STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		11/22/18

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

Electronically Signed | 11/16/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family member, and staff interview the facility failed to treat a resident in a dignified manner by not placing a clean shirt on the resident after giving the resident a bed bath for 1 of 3 residents sampled for dignity (Resident #1). The findings included: Resident #1 was admitted to the facility on 04/26/18 with diagnoses that included dementia without behavioral disturbances, atrial fibrillation, anemia, and dysphagia. Review of the comprehensive minimum data set (MDS) dated 09/24/18 revealed that Resident #1 was severely impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member with dressing and was receiving hospice care. An observation was made of Resident #1 on 10/24/18 at 11:15 AM. Resident #1 was resting in bed with eyes closed and would not open them to verbal stimuli. He was cachexic (ill appearing) but appeared comfortable. He was dressed in a blue long sleeve thermal shirt and was covered with a sheet and comforter from the waist down. His family member was visiting at bedside and indicated that Resident #1 had on that same blue long sleeve thermal shirt yesterday when she visited. An observation of Resident #1 was made on	F 550	1. On 10-25 -18, nursing assistant removed shirt and put clean clothes on resident #1. Charge nurse and family member notified of change in clothing. Dirty clothes were sent to laundry. Inadequate staffing along with poor judgment from staff is the process that led to the deficient practice. 2. On 10-25-18, hall nurses on day shift duty conducted room rounds for current residents, to ensure that everyone had on clean clothes, clean linen, recently groomed, and if showered per shower schedule. Each resident was found in good appearance. 3.Education for nursing staff started on 10 -26-18 by Administrator to include Neglect, ADL Care, and maintaining a sanitary and orderly interior. Education was continued by the Director of Nursing on 11-8-2018 regarding resident rights, abuse, neglect, dignity and when to change residents clothing/linen, and dining/serving. Education will be complete by 11-22-18 for current nursing staff. New nursing staff will also receive this in service during orientation. 4. The Director of nursing and/or member of administrative team will randomly select 2 rooms/residents to observe/monitor 2 x week for 1 month, then weekly x 2 months. Observations will be documented on a monitoring tool. In addition,The	

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F 550	Continued From page 2 10/24/18 at 12:58 PM. Resident #1 was resting in bed with his eyes open. He was lethargic and non-verbal. Resident #1 was dressed in a blue long sleeve thermal shirt and was covered with a sheet and comforter from the waist down. An observation of Resident #1 was made on 10/24/18 at 5:50 PM. Resident #1 was resting in bed with his eyes open. He remained lethargic and non-verbal. Resident #1 remained dressed in a blue long sleeve thermal shirt and was covered with a sheet and comforter from the waist down. An observation of Resident #1 was made on 10/25/18 at 9:42 AM. Resident #1 was resting in bed with his eyes open and was non- verbal. Resident #1 remained dressed in a blue long sleeve thermal shirt. His family member was again at bedside and again indicated that Resident #1 now had been dressed in that same shirt for 3 days. The family member stated that Resident #1 was always dressed in khaki pants with a button up shirt and he always put on clean clothes each day. An observation of Resident #1's closet was made on 10/25/18 at 9:49 AM. The closet was full of approximately 10 button up shirts, 2 long sleeve thermal shirts one grey and one green, and 3 pair of pajamas bottoms, and 10 pair of khaki dress pants. An observation of Resident #1 was made on 10/25/18 at 2:50 PM. Resident #1 was resting in bed with his eyes closed and appeared comfortable. He remained dressed in a blue long sleeve thermal sheet and was covered with a sheet and comforter from the waist down.	F 550	Director of nursing and/or licensed nurse will relay the results to Quality Assurance Performance Improvement Committee monthly for 3 months then quarterly for review and further recommendation to sustain compliance.	

