment and report to the physician if no change or deterioration within 2 weeks.
Review of her physician order dated 7/6/16, was in part, to clean sacrum with normal saline, apply Santyl (a chemical debriding ointment), Mipirocin 2% (an antibiotic ointment) and calcium alginate (used to absorb exudate) cover with foam dressing every day and as needed.
The resident's July 2016 and August 2016 treatment administration records (TAR) were reviewed. The boxes on the TAR did not have nurse's initial to indicate that the treatment was provided on 7/2/16 (Saturday), 7/3/16 (Sunday), 7/24/16 (Saturday), 8/6/16 (Saturday) and 8/7/16 (Sunday).
During an interview via telephone on 9/22/16 at 4:48pm, Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medication. She had not done any treatments. She was assigned to do the dressing changes for Resident #9 on 7/24/16 (Sunday) and 8/7/16 (Sunday) and Nurse #12 confirmed she did not perform these treatments.
During an interview on 9/22/16 at 3:06 pm, The Director of Nursing indicated she was not told that the treatments were not being completed on the weekends. She indicated she had heard murmurs that the nurses had no time to get wounds done. She indicated she felt the nurses were refusing to do the treatments because we had been

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swamped with staffing issues.
4. Resident #13 was admitted to the facility on 8/29/16. The Minimum Data Set (MDS) assessment dated 9/10/16 indicated that the resident was cognitively intact and with gangrene to her left foot and right toes. Her diagnoses were in part, gangrene, diabetes mellitus and peripheral vascular disease.
The physician's order dated 8/30/16 indicated to paint bilateral toes and left heel with betadine every day to keep the gangrene dry as possible.
Review of Resident #13's September 2016 treatment administration record (TAR) revealed that the treatment to the resident's bilateral toes and left heel was not documented as performed on 9/10/16 (Saturday) and 9/11/16 (Sunday).
During the interview on 9/20/16 at 2:47 PM, Nurse #1 (wound care nurse) revealed it was important to keep the resident's heel painted with betadine to prevent the spread of gangrene.
During interview on 9/20/16 at 2:47 PM, Resident #13 indicated that the betadine was applied to her feet most days.
During a wound observation on 9/21/16 at 7:00 AM of Resident #13's left and right feet revealed a darkened toes with mild edema on both feet. Nurse #1 was observed to paint the foot and heel with betadine and let it dry.
During an interview on 9/22/16 at 8:10 AM, Nurse #1, the wound care nurse, indicated that the treatments were not done when she was off during the week and on the weekends because she did not work weekends and had found the same dressing that she had put on the resident Friday with her initials on Monday morning.
During an interview on 9/22/16 at 2:22 PM, Nurse #9 (weekend supervisor) revealed she was responsible to provide the treatments on the weekends. When she worked on the hall with

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F 224	Continued From page 7 resident assignment, the treatments were delegated to the nurses assigned to the residents. She indicated that she changed the dressing for the stage 3 and 4 pressure ulcers and the treatments ordered for twice a day. The remaining treatments were omitted. Nurse #9 stated she was scheduled to provide the betadine treatment on 9/10/16 and 9/11/16 for Resident #13 and the treatment was not provided to the resident. She stated there wasn't enough time to do everything and she had informed the DON. Nurse #14 was assigned to Resident #13 on 9/10/16 and 9/11/16. Nurse #14 was not available for interview. During an interview on 9/22/16 at 3:06 pm, the DON indicated she was not told that the treatments were not being completed on the weekends. She indicated she had heard murmurs that the nurses had no time to get wounds done. She indicated she felt the nurses were refusing to do the treatments because we had been swamped with staffing issues.	F 224		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and family and staff interview , the facility failed to follow the care plan for wound care for 3 of 5 (Resident # 9, #10 and #11) sampled residents who received wound care. Findings included:	F 282	1. Resident #9 sacrum treatment was performed per physician order by the wound nurse on 9/21/16. Resident #10 suprapubic catheter treatment was performed per physician order by the	11/14/16

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F 282	Continued From page 8 1. Resident # 9 was admitted to the facility on 4/23/15. The Minimum Data Set (MDS) dated 6/22/16 revealed she had a memory problem and a stage 3 pressure ulcer. Diagnoses were in part, dementia and encephalopathy. She was discharged on 8/11/16. Review of the care plan dated 6/25/16, revealed Resident #9 had a stage 3 pressure ulcer on her sacrum. The approaches to heal the pressure ulcer were in part, to give medications as ordered, monitor the effectiveness of the treatment and report to the physician if no change or deterioration within 2 weeks. Review of her physician order dated 7/6/16, was in part, to clean sacrum with normal saline, apply Santyl (a chemical debriding ointment), Mipirocin 2% (an antibiotic ointment) and calcium alginate (used to absorb exudate) cover with foam dressing every day and as needed. The July and August 2016 treatment administration record (TAR) were reviewed. The boxes on the TAR did not have nurse's initial to indicate that the treatment was provided on 7/2 (Saturday), 7/3 (Sunday), 7/24/16 (Saturday), 8/6 (Saturday) and 8/7(Sunday). During interview on 9/20/16 at 2:33pm, Nurse #1, the wound care nurse, indicated the weekend nurse supervisor changed the dressings on the weekend. When the nursing supervisor was working on a hall passing medications, all nurses were responsible to do the treatments of their assigned residents. During an interview via telephone on 9/22/16, Nurse # 8 who was assigned to Resident #9 on 7/2 and 7/3/16, indicated the wound treatments were completed by the weekend nurse supervisor (Nurse #9.) During an interview via telephone on 9/22/16 at 2:22pm, Nurse #9 (weekend supervisor),	F 282	wound nurse on 9/22/16. Resident #11 lesion on back treatment was performed per physician order by the wound nurse on 9/22/16. Resident #13 bilateral toes and left heel treatment was performed per physician orders by wound nurse on 9/21/16. MD notified on 9/28/16. Education of staff assigned to these shifts began on 9/22/16. New treatment orders are reviewed daily Monday through Friday in clinical meeting and care planned by MDS Coordinator or Supervisor. Wounds will be reviewed in weekly Patient at Risk meetings. 2. Licensed Nursing staff were educated on performing treatments per physician□s orders by the Director of Nursing and or Staff Development Coordinator on 9/23/16 and prior to next shift worked. Any new licensed employee will receive this education upon orientation. All current licensed Nursing staff will be observed during a treatment round(perform treatments) and a skills checklist will be completed by Certified Wound Nurse and or Supervisor by 11-14-16 or prior to next shift. Every new Licensed Nursing staff will be observed during a treatment round(perform treatments) and a skills checklist will be completed by the Certified Wound Nurse and or Supervisor. 3. An audit of treatment administration records was performed by the ward clerk on 10/4/16. All incidences of omission was discussed with the Medical Director on 9/28/16 and was taken to the QA meeting on 10/22/16. Any nurse not	

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F 282	Continued From page 9 revealed she was responsible to complete the weekend treatments, and the pressure ulcer treatments. When she worked on the hall with a resident assignment the treatments were delegated to the nurses who had the assigned residents. She indicated when she was busy as the supervisor she had elected which treatments she would do and omitted the other treatments. The schedule revealed she was assigned to do the treatment on 8/6/16 for Resident #9. Review of the schedule revealed Nurse #12 was assigned to Resident #9 on 7/24/16 and 8/7/16 and the dressing change was documented as not done on both days. During an interview via telephone on 9/22/16 at 4:48pm. Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medication. She had not done any treatments. 2. Resident #10 was admitted to the facility on 4/12/16. The annual Minimum Data Set (MDS) dated 7/11/16 revealed he had moderate cognitive impairment and an indwelling catheter. His current diagnoses were in part, chronic urinary tract infection, urinary tract disease and dementia. Review of the care plan initiated 7/19/16 and updated on 7/21/16 revealed in part, for the nursing staff to provide suprapubic catheter care every shift and as needed. Review of the physician order dated 7/27/16, revealed to clean the surgical incision with warm soapy water and apply dry dressing every day and as needed. Review of the physician order dated 8/17/16, revealed to clean the right suprapubic catheter site with normal saline and apply Mipirocin 2% (an antibiotic) ointment and Santyl (a debridement agent) gauze every day . Review of the August 2016 treatment	F 282	completing treatments as ordered will receive disciplinary action per policy up to and including termination of employment. 4. Residents with treatments ordered by the physician have the potential to be affected. 5. An audit of treatment administration records will be conducted every day for completeness by the wound nurse and or the floor nurse for two months. Then the audit will be conducted three times per week for one month, then monthly for eleven months. The results of the audits will be discussed by the Director of Nursing and or Administrator during monthly QA meeting monthly for twelve consecutive months and then periodically to ensure compliance is met.	

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administration record (TAR) revealed suprapubic catheter documentation revealed the suprapubic catheter was not cleaned and changed on 8/6 (Saturday), 8/7 (Sunday), 8/13 (Saturday), 8/14 (Sunday), 8/15 (Monday), 8/20 (Saturday) or 8/21 (Sunday). Additionally, suprapubic catheter documentation revealed the suprapubic catheter was not cleaned and changed on 8/20 (Saturday) and 8/21 (Sunday), with Santyl and Mipirocin 2% ointment.

Review of the September 2016 TAR revealed the suprapubic catheter dressing change was documented as not done on 9/10 (Saturday) or 9/11 (Sunday).

During interview on 9/20/16 at 2:33pm, Nurse #1, the wound care nurse, indicated the weekend nurse supervisor changed the dressings on the weekend. When the nursing supervisor worked on a hall passing medications, all nurses were responsible to do the treatments of their assigned residents.

During an interview on 9/21/16 at 5:15pm, a family member of Resident #10 indicated his suprapubic catheter dressing changes were not done every weekend.

During an interview on 9/22/16 at 8:10am, Nurse #1 indicated treatment were not done when she was off during the week or on the weekends.

On 9/22/16 at 8:43pm, Nurse #1 was observed during the suprapubic dressing change. The suprapubic site was observed to have a scant amount of dried exudate and pink tissue from around the incision site. There was no foul odor. The site was cleaned with normal saline and covered with a perforated gauze dressing and paper tape.