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F 550	Continued From page 3 An interview was conducted with Nursing Assistant (NA) #1 on 10/25/18 at 2:54 PM. NA #1 confirmed that she was taking care of Resident #1. She stated that she had given him a very good bed bath earlier in the day and had put deodorant on him and applied a good amount of lotion to his skin. NA #1 confirmed that after she washed Resident #1 she had placed the same shirt back on him. She could not provide any reason why she had not changed the shirt after giving him his bed bath earlier in the day. NA #1 stated it was no problem and she would change the shirt immediately. An interview was conducted with Nurse #1 on 10/25/18 at 3:45 PM. Nurse #1 confirmed that she was responsible for Resident #1. She stated that she expected each resident to be treated in a dignified manner and placed in clean clothes each day or as needed. Nurse #1 stated that after a bed bath or shower was given to the resident they should definitely be placed in clean clothes. An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 5:01 PM. The DON stated that when Resident #1 was able he was up each day and dressed in khaki pants and button up shirt and he never wavered from the that attire. The DON stated that she expected Resident #1 to be placed in clean clothes each day after he was provided a bed bath or shower and more often if the clothes were soiled.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		11/22/18

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F 584	Continued From page 4 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 584	1. On 10-25-18 nursing assistant	

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F 584	Continued From page 5 interview the facility failed to change soiled linens after a bed bath for 1 of 3 residents sampled for clean homelike environment (Resident #1). The findings included: Resident #1 was admitted to the facility on 04/26/18 with diagnoses that included dementia without behavioral disturbances, atrial fibrillation, anemia, and dysphagia. Review of the comprehensive minimum data set (MDS) dated 09/24/18 revealed that Resident #1 was severely impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member with activities of daily living and was receiving hospice care. An observation was made of Resident #1 on 10/24/18 at 11:15 AM. Resident #1 was resting in bed with eyes closed and would not open them to verbal stimuli. He was cachexic (ill appearing) but appeared comfortable. He was dressed in a blue long sleeve thermal shirt and was covered with a sheet and comforter from the waist down. The sheet that was covering Resident #1 was observed to have 2 dime size areas of dried brown substances on them. An observation of Resident #1 was made on 10/24/18 at 12:58 PM. Resident #1 was resting in bed with his eyes open. He was lethargic and non-verbal. Resident #1 was dressed in a blue long sleeve thermal shirt and was covered with a sheet and comforter from the waist down. The sheet that was covering Resident #1 was observed to have 2 dime size areas of dried	F 584	removed soiled linen and replaced with clean linen for resident #1. Inadequate staffing along with poor judgment from staff is the process that led to the deficient practice. 2. On 10-25-18, hall nurses on day shift duty conducted room rounds for current residents, to ensure that everyone had on clean clothes, clean linen, recently groomed, and if showered per shower schedule. Each resident was found in good appearance. 3.Education for nursing staff started on 10 -26-18 by Administrator to include Neglect, ADL Care, and maintaining a sanitary and orderly interior. Education was continued by the Director of Nursing on 11-8-2018 regarding resident rights, abuse, neglect, dignity and when to change residents clothing/linen, and dining/serving. Education will be complete by 11-22-18 for current nursing staff. New nursing staff will also receive this Inservice during orientation. 4. The Director of nursing and/or member of administrative team will randomly select 2 rooms/residents to observe/monitor 2 x week for 1 month, then weekly x 2 months. Observations will be documented on a monitoring tool. In addition,The Director of Nursing will implement the plan of correction. The Director of nursing and/or licensed nurse will relay the results to Quality Assurance Performance Improvement Committee monthly for 3 months then quarterly for review and	