During an interview via telephone on 9/22/16 at 10:00am, Nurse #4 indicated she had not done any dressing changes until after 8/20/16. The

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schedule revealed she was assigned to do the treatment on 8/15/16 (Monday).
During an interview via telephone on 9/22/16 at 2:22pm, Nurse #9 (weekend supervisor), revealed she was responsible to complete the weekend treatments. When she worked on the hall with a resident assignment the treatments were delegated to the nurses who had the assigned residents. She indicated she had elected to do the treatments scheduled for twice a day and not to do the suprapubic dressing changes. The schedule revealed she was assigned to do Resident #10 suprapubic treatment on 8/6/16 (Saturday).
During an interview via telephone on 9/22 at 4:48pm, Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medication. She had not done any treatments. She was assigned to do the suprapubic dressing changes on 8/7 (Sunday), 8/14 (Sunday), 8/20 (Saturday) and 8/21 (Sunday).
Nurse #15 was not available for interview. She was assigned to do the dressing change on 8/13 (Saturday).
During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.

3. Resident # 11 was admitted to the facility on 3/26/14. The most recent Minimum Data Set (MDS) assessment dated 8/12/16 revealed that she had severe cognitive impairment and a wound. The most recent diagnoses were in part, Alzheimer disease and pyoderma gangrenosum (auto inflammatory disorder) to her back.
Review of the most recent wound care plan dated 1/8/16, revealed in part, wound care was to be

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done as ordered to the lesion on the medial back.
Review of the physician order dated 7/25/16, revealed to apply Clobetasol propionate 0.05% (a corticosteroid) ointment to the ulcer on the back daily and cover with adhesive and collagen powder (sic)(to enhance tissue growth) and calcium alginate (absorbed exudate).
Review of the physician order dated 8/19/16 revealed apply Flagyl (for a bacterial infection) 500 mg tablet crushed and apply to the wound bed medial back then follow current treatment above. Clarification order was added on 8/26/16, to apply the Flagyl for a total of 1 month.
Review of the July 2016 treatment administration record (TAR) revealed that treatment to the wound of Resident #10 was documented as not done on 7/2 (Saturday), 7/3 (Sunday) and on 7/24 (Sunday).
Review of the August 2016 TAR revealed the wound treatment was documented as not done on 8/5 (Friday), 8/7 (Sunday), 8/13 (Saturday), 8/14 (Sunday), 8/15 (Monday) or on 8/21 (Sunday). The Flagyl was not administered to the wound on 8/20 (Saturday) and 8/21 (Sunday).
Review of the September 2016 TAR revealed wound treatment was documented as not done and the Flagyl was documented as not administered on 9/10 (Saturday).
During an interview on 9/20/16 at 2:33pm, Nurse #1, the wound care nurse, indicated the weekend nurse supervisor changed the dressings on the weekend. When the nursing supervisor worked on a hall passing medications, all nurses were responsible to do the treatments of their assigned residents.
During interview on 9/21/16 at 8:35am, Nurse #1 indicated the wound was changed daily due to the tissue necrotization. A crushed 500 mg Flagyl tablet was used in the wound bed. The

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management of the wound was dressing changes.
During the dressing change observation on 9/22/16 at 8:10am, revealed a large clean pink wound with dark rolled edges and no odor. The wound was cleaned with normal saline and dressed with Clebetasol, calcium alginate and Flagyl and dressed.
During interview on 9/22/16 at 8:10am, with Nurse #1, she indicated this wound was not always being changed while she was out on vacation and on the weekends. She produced the medication card of Flagyl and indicated the pills were still in the card when she returned from the weekend.
During an interview on 9/22/16 at 9:20am, the Physician indicated Resident #11 dressing changes were required for the wounds to be clean and the dressing to be changed daily with Flagyl to promote the healing of the wound.
During an interview via telephone on 9/22/16 at 11:15 am, Nurse #6 indicated she had not worked any weekends. She indicated she worked with Resident # 11 and changed the dressing on her left shoulder that had a cause an ulcer to her back. She was unable to recall the treatment.
Nurse # 6 was assigned to do wound care to Resident #11's back on 8/5/16 (Friday).
During an interview via telephone on 9/22/16 at 1:43pm, Nurse # 8 indicated the wound care nurse or the weekend supervisor completed the dressings and the treatments. The supervisor delegated the nurses when to do treatments and dressings. The TAR was kept on the wound cart. She wasn't aware of any treatment she had missed. Review of the schedule revealed Nurse #8 was scheduled to do the treatment on 7/2(Saturday) and 7/3 (Sunday).
During an interview via telephone on 9/22 at

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F 282	Continued From page 14 4:48pm. Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medication. She had not done any treatments. She was assigned to do the dressing changes on Resident #11 on 7/24 (Sunday), 8/7 (Sunday), 8/14 (Sunday) and 8/21(Sunday). Nurse # 14 the assigned nurse for the hall on 9/10/16 (Saturday) was not available for interview. During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.	F 282		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and physician and staff interview, the facility failed to have the resident assessed/examined by a qualified person for possible injuries before moving a resident after the fall for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained a head injury and cervical strain from the fall. The facility also failed to treat wounds as ordered for 3 (Residents # 10, #11 and #13) of 3 sampled residents reviewed for wounds.	F 309	F 309 1. Resident #5 was moved prior to an assessment by a medical professional after an accident in which entailed the resident falling out of the facility van. The resident was transferred to the emergency room for evaluation and treatment. 2. Residents who require van transportation have the potential to be	11/14/16

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F 309	Continued From page 15 Immediate Jeopardy began on 9/10/16 when Resident #5 was moved prior to have a qualified person assessed/examined her for possible injuries after the fall and was removed on 9/23/16 at 4:14 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for Residents #10, #11 & #13 and for Resident #5 to ensure all staff were in-serviced on facility's accident and incident policy and procedure. The findings included: The facility's policy and procedure for accident and incidents dated 3/11/04 was reviewed. The policy read in part " Regardless of how minor an accident or incident may be, it must be reported to the department supervisor. Employees witnessing an accident or incident involving a resident must report the occurrence to his or her immediate supervisor as soon as possible. Do not leave an accident victim unattended unless it is absolutely necessary to summon assistance. The charge nurse must be informed of all accidents or incidents so that medical attention can be provided. Should you witness an accident or find it necessary to aid an accident victim, you should render immediate assistance. Do not move the victim until he/she has been examined for possible injuries. " 1. Resident #5 was admitted to the facility on 5/20/15 with multiple diagnoses including End Stage Renal Disease on hemodialysis. The quarterly Minimum Data Set (MDS) assessment dated 9/6/16 indicated that Resident #5's	F 309	affected. 3. An audit of residents receiving transportation via facility van was conducted on 9/22/16 by Staff Development Coordinator to determine accident or incident occurrence. Only Resident #5 was affected. 4. All staff were educated on the accident and incident policy and procedure and not moving a resident prior to a medical assessment following an incident on 9/20/16 or prior to their next shift worked by the Director of Nursing and or Administrator. New employees will be educated upon orientation. 5. In-house facility transportation was terminated on 9/22/16. An independent transportation company is providing transportation services. 1. Resident #10 suprapubic catheter treatment was performed per physician order by the wound nurse on 9/22/16. Resident #11 lesion on back treatment was performed per physician order by the wound nurse on 9/22/16. Resident #13 bilateral toes and left heel treatment was performed per physician orders by wound nurse on 9/21/16. Physician was notified on 9/21/16. Education of staff assigned to these shifts began 9/22/16. 2. Licensed Nursing staff were educated on performing treatments per physician□s orders by the Director of Nursing and or Staff Development Coordinator on 9/23/16	

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F 309	Continued From page 16 cognition was moderately impaired. The assessment also indicated that the resident was independent with transfers and needed limited assistance with ambulation. On 9/20/16 at 9:25 AM and on 9/21/16 at 9:25 AM, Resident #5 was interviewed. She stated that it was "negligence on the part of the driver for not paying attention on what she was doing." Resident #5 stated the Van Driver was pushing her backward in wheelchair and the driver was facing the back door. The resident stated that the driver should have noticed that the lift was not up but the driver did not and she ended up falling. She indicated that she had bruises on her thigh, back and elbow from the fall. She revealed that she hit her head on something and was hurting bad. The resident indicated that she asked the driver to take her to the hospital because she was scared she might have broken bones. The resident stated that the driver should have called emergency medical services (EMS) and not picked her up and placed her back in wheelchair because she might have some broken bones but she did. The incident report dated 9/10/16 at 10:00 AM revealed that while removing Resident #5 from the van at the dialysis center, the resident who was sitting in a wheelchair fell from the van. The resident was taken to the emergency room immediately for evaluation. The written statement from Van Driver #1 dated 9/10/16 was reviewed. The written statement read " I was at the dialysis office at 10:10 AM unloading residents. I unloaded the first patient. I thought I lifted the lift back up to prepare for the next resident to come off. By me thinking I already put the lift back up I got on the van through the side door. Unhooked her straps from the front and back and unfastened her seatbelt. I	F 309	or prior to next shift worked. Any new licensed employee will receive this education upon orientation. Every licensed nurse will be observed during a treatment round(providing treatments) and a skills checklist will be completed by the Certified wound care nurse and or supervisor by 11-14-16 or prior to next shift. Any new licensed nurse will be observed during a treatment round(providing treatments) and a skills checklist will be completed by the certified wound care nurse or supervisor. 3. An audit of treatment administration records was performed by the ward clerk on 10/4/16. All incidences of omission was discussed with the Medical Director on 9/28/16 and taken to QA meeting on 10/22/16. Any licensed nurse not completing treatments as ordered will receive disciplinary action per policy up to and including termination of employment. 4. Residents with treatments ordered by the physician have the potential to be affected. 5. An audit of treatment administration records will be conducted every day for completeness by the wound nurse and or the floor nurse for two months. Then the audit will be conducted three times per week for one month, then monthly for eleven months. The results of the audits will be discussed by Director of Nursing and or Administrator during monthly QA meeting	

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F 309	Continued From page 17 proceeded to push the resident back to the lift. When I realized I didn't have the lift part up I tried to pull her back but was unsuccessful and we both fell. I jumped up asked the resident if she was okay. I ran into the dialysis to get help. No one was in the front part. So I knocked on the side door, no one came. So I went back to the resident. Sat her up looked over her body real good. I ran back in to the dialysis to get help with putting her in the chair, no one came to the door again. So I went back to the resident asked her if she was feeling any pain anywhere. She said only her head and elbow. Once I found out what was wrong I went back in to dialysis, knocked on door again, no one came. So I went back outside to the resident, picked her up and put her back in the wheelchair. She complained of her head hurting bad and said that she wanted to go to the hospital. So I went in to the dialysis so I could use the phone to call emergency medical service (EMS) and the facility, but no one came out again. So I went and told the resident I could not get nobody so I could the phone. She said once again that " I wanna go to the hospital " . So I loaded the resident in the van, strapped her down with all the necessary straps, buckled her seatbelt and proceeded to take her to the emergency room. At 10:38 AM, when I got to the emergency room. I unloaded the resident and took her inside the hospital. I told the hospital that we fell off the van and she hit her head and wanted to make sure she was okay. I used the security guard's phone to call the facility. I called the facility and got instructions to stay there with the resident. I spoke with the supervisor in charge. " The emergency room (ER) discharge instruction dated 9/10/16 revealed diagnoses of superficial head injury and cervical strain and was given a prescription for Ultram (an Opioid pain	F 309	monthly for twelve consecutive months and then periodically to ensure compliance is met.	

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medication) 50 milligrams (mgs) 1-2 tablets by mouth every 4-6 hours as needed for pain.
On 9/20/16 at 10:20 AM, Van Driver #2 was interviewed. She stated that she was the transportation coordinator, worked Monday through Friday and at times on weekends. She indicated that she was trained not to move the resident after the fall. She stated that she would call the facility first and inform the nurse about the accident. Then she would follow the advice from the nurse to either call EMS or wait for the staff to come assess the resident.
On 9/20/16 at 11:35 AM, the Director of Nursing (DON) was interviewed. The DON stated that she was informed on 9/10/16 that there was an accident involving the van. She stated that she expected the driver not to move the resident after the fall but the driver had tried to get some help but she could not find anybody. So the driver had to move the resident and took her to the ER. The DON further indicated that Van Driver #1 was not allowed to drive the van anymore and the rest of the drivers were reeducated on 9/10/16.
On 9/20/16 at 2:52 PM, the Administrator and the DON were interviewed. The Administrator stated that she started working at the facility as an administrator 2 weeks ago. The DON stated that the department heads had been reviewing the incident reports on a daily basis and there were no other residents with the same incident happened in the past. The DON revealed that they had not been monitoring the van drivers before or after the 9/10/16 incident.
On 9/20/16 at 3:10 PM, Van Driver #1 was interviewed. She stated that she was trained 2-3 months ago, on the proper use of the securement system in the facility van and on the proper use of the lift gate to load and unload residents safely. She stated that she had been driving the

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transport van for almost 2 months now. At the dialysis parking lot, she unloaded the first resident and took her to the dialysis clinic. She proceeded to unload the second resident, Resident #5. After she unstrapped and unbuckled her, she pushed her wheelchair backward to unload her from the van. She did not realize the lift gate was not up so she and the resident fell off the van. She revealed that she left the resident lying on the ground to get help from the dialysis clinic but she could not get any help. After several attempts of getting help, she picked the resident up and placed her in the wheelchair by herself. After Resident #5 was placed in the wheelchair, she unloaded the third resident and brought her to the dialysis clinic. Then she loaded Resident #5 into the van and took her to the emergency room. Van Driver #1 stated that Resident #5 was complaining that her head was hurting and she wanted to go to the ER. She stated that the facility's transport van had no cell phone and her personal phone was left at the facility for charging. She stated that she had no way to call EMS or the facility and she could not get any help, so she had to do something, which Van Driver #1 stated was to, " pick the resident up and take her to the ER. "
The training records for Van Driver #1 were reviewed. The in-service sheet dated 7/14/16 indicated that Van Driver #1 was trained on the proper use of the securement system in the facility transport van to safely transport residents and on how to properly use the lift gate on the facility transport van to load and unload residents safely and all related safety procedures. There was no record that Van Driver #1 was trained on the facility's accident/incident policy and procedure on reporting and assessing the resident prior to driving the van.

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On 9/22/16 at 9:00 AM, Resident #5's attending physician was interviewed. She indicated that her expectation was for the Van Driver to call the facility staff or EMS to transport the resident to the ER after the fall. She added that she was told that the driver had tried to get help but was unable to get any help so she moved the resident by herself, placed her in wheelchair and took her to the ER.
On 9/20/16 at 5:00 PM, the Administrator and the DON were informed of the immediate jeopardy.
The facility provided an acceptable credible allegation of compliance on 9/23/16 at 4:14 PM.
The credible allegation indicated:
On September 10, 2016, Resident #5 was being transported to the dialysis center. Upon arrival, the transportation aide had unloaded another resident. When she returned, she came back in the van through the side door. She proceeded to unlock/unhook the resident in question and proceeded to unload the resident. At which time the lift was on ground level and was not level with the exit of the van. The transportation aide realized this when the audible alarm sounded to indicate something was wrong. She tried to stop the resident from exiting. The momentum pulled them both off the van, landing on the ground. This occurred at 10:10am. The transportation aide went inside the dialysis center three separate times and knocked on the treatment room door to try to get assistance. When she did not get anyone to come to the door and did not have a cell phone available (she left the cell phone at the facility to charge), she looked the resident over for any apparent injuries and asked the resident if she was in pain. Resident stated her head and elbow hurt and wanted to go to the emergency room. The transportation aide lifted the wheelchair with the resident in it to an upright

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position. She loaded the resident in the facility van to go to the Emergency Room for evaluation at 10:35 am. The resident was evaluated for injury in the Emergency room due to complaints of headache and elbow hurting.
On September 10, 2016, the transportation aide was removed from providing transportation services now and in the future. The transportation aide stated the incident was due to her human error.
The facility reviewed residents that were potentially affected by the alleged deficient practice. It is determined that any resident who would require transportation on the facility van would be at risk. The Administrator and or Director of Nursing will in-service all staff on facility ' s accident/incident policy and procedure to include reporting and assessing residents.
In-servicing began on September 20, 2016. Any one not in-serviced will be educated prior to the start of their next shift.
Staff will seek appropriate medical assessment prior to moving residents who may be at risk for or have an injury, after an incident and or accident. " Regardless of how minor an accident or incident may be, it must be reported to the department supervisor. Employee witnessing an accident or incident involving a resident must report the occurrence to his or her immediate supervisor as soon as possible. "
Staff will be in-serviced upon new hire orientation regarding incidents and accident policy as well as the process for assessment by medical staff prior to moving resident after an accident or incident or possible injury by Staff Development Coordinator or assigned administrative nurse.

The credible allegation was verified on 9/23/16 at 5:04 PM by interviewing the staff including the

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van drivers that they have received in-service on the facility's accident/incident policy and procedure. The in-service records were reviewed and the in-service on accident/incident policy and procedure was started on 9/20/16. Interview with the van drivers revealed that the in house transport was terminated and a third party transportation company would transport all residents for appointments. The transport van was observed parked out of service and the key was locked at the administrator's office.

2. Resident #10 was admitted to the facility on 4/12/16. The annual Minimum Data Set (MDS) dated 7/11/16 revealed he had moderate cognitive impairment and an indwelling catheter. His current diagnoses were in part, chronic urinary tract infection, urinary tract disease and dementia.
Review of the care plan initiated 7/19/16 and updated on 7/21/16 revealed in part, for the nursing staff to provide suprapubic catheter care every shift and as needed.
Review of the physician order dated 7/27/16, revealed to clean the surgical incision with warm soapy water and apply dry dressing every day and as needed.
Review of the physician order dated 8/17/16, revealed to clean the right suprapubic catheter site with normal saline and apply Mipirocin 2% (an antibiotic) ointment and Santyl (a debridement agent) gauze every day .
Review of the August 2016 treatment administration record (TAR) revealed suprapubic catheter documentation revealed the suprapubic catheter was not cleaned and changed on 8/6 (Saturday), 8/7 (Sunday), 8/13 (Saturday), 8/14 (Sunday), 8/15 (Monday), 8/20 (Saturday) or 8/21

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(Sunday). Additionally, suprapubic catheter documentation revealed the suprapubic catheter was not cleaned and changed on 8/20 (Saturday) and 8/21 (Sunday), with Santyl and Mipirocin 2% ointment.
Review of the September 2016 TAR revealed the suprapubic catheter dressing change was documented as not done on 9/10 (Saturday) or 9/11 (Sunday).
During interview on 9/20/16 at 2:33pm, Nurse #1, the wound care nurse, indicated the weekend nurse supervisor changed the dressings on the weekend. When the nursing supervisor worked on a hall passing medications, all nurses were responsible to do the treatments of their assigned residents.
During an interview on 9/21/16 at 5:15pm, a family member of Resident #10 indicated his suprapubic catheter dressing changes were not done every weekend.
During an interview on 9/22/16 at 8:10am, Nurse #1 indicated treatment were not done when she was off during the week or on the weekends.
On 9/22/16 at 8:43pm, Nurse #1 was observed during the suprapubic dressing change. The suprapubic site was observed to have a scant amount of dried exudate and pink tissue from around the incision site. There was no foul odor. The site was cleaned with normal saline and covered with a split gauze and paper tape.
During an interview via telephone on 9/22/16 at 10:00am, Nurse #4 indicated she had not done any dressing changes until after 8/20/16. The schedule revealed she was assigned to do the treatment on 8/15/16 (Monday).
During an interview via telephone on 9/22/16 at 2:22pm, Nurse #9 (weekend supervisor), revealed she was responsible to complete the weekend treatments. When she worked on the

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hall with a resident assignment the treatments were delegated to the nurses who had the assigned residents. She indicated she had elected to do the treatments scheduled for twice a day and not to do the suprapubic dressing changes. The schedule revealed she was assigned to do Resident #10 suprapubic treatment on 8/6/16 (Saturday).
During an interview via telephone on 9/22 at 4:48pm, Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medication. She had not done any treatments. She was assigned to do the suprapubic dressing changes on 8/7 (Sunday), 8/14 (Sunday), 8/20 (Saturday) and 8/21 (Sunday).
Nurse #15 was not available for interview. She was assigned to do the dressing change on 8/13 (Saturday).
During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.

3. Resident # 11 was admitted to the facility on 3/26/14. The most recent Minimum Data Set (MDS) assessment dated 8/12/16 revealed that she had severe cognitive impairment and a wound. The most recent diagnoses were in part, Alzheimer disease and pyoderma gangrenosum (auto inflammatory disorder) to her back.
Review of the most recent wound care plan dated 1/8/16, revealed in part, wound care was to be done as ordered to the lesion on the medial back.
Review of the physician order dated 7/25/16, revealed to apply Clobetasol propionate 0.05% (a corticosteroid) ointment to the ulcer on the back daily and cover with adhesive and collagen powder (sic)(to enhance tissue growth) and

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calcium alginate (absorbed exudate).
Review of the physician order dated 8/19/16 revealed apply Flagyl (for a bacterial infection) 500 mg tablet crushed and apply to the wound bed medial back then follow current treatment above. Clarification order was added on 8/26/16, to apply the Flagyl for a total of 1 month.
Review of the July 2016 treatment administration record (TAR) revealed that treatment to the wound of Resident #10 was not documented as done on 7/2 (Saturday), 7/3 (Sunday) and on 7/24 (Sunday).
Review of the August 2016 TAR revealed the wound treatment was documented as not done on 8/5 (Friday), 8/7 (Sunday), 8/13 (Saturday), 8/14 (Sunday), 8/15 (Monday) or on 8/21 (Sunday). The Flagyl was not administered to the wound on 8/20 (Saturday) and 8/21 (Sunday).
Review of the September 2016 TAR revealed wound treatment was documented as not done and the Flagyl was documented as not administered on 9/10 (Saturday).
During an interview on 9/20/16 at 2:33pm, Nurse #1, the wound care nurse, indicated the weekend nurse supervisor changed the dressings on the weekend. When the nursing supervisor worked on a hall passing medications, all nurses were responsible to do the treatments of their assigned residents.
During interview on 9/21/16 at 8:35am, Nurse #1 indicated the wound was changed daily due to the tissue necrotization. A crushed 500 mg Flagyl tablet was used in the wound bed. The management of the wound was dressing changes.
During the dressing change observation on 9/22/16 at 8:10am, revealed a large clean pink wound with dark rolled edges and no odor. The wound was cleaned with normal saline and

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dressed with Clebetasol, calcium alginate and Flagyl and dressed.
During interview on 9/22/16 at 8:10am, with Nurse #1, she indicated this wound was not always being changed while she was out on vacation and on the weekends. She produced the medication card of Flagyl and indicated the pills were still in the card when she returned from the weekend.
During an interview on 9/22/16 at 9:20am, the Physician indicated Resident #11 dressing changes were required for the wounds to be clean and the dressing to be changed daily with Flagyl to promote the healing of the wound.
During an interview via telephone on 9/22/16 at 11:15 am, Nurse #6 indicated she had not worked any weekends. She indicated she worked with Resident # 11 and changed the dressing on her left shoulder that had a cause an ulcer to her back. She was unable to recall the treatment. Nurse # 6 was assigned to do wound care to Resident #11's back on 8/5/16 (Friday).
During an interview via telephone on 9/22/16 at 1:43pm, Nurse # 8 indicated the wound care nurse or the weekend supervisor completed the dressings and the treatments. The supervisor delegated the nurses when to do treatments and dressings. The TAR was kept on the wound cart. She wasn't aware of any treatment she had missed. Review of the schedule revealed Nurse #8 was scheduled to do the treatment on 7/2(Saturday) and 7/3 (Sunday).
During an interview via telephone on 9/22 at 4:48pm. Nurse # 12 revealed she was not hired to do treatments. She was hired to pass medication. She had not done any treatments. She was assigned to do the dressing changes on Resident #11 on 7/24 (Sunday), 8/7 (Sunday), 8/14 (Sunday) and 8/21(Sunday).

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Nurse # 14 the assigned nurse for the hall on 9/10/16 (Saturday) was not available for interview.
During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.

4. Resident # 13 was admitted on 8/29/16. The Minimum Data Set (MDS) assessment dated 9/10/16 indicated that the resident was cognitively intact and with gangrene to her left foot and right toes. Her diagnoses were in part, gangrene, diabetes mellitus, and peripheral vascular disease.
The physician's order dated 8/30/16 indicated to paint bilateral toes and left heel with betadine every day to keep gangrene dry as possible.
Review of the September 2016 treatment administration record (TAR) revealed the treatment was documented as not done on 9/10/16 (Saturday) and 9/11/16 (Sunday).
During an interview on 9/20/16 at 2:27pm, Nurse # 1, the wound care nurse, revealed it was important to keep the heel painted with betadine to prevent the spread of gangrene.
During interview on 9/20/16 at 2:47pm, Resident #13 indicated the betadine was applied to her feet most days.
During a wound observation on 9/21/16 at 7:00am, of the left and right feet, revealed a darkened toes and amputation of the small toes on the right foot and partially amputated 1st toe and total amputation of the 2nd toe. Mild edema was noted to both feet. Nurse #1 painted the foot and heel with betadine bilaterally and let it dry and reapplied the heel protector.
During an interview on 9/22/16 at 8:10am, Nurse

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F 309	Continued From page 28 #1, the wound care nurse, indicated treatment were not done when she was off during the week or on the weekends. During an interview via telephone on 9/22/16 at 2:22pm, Nurse #9 (weekend supervisor), revealed she was responsible to complete the weekend treatments. When she worked on the hall with a resident assignment the treatments were delegated to the nurses who had the assigned residents. She indicated she changed the stage 3 and 4 pressure ulcers dressings and dressings that were scheduled for twice a day, the remaining treatments were omitted. Nurse #9 was scheduled to provide treatments on 9/10 and 9/11/16. Nurse # 14 the assigned nurse for the hall on 9/10 and 9/11 was not available for interview. During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.	F 309		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		11/14/16

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F 314	Continued From page 29 Based on record review, observation, resident and staff interview, the facility failed to treat the pressure ulcers as ordered on weekends for 2 of 3 sampled residents with pressure ulcers (Resident#9 and #13). Findings included: 1. Resident # 9 was admitted to the facility on 4/23/15. The Minimum Data Set (MDS) dated 6/22/16 revealed she had a memory problem and a stage 3 pressure ulcer. Diagnoses were in part, dementia and encephalopathy. She was discharged on 8/11/16. Review of the care plan dated 6/25/16, revealed Resident #9 had a stage 3 pressure ulcer on her sacrum. The approaches to heal the pressure ulcer were in part, to give medication as ordered, monitor the effectiveness of the treatment and report to the physician if no change or deterioration within 2 weeks. Review of the resident's physician order dated 7/6/16, was in part, to clean sacrum with normal saline, apply Santyl (a chemical debriding ointment), Mipirocin 2% (an antibiotic ointment) and calcium alginate (used to absorb exudate) cover with foam dressing every day and as needed. The July and August 2016 treatment administration record (TAR) were reviewed. The boxes on the TAR did not have nurse's initial to indicate that the treatment was provided on 7/2 (Saturday), 7/3 (Sunday), 7/24/16 (Saturday), 8/6 (Saturday) and 8/7(Sunday). Review of the schedule revealed Nurse #12 was assigned to Resident #9 on 7/24/16 and 8/7/16 and the dressing change was documented as not done on both days. During an interview via telephone on 9/22/16 at 4:48pm. Nurse # 12 revealed she was not hired	F 314	F 314 1. Resident #9 sacrum treatment was performed per physician order by the wound nurse on 9/22/16. Resident #13 bilateral toes and heel treatment was performed per physician order by the wound nurse on 9/21/16. Physician was notified on 9/28/16. Education of staff assigned to these shifts began on 9/22/16. 2. Licensed Nursing staff were educated on performing treatments per physician□s orders by the Director of Nursing and or Staff Development Coordinator on 9/23/16 or prior to next shift. All new employees will receive this education upon orientation. 3. All licensed nurses will have job descriptions reviewed with Director of Nursing and or Staff Development Coordinator and signed by 10/22/16 or prior to next shift. Job descriptions for licensed nurses will be reviewed with the Director of Nursing and or Staff Development coordinator quarterly for one year and annually thereafter. New licensed nurses will review job description upon orientation and follow quarterly cycle and annually thereafter. 4. An audit of treatment administration records was performed by the ward clerk on 10/4/16. All incidences of omission was discussed the Medical Director on 9/28/16 and was taken to the QA meeting on 10/22/16.	

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F 314	Continued From page 30 to do treatments. She was hired to pass medication. She had not done any treatments. During interview on 9/20/16 at 2:33pm, Nurse #1, the wound care nurse, indicated the weekend nurse supervisor changed the dressings on the weekend. When the nursing supervisor was working on a hall passing medications, all nurses were responsible to do the treatments of their assigned residents. During an interview via telephone on 9/22/16, Nurse # 8, who was assigned to Resident #9 on 7/2 and 7/3/16, indicated the wound treatments were completed by the weekend nurse supervisor (Nurse #9.) During an interview via telephone on 9/22/16 at 2:22pm, Nurse #9 (weekend supervisor), revealed she was responsible to complete the weekend treatments, and the pressure ulcer treatments. When she worked on the hall with a resident assignment the treatments were delegated to the nurses who had the assigned residents. She indicated when she was busy as the supervisor she had elected which treatments she would do and omitted the other treatments. The schedule revealed she was assigned to do the treatment on 8/6/16 for Resident #9. Nurse #9 indicated she had reported to the Director of Nursing that the treatments had not been done because of shortage of staff on the weekends. She indicated there wasn't always a nurse to call in for work and she had to take a resident assignment. On 9/22/16 at 3:06 PM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had a full time treatment nurse who was scheduled to provide the treatments Monday through Friday. The weekend supervisor was responsible to provide the treatment on the	F 314	5. Residents with written treatments ordered have the potential to be affected. 6. Every licensed nurse will be observed during treatment round(perform treatment) and a skills checklist will be completed by certified wound care nurse or supervisor by 11-14-16. Any new licensed nurse will be observed during a treatment round(perform treatment) and a skills checklist will be completed by the certified wound nurse or supervisor. Random treatment checks will be conducted by the certified wound care nurse or supervisor monthly. An audit of treatment administration records will be conducted every day for completeness by the wound nurse and or floor nurse for two months. Then the audit will be conducted three times per week for one month, then monthly for eleven months. 7. Results of the treatment administration records will be discussed by the Director of Nursing and or the Administrator during monthly QA meetings monthly for twelve consecutive months then periodically to ensure compliance is met.	

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weekends. She added that she had heard murmurs that the nurses had no time to get wounds done. She indicated she felt the nurses were refusing to do the treatments because the facility had been swamped with staffing issues, three months ago when there were aides and nurses that quit.

2. Resident # 13 was admitted to the facility on 8/29/16. The Minimum Data Set (MDS) dated 9/10/16 indicated that the resident was cognitively intact and with a deep tissue injury to her heel. Her diagnoses were in part, gangrene, diabetes mellitus, and peripheral vascular disease.
The physician's order dated 8/30/16 indicated to paint bilateral toes and left heel with betadine every day to keep gangrene dry as possible.
Review of the September 2016 treatment administration record (TAR) revealed the treatment was documented as not done on 9/10/16 (Saturday) and 9/11/16 (Sunday).
During an interview on 9/20/16 at 2:27pm, Nurse # 1, the wound care nurse, revealed it was important to keep the heel painted with betadine to prevent the spread of gangrene and to protect the left heel.
During interview on 9/20/16 at 2:47pm, Resident #13 indicated the betadine was applied most days.
On 9/21/16 at 7:00am, a pressure wound observation of the left heel revealed a darkened heel and boggy lateral heel. Nurse #1 painted the foot and heel with betadine let dry and reapplied the heel protector.
Nurse # 14, the assigned nurse for the hall, was not available for interview.
During an interview on 9/22/16 at 8:10am, Nurse #1 indicated pressure ulcer wound dressings were not done on the weekends.

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F 314	Continued From page 32 Nurse #9 was scheduled to provide treatments on 9/10 and 9/11/16 to Resident #13. During an interview via telephone on 9/22/16 at 2:22pm, Nurse #9 (weekend supervisor), revealed she was responsible to complete the weekend treatments, and the pressure ulcer treatments. When she worked on the hall with a resident assignment the treatments were delegated to the nurses who had the assigned residents. She indicated she changed the stage 3 and 4 pressure ulcers and dressings that were scheduled for twice a day, the rest were omitted. Nurse #9 indicated she had reported to the Director of Nursing that the treatments had not been done because of shortage of staff on the weekends. She indicated there wasn't always a nurse to call in for work and she had to take a resident assignment. On 9/22/16 at 3:06 PM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had a full time treatment nurse who was scheduled to provide the treatments Monday through Friday. The weekend supervisor was responsible to provide the treatment on the weekends. She added that she had heard murmurs that the nurses had no time to get wounds done. She indicated she felt the nurses were refusing to do the treatments because the facility had been swamped with staffing issues, three months ago when there were aides and nurses that quit. During interview on 9/22/16 at 5:30pm, the Director of Nursing indicated that nurses were expected to do the treatments of the residents they were assigned and to document after each shift.	F 314		
F 323	483.25(h) FREE OF ACCIDENT	F 323		10/21/16

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F 323 SS=J	Continued From page 33 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to raise the lift gate up before pushing the resident who was sitting in a wheelchair out of the transport van causing the resident to fall backward for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained a head injury and cervical strain from the fall. Immediate Jeopardy began on 9/10/16 when Resident #5 fell off the transpiration van and was removed on 9/23/16 at 4:14 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure all staff were in-serviced on the facility's accident/incident policy and procedure. The findings included: Resident #5 was admitted to the facility on 5/20/15 with multiple diagnoses including End Stage Renal Disease on hemodialysis. The quarterly Minimum Data Set (MDS) assessment dated 9/6/16 indicated that Resident #5's cognition was moderately impaired with the Brief Interview for Mental Status (BIMS) score of 11,	F 323	F 323 1. Resident #5 was moved prior to an assessment by a medical professional after an accident in which entailed the resident falling out of the facility van and was transferred to emergency room for evaluation and treatment. 2. Residents who require van transportation have the potential to be affected. 3. An audit of residents receiving transportation via facility van was conducted on 9/22/16 by Staff Development Coordinator to determine accident or incident occurrence. Only Resident #5 was affected. 4. All staff were educated on the accident and incident policy and procedure on 9/20/16 or prior to their next shift worked. All staff were educated on not moving a resident without an assessment after an accident by the Director of Nursing and or Administrator	

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F 323	Continued From page 34 independent with transfers and needed limited assistance with ambulation. On 9/20/16 at 9:25 AM and on 9/21/16 at 9:25 AM, Resident #5 was interviewed. She stated that " it was negligence on the part of the driver for not paying attention on what she was doing. " The Van Driver was pushing her backward in wheelchair and the driver was facing the back door. The driver should have noticed that the lift was not up but the driver did not and she ended up falling. She had bruises on her thigh, back and elbow from the fall. She hit her head on something and was hurting bad. She asked the driver to take her to the hospital because she was scared she might have broken bones. The incident report dated 9/10/16 at 10:00 AM revealed that while removing Resident #5 from the van at the dialysis center, the resident who was sitting in a wheelchair fell from the van. The resident was taken to the emergency room immediately for evaluation. The written statement from Van Driver #1 (driver of the van during the accident) dated 9/10/16 was reviewed. The written statement read " I was at the dialysis office at 10:10 AM unloading residents. I unloaded the first patient. I thought I lifted the lift back up to prepare for the next resident to come off. By me thinking I already put the lift back up I got on the van through the side door. Unhooked her straps from the front and back and unfastened her seatbelt. I proceeded to push the resident back to the lift. When I realized I didn't have the lift part up. I tried to pull her back but was unsuccessful and we both fell. I jumped up asked the resident if she was okay. I ran into the dialysis to get help. No one was in the front part. So I knocked on the side door, no one came. So I went back to the resident. Sat her up, looked over her body real good. I ran back in	F 323	on 9/20/16 or prior to start of next shift. New employees will be educated upon orientation on these processes. 5. In-house facility transportation was terminated on 9/22/16. An independent company provides transportation services.	

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to the dialysis to get help with putting her in the chair, no one came to the door again. So I went back to the resident asked her if she was feeling any pain anywhere. She said only her head and elbow. Once I found out what was wrong I went back in to dialysis, knocked on door again, no one came. So I went back outside to the resident, picked her up and put her back in the wheelchair. She complained of her head hurting bad and said that she wanted to go to the hospital. So I went in to the dialysis so I could use the phone to call emergency medical service (EMS) and the facility, but no one came out again. So I went and told the resident I could not get nobody so I could the phone. She said once again that " I wanna go to the hospital " . So I loaded the resident in the van, strapped her down with all the necessary straps, buckled her seatbelt and proceeded to take her to the emergency room. At 10:38 AM, when I got to the emergency room. I unloaded the resident and took her inside the hospital. I told the hospital that we fell off the van and she hit her head and wanted to make sure she was okay. I used the security guard's phone to call the facility. I called the facility and got instructions to stay there with the resident. I spoke with the supervisor in charge. "

The emergency room discharge instruction dated 9/10/16 revealed diagnoses of superficial head injury and cervical strain and the resident was given a prescription for Ultram (an Opioid pain medication) 50 milligrams (mgs) 1-2 tablets by mouth every 4-6 hours as needed for pain.

On 9/20/16 at 10:20 AM, Van Driver #2 was interviewed. She stated that she was the transportation coordinator, worked Monday through Friday and at times on weekends. She indicated that she was trained not to move the resident after the fall. She stated that she would

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call the facility first and inform the nurse about the accident. Then she would follow the advice from the nurse to either call EMS or wait for the staff to come assess the resident.
On 9/20/16 at 11:20 AM, the transport van was observed. The lift gate was observed at the back of the van. The lift gate can go up or down using a switch. The lift gate was used to load and unload the resident from the van. The lift was observed to be working properly at this time.
On 9/20/16 at 11:35 AM, the DON was interviewed. She stated that she was informed on 9/10/16 that there was an accident involving the van. She was told that the Van Driver was in the process of unloading Resident #5 from the van at the dialysis parking lot. Apparently, the lift was not up and the resident fell backwards and the driver fell on top of the resident. She added that it was a human error on the part of the driver.
On 9/20/16 at 2:52 PM, the administrator and the DON were interviewed. The administrator stated that she started working at the facility as an administrator 2 weeks ago. The DON stated that the department heads had been reviewing the incident reports on a daily basis and there were no other residents with the same incident happened in the past. She revealed that they had not been monitoring the van drivers on proper use of lift gate before or after the 9/10/16 incident. She further indicated that they figured out that the root cause of the accident was the driver exited the van via the lift gate and entered the van via the side door instead of using the lift gate.
On 9/20/16 at 3:10 PM, Van Driver #1 was interviewed. She stated that she was trained on the proper use of the securement system in the facility van and on the proper use of the lift gate to load and unload residents safely last 2-3 months

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ago. She stated that she had been driving the transport van for almost 2 months now. She stated that she was transporting 3 residents to the dialysis center that Saturday of 9/10/16. She was already late because 1 resident was not ready yet that morning so she was rushing. At the dialysis parking lot, she unloaded the first resident and took her to the dialysis clinic. She proceeded to unload the second resident, Resident #5. After she unstrapped and unbuckled her, she pushed her backward in wheelchair to unload her from the van. She did not realize the lift gate was not up so she and the resident fell off the van. She revealed that she left the resident lying on the ground to get help from the dialysis clinic but she could not get any help. After several attempts of getting help, she picked the resident up and placed her in the wheelchair by herself. After Resident #5 was placed in the wheelchair, she unloaded the third resident and brought her to the dialysis clinic. Then she loaded Resident #5 into the van and took her to the emergency room. Van Driver #1 stated that Resident #5 was complaining that her head was hurting and she wanted to go to the ER. She stated that the facility's transport van had no cell phone and her personal phone was left at the facility for charging. She stated that she had no way to call EMS or the facility and she could not get any help, so she had to do something, " picked the resident up and took her to the ER. "

The training records for Van Driver #1 were reviewed. The in-service sheet dated 7/14/16 indicated that Van Driver #1 was trained on the proper use of the securement system in the facility transport van to safely transport residents and on how to properly use the lift gate on the facility transport van to load and unload residents

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safely and all related safety procedures.
On 9/22/16 at 5:00 PM, the administrator was interviewed. She stated that the decision was made to terminate the use of the in house transportation and a third party transportation company would transport all residents to and from appointments.
On 9/20/16 at 5:00 PM, the Administrator and the DON were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 9/23/16 at 4:14 PM. The credible allegation indicated:
On September 10, 2016, Resident #5, was being transported to the dialysis center. Upon arrival, the transportation aide had unloaded another resident. When she returned, she came back in the van through the side door. She proceeded to unlock/unhook the resident in question and proceeded to unload the resident. At which time the lift was on ground level and was not level with the exit of the van. The transportation aide realized this when the audible alarm sounded to indicate something was wrong. The transportation aide was pushing the resident and tried to stop the resident from exiting. The momentum pulled them both off the van, landing on the ground. This occurred at 10:10am. The transportation aide tried to get assistance from the dialysis center on three occasions to no avail. (The facility's transportation policy does not dictate cell phone necessity.) The transportation aide looked the resident over for any apparent injuries and asked the resident if she was in pain. Resident stated her head and elbow hurt and wanted to go to the emergency room. The transportation aide placed the resident back in her wheelchair and transported her via facility van to the Emergency Room for evaluation at 10:35 am. The resident was evaluated for injury in the

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Emergency room due to complaints of headache and elbow hurting. The Emergency department performed a Head Computed Tomography (CT) scan and there were no skull fractures or anomalies. The resident was released from the hospital and was prescribed to take a pain medication every four to six hours as needed and follow up with attending physician as needed. Resident was transported back to the facility at 6:00 pm via the transport company with pain medication and an abrasion to elbow.
The transportation aide contacted the facility as soon as she had access to a telephone on September 10, 2016 at 10:40am. The transportation aide left her cell phone at the facility due to needing to be charged. The Weekend supervisor was updated, the Director of Nursing was contacted at 11:42 am and an incident/occurrence sheet and investigation was started to ensure safe practices were in place. Administrator was updated at 11:46 am and made aware of incident and plan of investigation. The Regional Vice President was made aware at 11:56 am. The Physician was notified on September 10, 2016 at 4:03 pm and the responsible party was notified on September 10, 2016 at 1:00 pm.
The facility transportation aide was suspended on September 10, 2016 at 12:12 pm and any resident that still required transportation services was routed to transport company.
The facility reviewed residents that were potentially affected by the alleged deficient practice. It is determined that any resident who would require transportation on the facility van would be at risk. On September 20, 2016, a 100% audit was completed for current residents with or without transports with no injuries.
The transportation aide involved was interviewed

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for details of fall by Director of Nursing and root cause analysis was established on September 10, 2016.
On September 10, 2016, the transportation aide was removed from providing transportation services now and in the future. The transportation aide stated the incident was due to her human error.
The Director or Nursing called in the current transportation aides on September 10, 2016 to be in-serviced with new process for the exiting and reentering of the van during transports. We have three active transportation aides, training began on September 10, 2016 through September 11, 2016.
On September 12, 2016, the lift on the van was inspected for proper working order by servicing agent. The lift for the van is in proper working order per the servicing agent.
The suspension of transportation services was discontinued on September 13, 2016 after in-service of process and new safety measures was implemented. The in-service entailed exiting and entering the van in the same manner as to assure the lift is in the proper position for loading and unloading of residents.
Added to the pre-trip daily inspection report for transport driver form was the additional check for access to cell phone for emergencies with a charging system in place on September 20, 2016.
All transportation aides were in-serviced on this on September 20, 2016 through September 21, 2016 by Administrator and or Director of Nursing.
As of September 22, 2016 at 5:00pm, it has been determined to ensure 100% safety for all residents, in-house transportation has been terminated. All resident transport will be provided by a third party transportation company and any future transport companies identified. The van

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F 323	Continued From page 41 has been parked and locked up in the facility parking lot. The transportation aides, department heads and administrative nurses were notified of the termination of in house transports for residents on September 22, 2016 at 5:00 pm. The keys for the van are locked up in the Administrator's office. The credible allegation was verified on 9/23/16 at 5:04 PM by interviewing the staff including the van drivers that they have received in-service on the facility's accident/incident policy and procedure. The in-service records were reviewed and it was started on 9/20/16. Interview with the van drivers revealed that the in house transport was terminated and a third party transportation company would transport all residents for appointments. The transport van was observed parked out of service and the key was locked at the administrator's office.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353		11/14/16

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F 353	Continued From page 42 Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and physician, resident and staff interview, the facility failed to have adequate staff to ensure treatments to pressure ulcers and wounds were provided as ordered for 4 (Residents #9, # 10, #11 and #13) of 6 sampled residents reviewed for pressure ulcers and wounds. The findings included: This tag is cross referred to: 1. F314 - Based on record review, observation, resident and staff interview, the facility failed to treat the pressure ulcers as ordered on weekends for 2 of 3 sampled residents with pressure ulcers (Resident#9 & #13). During an interview on 9/22/16 at 2:22 PM, Nurse #9, the weekend supervisor, indicated she had reported to the Director of Nursing that the treatments had not been done because of shortage of staff on the weekends. She indicated there wasn't always a nurse to call in for work and she had to take a resident assignment. On 9/22/16 at 3:06 PM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had a full time treatment nurse who was scheduled to provide the treatments Monday through Friday. The weekend supervisor was responsible to provide the treatment on the weekends. She added that she had heard murmurs that the nurses had no time to get	F 353	F 353 1. According to the weekend supervisor, treatments were not performed per physician order for Resident #9, #10, #11 and #13 due to misunderstanding of assigned duties. Resident #9 sacrum treatment was performed per physician order by wound nurse on 9/21/16. Resident #10 suprapubic catheter treatment was performed per physician order by wound nurse on 9/22/16. Resident #11 lesion on back treatment was performed per physician order by wound care nurse on 9/22/16. Resident #13 bilateral toes and left heel treatment was performed per physician order by wound nurse on 9/21/16. Physician was notified on 9/28/16. Education was provided to staff assigned to these treatments began on 9/22/16. 2. Residents with written treatments ordered have the potential to be affected. 3. Licensed nursing staff were educated on performing treatments per physician orders by Director of Nursing and or Staff Development coordinator on 9/23/16 or prior to start of next shift. Any new licensed nurse will receive this education on orientation. Every licensed nurse will be observed during a treatment	

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F 353	Continued From page 43 wounds done. She indicated she felt the nurses were refusing to do the treatments because the facility had been swamped with staffing issues, three months ago when there were aides and nurses that quit. 2. Resident #10 was admitted to the facility on 4/12/16. His Minimum Data Set (MDS) dated 7/11/16, revealed he had moderate cognitive impairment and an indwelling catheter. His current diagnoses were in part, chronic urinary tract infection, urinary tract disease and dementia. Review of the care plan initiated 7/19/16 and updated on 7/21/16 revealed in part, for the nursing staff was to provide suprapubic catheter care every shift and as needed. Review of the physician order dated 7/27/16, revealed to clean the incision with warm soapy water and apply dry dressing every day and as needed. Review of the physician order dated 8/17/16, revealed to clean the right suprapubic catheter site with normal saline and apply Mipirocin 2% (an antibiotic) ointment and Santyl (a debridement agent) gauze every day . Review of the August treatment administration record (TAR) revealed, the suprapubic catheter was not cleaned and changed on 8/6 (Saturday), 8/7 (Sunday), 8/13 (Saturday), 8/14 (Sunday), 8/15 (Monday), 8/20 (Saturday) or 8/21 (Sunday). Additionally, on Saturday 8/20 and Sunday 8/21 catheter dressing was not changed and dressed with Santyl and Mipirocin 2% ointment. Review of the September TAR revealed the suprapubic catheter dressing change was not done on 9/10 (Saturday) or 9/11/16 (Sunday). During an interview on 9/22/16 at 2:22 PM, Nurse	F 353	round(perform treatments) and a skills check sheet will be completed by the certified wound nurse or supervisor by 11-14-16 or prior to next shift. Any new licensed nurse will be observed during treatment round(performing treatments)and a skills check sheet will be completed by certified wound care nurse or supervisor. Staff were hired and orientation began on 10/6/16 and on-going. All current licensed personnel have signed job descriptions by 10/24/16 or prior to next shift and were reviewed by Director of Nursing and or Staff Development Coordinator. Any new licensed personnel will sign job descriptions upon orientation. 4. The Administrator and or Director of Nursing will evaluate staffing needs daily Monday through Friday in clinical meeting and make adjustments as needed. Classified want ad to continue to recruit new employees. 5. In-house employees and continued recruitment and hiring will provide staffing as needed for coverage. 6. Staffing will be monitored daily(Monday through Friday to include weekend schedules) by the staffing coordinator and discussed with Director of Nursing and or Administrator in daily (Monday through Friday) clinical meeting. An on-call sheet will be put out the last two weeks of the month for full time nurses to sign up for weekend call duty. Each full time nurse is required to sign up for one weekend. Continued efforts to hire	

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F 353	Continued From page 44 #9, the weekend supervisor, indicated she had reported to the Director of Nursing that the treatments had not been done because of shortage of staff on the weekends. She indicated there wasn't always a nurse to call in for work and she had to take a resident assignment. On 9/22/16 at 3:06 PM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had a full time treatment nurse who was scheduled to provide the treatments Monday through Friday. The weekend supervisor was responsible to provide the treatment on the weekends. She added that she had heard murmurs that the nurses had no time to get wounds done. She indicated she felt the nurses were refusing to do the treatments because the facility had been swamped with staffing issues, three months ago when there were aides and nurses that quit. 3. Resident # 11 was admitted to the facility on 3/26/14. Her most recent Minimum Data Set (MDS) dated 8/12/16 revealed a severe memory impairment and a wound. The most recent diagnoses were in part, Alzheimer disease and pyoderma granuloma. Review of the care plan dated 1/8/16, revealed in part, wound care was to be done as ordered to the lesion on the medial back. Review of the physician order dated 7/25/16, revealed to apply Clobetasol propionate 0.05% (a corticosteroid) ointment to the ulcer on the back daily and cover with adhesive and collagen powder (to enhance tissue growth) and calcium alginate (absorbed exudate). Review of the physician order dated 8/19/16 revealed apply Flagyl (for a bacterial infection) 500 mg tablet crushed and apply to the wound bed medial back then follow current treat above. Clarification order was added on 8/26/16, to apply	F 353	as needed staff to be utilized on on-call schedule. Staffing needs will be presented in QA by Administrator and or Director of Nursing.	

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F 353	Continued From page 45 the Flagyl for a total of 1 month. Review of the treatment administration record (TAR) for July revealed wound treatment was not done on 7/2 (Saturday), 7/3 (Sunday) and on 7/24 (Sunday). Review of the TAR for August revealed no wound treatment was done on 8/5 (Friday), 8/7 (Sunday), 8/13 (Saturday), 8/14 (Sunday) 8/15 (Monday) or on 8/21 (Sunday). The Flagyl was not administered to the wound on 8/20 (Saturday) and 8/21 (Sunday). Review of the September TAR revealed no dressing change or Flagyl was administered on 9/10 (Saturday). During an interview on 9/22/16 at 2:22 PM, Nurse #9, the weekend supervisor, indicated she had reported to the Director of Nursing that the treatments had not been done because of shortage of staff on the weekends. She indicated there wasn't always a nurse to call in for work and she had to take a resident assignment. On 9/22/16 at 3:06 PM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had a full time treatment nurse who was scheduled to provide the treatments Monday through Friday. The weekend supervisor was responsible to provide the treatment on the weekends. She added that she had heard murmurs that the nurses had no time to get wounds done. She indicated she felt the nurses were refusing to do the treatments because the facility had been swamped with staffing issues, three months ago when there were aides and nurses that quit.	F 353		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that	F 490		11/14/16

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KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(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 490	Continued From page 46 enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident, physician and staff interview, the facility's administration failed to effectively manage and to have an effective system in place to maintain compliance with F323 as evidenced by repeated immediate jeopardy citations at F323 during the recertification survey of 2/4/16 and 3/26/15 and complaint investigation survey of 9/23/16 and failed to provide a communication device in the transportation van for use in case of emergency for 1 (Resident #5) of 1 sampled resident with a van accident. The facility failed to have a resident assessed/examined by a qualified person for possible injuries before moving a resident after the fall for 1 (Resident #5) of 1 sampled resident with a van accident (F309). The facility failed to provide adequate staff to provide wound care per physician orders for 4 (Residents #9, # 10, #13 and #11) of 6 residents reviewed for wound care (F224, F309, F314, F353). Immediate Jeopardy (IJ) began on 9/10/16 when Resident #5 fell off the transportation van and was moved before a qualified person assessed/examined her for possible injuries and the IJ was removed on 9/23/16 at 4:14 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level E (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to	F 490	F 490 1. Resident #5 fell off the facility transport and was moved prior to an assessment by a qualified person due to not having means of communication on the van and was transferred to the emergency room for evaluation and treatment. 2. An in-service was conducted by the Administrator and/or Director of Nursing on 9/10/16 for new safety measures regarding proper way of entering/exiting van to ensure lift is in proper position to receive residents. Automobile emergency phone and charger in place in van. 3. The Administrator and or Director of Nursing educated all staff on facility'□s accident/incident policy and procedures on 9/20/16. Any one not in-serviced , will be educated prior to the start of their next shift. All new employees will receive this information during orientation. An in-service was conducted to not move a resident prior to assessment by a qualified medical professional after an incident on 9/20/16 by Director of Nursing and or Staff Development Coordinator. All new staff will be educated upon orientation. 4. Accidents and or incidents will be reviewed during morning department head meetings daily Monday through	

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F 490	Continued From page 47 ensure all staff were in-serviced on facility's accident/incident policy and procedure and to correct deficient practice for residents #9, #10, #11 and #13 which was cited at a scope and severity of an E. Findings included: This tag is cross referred to: 1. F323 - Based on record review and staff interview, the facility failed to raise the lift gate up before pushing the resident who was sitting in a wheelchair out of the transport van causing the resident to fall backward for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained a head injury and cervical strain from the fall. The facility was cited F323 during the recertification survey of 2/4/16 at immediate jeopardy level for not securing the resident and the wheelchair in the transportation van during transport causing the resident to have a fall. The facility was cited F323 during the recertification survey of 3/26/15 at immediate jeopardy level for not maintaining the water temperatures at or less than 116 degrees Fahrenheit. 2. F309 - Based on record review and physician and staff interview, the facility failed to have the resident assessed/examined by a qualified person for possible injuries before moving a resident after the fall for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained a head injury and cervical strain from the fall. The facility also failed to treat wounds as ordered for 3 (Residents # 10, #11 and #13) of 3 sampled residents reviewed for wounds. On 9/20/16 at 2:52 PM, the administrator and the	F 490	Friday to determine root cause analysis. Accidents and incidences will be discussed in weekly patient at risk meetings to ensure interventions are appropriate 5. Accidents and incidents will be reviewed during QA meetings to monitor trends and compliance of current practices. A corporate representative will be present or on conference call for these QA meetings to ensure compliance with corrective actions. 7. During QA meeting, areas of identified concern will be addressed by the committee. In turn the staff will be educated during staff meetings on two policies and or procedures identified. Education will be conducted by Administrative staff. The Administrator will oversee the adherence to the education schedule and policy adherence. The Regional Vice President will oversee the Administrator for overall compliance of facility policy and procedures. 1. Resident #9 sacrum treatment was performed per physician order by the wound nurse on 9/21/16. Resident #10 suprapubic catheter treatment was performed per physician order by the wound nurse on 9/22/16. Resident #11 lesion on back treatment was performed per physician order by the wound nurse on 9/22/16. Resident #13 bilateral toes and left heel treatment was performed per physician orders by wound nurse on 9/21/16. Physician was notified on 9/28/16. Residents #9, #10, #11 and #13	

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F 490	Continued From page 48 Director of Nursing (DON) were interviewed. The administrator stated that she started working at the facility as an administrator 2 weeks ago. She stated that she could call her Regional Vice President for any questions. She indicated that a cell phone will be placed in the van permanently for the staff to use in case of emergency. The DON stated that the accident was a human error. On 9/20/16 at 5:00 PM, the Administrator and the DON were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 9/23/16 at 4:14 PM. The credible allegation indicated: On September 10, 2016, resident was being transported to the dialysis center. Upon arrival, the transportation aide was unloading the resident and the resident fell off the back of the 10:10 am. The transportation aide tried to get assistance from the dialysis center to no avail. The transportation aide ensured the resident was safe and transported her to the Emergency room for evaluation 10:35 am. The facility transportation aide was suspended on September 10, 2016 at 12:12 pm permanently from driving the van. Facility transportation was suspended on September 10, 2016 and any resident that still required transportation services was routed to a third party transport company. The full time transportation aide called the third party transport company to set up appointments. The vehicle was inspected on September 12, 2016 for proper working order of the by the servicing agent. The lift on the van was found to be in proper working order. Transportation services were resumed by facility transportation aides on September 13, 2016. The Administrator and or Director of Nursing will in-service all staff on facility's accident/incident	F 490	were not adversely affected. Education was provided to the staff assigned to treatments began on 9/22/16. 2. Licensed Nursing staff were educated on performing treatments per physician□s orders by the Director of Nursing and or Staff Development Coordinator on 9/23/16 and prior to next shift worked. Any new licensed employee will receive this education upon orientation. Every licensed nurse will be observed during treatment round(performing treatment)and skills checklist will be completed by Certified wound care nurse and or supervisor by 11-14-16 or prior to next shift. Every new licensed nurse will be observed during treatment round(performing treatments) and skills checklist will be completed by certified Wound Care nurse and or supervisor. 3. An audit of treatment administration records was performed by the ward clerk on 10/4/16. All incidences of omission was be discussed with the Medical Director on 9/28/16 and was taken to QA meeting on 9/28/16. Any licensed nurse not completing treatments as ordered will receive disciplinary action per policy up to and including termination of employment. 4. Residents with treatments ordered by the physician have the potential to be affected. 5. An audit of treatment administration records will be conducted every day for completeness by the wound nurse and or	

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F 490	Continued From page 49 policy and procedure to include reporting and assessing residents. In-servicing began on September 20, 2016. Any one not in-serviced will be educated prior to the start of their next shift. Staff will seek appropriate medical assessment prior to moving residents who may be at risk for or have an injury, after an incident and or accident. "Regardless of how minor an accident or incident may be, it must be reported to the department supervisor. Employee witnessing an accident or incident involving a resident must report the occurrence to his or her immediate supervisor as soon as possible. " Currently, the facility (nursing administration and department heads) meet daily Monday through Friday in stand up meeting and reviews incidents and accident reports. The facility meets monthly to review in QA meeting any accident and or incidents to monitor trends and compliance of current practices. As of September 22, 2016 at 5:00pm, it has been determined to ensure 100% safety for all residents, in-house transportation has been terminated. All resident transport will be provided by a third party transportation company. The van has been parked and locked up in the facility parking lot. In-servicing began on September 22, 2016. Any one not in-serviced will be educated prior to the start of their next shift. The keys for the van are locked up in the Administrator's office in a locked box. During the QA meeting, areas of identified concern will be addressed by the committee. And in turn the staff will be educated during the staff meetings held by the administrative staff. Education will consist of on one to two policies identified per meeting to educate and set expectations to adhere to these policies. If these policies and procedures are not adhered to,	F 490	the floor nurse for two months. Then the audit will be conducted three times per week for one month, then monthly for eleven months. Results of audits will be discussed by Director of Nursing and or Administrator during monthly QA meetings monthly for twelve consecutive months then periodically to ensure compliance is met. 6. Every month, a representative will be present or on conference call for QA meeting. Every week the incident and accident log will be sent by the Staff Development Coordinator to corporate office for review for six months and monthly thereafter. The corporate office/ regional supervisor and/ or consultants will review and provide collaboration and assistance to ensure processes are being followed according to policy. 1. According to the weekend supervisor, treatments were not performed per physician order for Resident #9, #10, #11 and #13 due to misunderstanding of assigned duties. Resident #9 sacrum treatment was performed per physician order by wound nurse on 9/21/16. Resident #10 suprapubic catheter treatment was performed per physician order by wound nurse on 9/22/16. Resident #11 lesion on back treatment was performed per physician order by wound care nurse on 9/22/16. Resident #13 bilateral toes and left heel treatment was performed per physician order by wound nurse on 9/21/16. Physician was notified on 9/28/16. Education was	

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F 490	Continued From page 50 disciplinary action will take place up to and including termination. The Administrator will oversee the adherence to the education schedule and policy adherence. The Regional Vice President will oversee the Administrator for overall compliance of facility policy and procedures. The credible allegation was verified on 9/23/16 at 5:04 PM by interviewing the staff including the van drivers that they have received in-service on the facility's accident/incident policy and procedure. The in-service records were reviewed and it was started on 9/20/16. Interview with the van drivers revealed that the in house transport was terminated and a third party transportation company would transport all residents for appointments. The transport van was observed parked out of service and the key was locked at the administrator's office. 2. F224 - Based on record review, observation and physician, resident and staff interview, the facility neglected to provide wound treatment as ordered by the physician for 4 (Residents #9, # 10, #11 and #13) of 6 sampled residents reviewed for wound treatment. During an interview on 9/22/16 at 3:06 pm, the Director of Nursing (DON) indicated she was not told that the treatments were not being completed on the weekends. She indicated she had heard murmurs that the nurses had no time to get treatments done. She indicated she felt the nurses were refusing to do the treatments because they had been swamped with staffing issues. 3. F314 - Based on record review, observation, resident and staff interview, the facility failed to treat the pressure ulcers as ordered on weekends for 2 of 3 sampled residents with pressure ulcers	F 490	provided to staff assigned to these treatments began on 9/22/16. 2. Residents with written treatments ordered have the potential to be affected. 3. Licensed nursing staff were educated on performing treatments per physician orders by Director of Nursing and or Staff Development coordinator on 9/23/16 or prior to start of next shift. Any new licensed nurse will receive this education on orientation. Every licensed nurse will be observed during a treatment round(perform treatments) and a skills check sheet will be completed by the certified wound nurse or supervisor by 11-14-16 or prior to next shift. Any new licensed nurse will be observed during treatment round(performing treatments)and a skills check sheet will be completed by certified wound care nurse or supervisor. Staff were hired and orientation began on 10/6/16 and on-going. All current licensed personnel have signed job descriptions by 10/24/16 or prior to next shift and were reviewed by Director of Nursing and or Staff Development Coordinator. Any new licensed personnel will sign job descriptions upon orientation. 4. The Administrator and or Director of Nursing will evaluate staffing needs daily Monday through Friday in clinical meeting and make adjustments as needed. Classified want ad to continue to recruit new employees. 5. In-house employees and continued recruitment and hiring will provide staffing as needed for coverage.	

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F 490	Continued From page 51 (Resident#9 and #13). During an interview on 9/22/16 at 3:06 pm, the Director of Nursing (DON) indicated she was not told that the treatments were not being completed on the weekends. She indicated she had heard murmurs that the nurses had no time to get treatments done. She indicated she felt the nurses were refusing to do the treatments because they had been swamped with staffing issues. 4. F353 - Based on record review, observation, and physician, resident and staff interview, the facility failed to have adequate staff to ensure treatments to pressure ulcers and wounds were provided as ordered for 4 (Residents #9, # 10, #11 and #13) of 6 sampled residents reviewed for pressure ulcers and wounds. During an interview on 9/22/16 at 2:22 PM, Nurse #9, the weekend supervisor, indicated she had reported to the Director of Nursing that the treatments had not been done because of shortage of staff on the weekends. She indicated there wasn't always a nurse to call in for work and she had to take a resident assignment. On 9/22/16 at 3:06 PM, the Director of Nursing (DON) was interviewed. The DON stated that the facility had a full time treatment nurse who was scheduled to provide the treatments Monday through Friday. The weekend supervisor was responsible to provide the treatment on the weekends. She added that she had heard murmurs that the nurses had no time to get wounds done. She indicated she felt the nurses were refusing to do the treatments because the facility had been swamped with staffing issues, three months ago when there were aides and	F 490	6. Staffing will be monitored daily(Monday through Friday to include weekend schedules) by the staffing coordinator and discussed with Director of Nursing and or Administrator in daily (Monday through Friday) clinical meeting. An on-call sheet will be put out the last two weeks of the month for full time nurses to sign up for weekend call duty. Each full time nurse is required to sign up for one weekend. Continued efforts to hire as needed staff to be utilized on on-call schedule. Staffing needs will be presented in QA by Administrator and or Director of Nursing. A representative from corporate will be present or on conference call for QA meetings to provide oversight to ensure compliance with corrective actions.	

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F 490	Continued From page 52 nurses that quit.	F 490		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and physician, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedure and failed to monitor the interventions put into place following the 2/4/16 recertification	F 520	F 520 1. Prior Survey plan of correction was not followed as written. 2. Residents requiring van transportation had the potential to be affected. In-house transport was terminated on 9/22/16. An	11/14/16

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F 520	Continued From page 53 survey. The facility has repeated deficiencies on accidents (F323), and care and services (F309) on the recertification survey of 2/4/16 and on the complaint survey of 9/25/16. The facility had systemic failure to treat pressure sores as ordered by the physician (F314). The continued failure of the facility during the two federal surveys of record and the systemic failure to treat pressure sores as ordered showed a pattern of the facility's inability to sustain an effective QAA program. Immediate Jeopardy (IJ) began on 9/10/16 when Resident #5 fell off the transportation van and the IJ was removed on 9/23/16 at 4:14 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level E (not actual harm with potential for more than minimal harm that is not immediate jeopardy) for Residents' # 9, #10, #11 and #13) and to ensure all staff were in-serviced on the facility's accident/incident policy and procedure. Findings included: This tag is cross referred to: 1. F323 - Based on record review and staff interview, the facility failed to raise the lift gate up before pushing the resident who was sitting in a wheelchair out of the transport van causing the resident to fall backward for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained head injury and cervical strain from the fall During the recertification survey of 2/4/16, the facility was cited F323 for not properly securing the resident and the wheelchair in the transport van, failed to notify the administrator about the incident and failed to complete a root cause analysis of the incident. On 9/20/16 at 2:52 PM, the administrator and the	F 520	independent transportation company provides all resident transportation services. 3. Department heads meet Monday through Friday and review accidents and or incidents and to determine root cause analysis. Incidents and accidents are reviewed weekly in patient at risk meeting to ensure interventions are appropriate. 4. The QA committee meets monthly to review accidents and or incidents to monitor trends and compliance of current practices. 5. Every month, a member of the corporate team will be either on-site or by conference call for QA meeting. Every week the incident and accident log will be sent by the Staff Development Coordinator to corporate office for review for six months and monthly thereafter. The corporate office/ regional supervisor and/ or consultants will review, provide collaboration and assistance to ensure processes are being followed according to policy. 1. Resident #5 was moved prior to an assessment by a medical professional after an accident in which entailed the resident falling out of the facility van and was transferred to emergency room for evaluation and treatment. 2. Residents who require van transportation have the potential to be affected. 3. An audit of residents receiving transportation via facility van was	

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F 520	Continued From page 54 DON were interviewed. The administrator stated that she started working at the facility as an administrator 2 weeks ago. The DON stated that the department heads had been reviewing the incident reports on a daily basis and there were no other residents with the same incident happened in the past. The DON revealed that they had not been monitoring the van drivers before or after the 9/10/16 incident. The Administrator stated that the previous administrator might have done the monitoring for the duration stated on the plan of correction from the last survey. 2. F309 - Based on record review and physician and staff interview, the facility failed to have the resident assessed/examined by a qualified person for possible injuries before moving a resident after the fall for 1 (Resident #5) of 1 sampled resident with a van accident. Resident #5 sustained a head injury and cervical strain from the fall. The facility also failed to treat the wounds as ordered for 3 (Residents # 10, #11 & #13) of 3 sampled residents reviewed for wounds. During the recertification survey of 2/4/16, the facility was cited F309 for not providing psychological interventions for 2 of 2 sampled residents. On 9/20/16 at 2:52 PM, the administrator and the DON were interviewed. The administrator stated that she started working at the facility as an administrator 2 weeks ago. The DON revealed that they had not been monitoring the van drivers before or after the 9/10/16 incident. The Administrator stated that the previous administrator might have done the monitoring for the duration stated on the plan of correction from the last survey.	F 520	conducted on 9/22/16 by Staff Development Coordinator to determine accident or incident occurrence. Only Resident #5 was affected. 4. All staff were educated on the accident and incident policy and procedure on 9/20/16 or prior to their next shift worked. All staff were educated on not moving a resident without an assessment after an accident by the Director of Nursing and or Administrator on 9/20/16 or prior to start of next shift. New employees will be educated upon orientation on these processes. 5. In-house facility transportation was terminated on 9/22/16. An independent company provides transportation services. 1. Resident #9 sacrum treatment was performed per physician order by the wound nurse on 9/22/16. Resident #13 bilateral toes and heel treatment was performed per physician order by the wound nurse on 9/21/16. Resident #9 and #13 did not have any adverse affects. Physician was notified on 9/28/16. Education was provided to nurses assigned to do treatments began on 9/22/16. 2. Licensed Nursing staff were educated on performing treatments per physician□s orders by the Director of Nursing and or Staff Development Coordinator on 9/23/16. All new employees will receive this education upon orientation.	

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F 520	Continued From page 55 On 9/20/16 at 5:00 PM, the Administrator and the DON were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 9/23/16 at 4:14 PM. The credible allegation indicated: The QA committee meets every month and discusses all incidents and accidents. The monitoring tools were in place as per the plan of correction from the prior incident in February 2016. There were no issues regarding transportation. However, in this incident, the accident stemmed from human error. Currently, the facility (nursing administration and department heads) meet daily Monday through Friday in stand up meeting and reviews incidents and accident reports. The QA committee (Administrator, Director of Nursing, Staff Development Coordinator, Social Worker, Dietary Manager, Environmental Services Manager, Medical Director, Activities Supervisor, Maintenance Director, Medical Records and MDS Coordinator) meets monthly to review in QA meeting any accident and or incidents to monitor trends and compliance of current practices. The facility had an emergency QA meeting on 9/20/16 to discuss the four IJ tags listed above to implement measures to ensure the continued safety and well- being of all the residents in the facility. Our current policy and procedures in place were adequate for the safety of residents during transportation. This incident was a result of human error. There is an audible alarm signal in place in the van when improper use of the lift is occurring. This system was operating properly when this incident occurred. Every month the QA meeting minutes will be sent to corporate office for review to provide collaboration on any identified issues.	F 520	3. All licensed nurses will have job descriptions reviewed with Director of Nursing and or Staff Development Coordinator and signed by 10/22/16 or prior to next shift. Job descriptions for licensed nurses will be reviewed with the Director of Nursing and or Staff Development coordinator quarterly for one year and annually thereafter. New licensed nurses will review job description upon orientation and follow quarterly cycle and annually thereafter. 4. An audit of treatment administration records was performed by the ward clerk on 10/4/16. All incidences of omission was discussed with the Medical Director on 9/28/16 and was taken to QA on 10/22/16. 5. Residents with written treatments ordered have the potential to be affected. 6. Every licensed nurse will be observed during treatment round(perform treatment) and a skills checklist will be completed by certified wound care nurse or supervisor by 11-14-16 or prior to next shift. Any new licensed nurse will be observed during a treatment round(perform treatment) and a skills checklist will be completed by the certified wound nurse or supervisor. Random treatment checks will be conducted by the certified wound care nurse or supervisor monthly. An audit of treatment administration records will be conducted every day for completeness by the wound nurse and or floor nurse for two months. Then the audit will be conducted three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWOOD NURSING CENTER	915 PEE DEE ROAD ABERDEEN, NC 28315

(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 520	Continued From page 56 Consultants will provide assistance with these issues identified. Every week the incident and accident log will be sent to corporate office for review for six months and monthly thereafter. The corporate office and consultants will review and provide assistance to ensure the processes are being followed according to policy. A member of the corporate staff will be on-site during the quarterly QA meetings to ensure the facility is following policies. The credible allegation was verified on 9/23/16 at 5:04 PM by interviewing the staff including the van drivers that they have received in-service on the facility ' s accident/incident policy and procedure. The in-service records were reviewed and it was started on 9/20/16. Interview with the van drivers revealed that the in house transport was terminated and a third party transportation company would transport all residents for appointments. The transport van was observed parked out of service and the key was locked at the administrator's office. 3. F314- Based on record review, observation, resident and staff interview, the facility failed to treat the pressure ulcers as ordered on weekends for 2 of 3 sampled residents with pressure ulcers (Resident#9 and #13).	F 520	times per week for one month, then monthly for eleven months. 7. Results of the audits will be discussed by the Director of Nursing and or the Administrator during monthly QA meetings monthly for twelve consecutive months then periodically to ensure compliance is met.	