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F 584	Continued From page 6 brown substances on them. An observation of the linen cart that was parked on the unit where Resident #1 resided was made on 10/24/18 at 3:29 PM. The linen cart was observed to fully stocked of clean linen that was in good repair. An observation of Resident #1 was made on 10/24/18 at 5:50 PM. Resident #1 was resting in bed with his eyes open. He remained lethargic and non-verbal. Resident #1 remained dressed in a blue long sleeve thermal shirt and was covered with a sheet and comforter from the waist down. The sheet that was covering Resident #1 was observed to have 2 dime size areas of dried brown substances on them. An observation of Resident #1 was made on 10/25/18 at 9:42 AM. Resident #1 was resting in bed with his eyes open and was non- verbal. Resident #1 remained dressed in a blue long sleeve thermal shirt and was covered with a sheet and comforter. The sheet that was covering Resident #1 was observed to have 2 dime size areas of dried brown substances on them. An observation of the linen cart that was parked on the unit where Resident #1 resided was made on 10/25/18 at 10:47 AM. The linen cart was observed to fully stocked of clean linen that was in good repair. An observation of Resident #1 was made on 10/25/18 at 2:50 PM. Resident #1 was resting in bed with his eyes closed and appeared comfortable. He remained dressed in a blue long sleeve thermal sheet and was covered with a sheet and comforter from the waist down. The	F 584	further recommendation to sustain compliance.	

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F 584	Continued From page 7 sheet that was covering Resident #1 was observed to have 2 dime size areas of dried brown substances on them. An interview was conducted with Nursing Assistant (NA) #2 on10/25/18 at 2:54 PM. NA #2 confirmed that she was taking care of Resident #1 on 10/24/18 and 10/25/18. She stated that linens were changed once a week or with shower or bath days or if soiled. She stated that she had provided Resident #1 with a good bed bath earlier in the day and had applied deodorant and a generous amount of lotion to his skin. NA #2 confirmed that she had not changed Resident #1 ' s sheet after his bed bath and she did not notice the dirty spots that were on the sheets. NA #2 stated "oh I can change them now I did not know they were dirty." An interview was conducted with Nurse #1 on 10/25/18 at 3:45 PM. Nurse #1 stated that linens were expected to be changed on shower/bath days or when soiled. She added if Resident #1 ' s sheets were soiled they should be immediately changed. An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 5:01 PM. The DON stated that she expected the staff to change the linen on shower/bath days or anytime they were soiled. The DON stated if Resident #1 ' s linens were soiled then she would expect the staff to immediately change them.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		11/22/18

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F 600	Continued From page 8 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interview the facility neglected to feed a dependent resident for 1 of 3 residents sampled for activities of daily living (Resident #1). The findings included: Resident #1 was admitted to the facility on 04/26/18 with diagnoses that included dementia without behavioral disturbances, atrial fibrillation, anemia, and dysphagia. Review of the comprehensive minimum data set (MDS) dated 09/24/18 revealed that Resident #1 was severely impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member with eating and was receiving hospice care. Review of a care plan dated 10/02/18 read in part, Resident #1 has an activity of daily living (ADL) deficit related to advanced dementia and received hospice services. The goal read,	F 600	1. On 10-24-18, Dietary manager delivered tray #3 to resident #1 with correct consistency. Nursing assistant assisted and attempted to feed resident which was declined by resident. Inadequate staffing is the process that led to the deficient practice. 2.On 10-24-18, hall nurses on duty checked to ensure residents requiring assistance, received assistance with meals. No other residents were affected by this deficient practice. 3.Education for nursing staff started on 10 -26-18 by Administrator to include Neglect, ADL Care, and maintaining a sanitary and orderly interior. Education was continued by the Director of Nursing on 11-8-2018 regarding resident rights, abuse, neglect, dignity and when to change residents clothing/linen, and dining/serving. Education will be complete by 11-22-18 for current nursing	

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F 600	Continued From page 9 Resident #1 will have care needs met through the review date as evidence by his neat appearance. The interventions included, Resident #1 needed extensive assistance with all intake. Review of Resident #1's Kardex revealed that he required assistance with all intake. An interview was conducted with Resident #1's family member on 10/24/18 at 11:15 AM. The family stated she visited the facility multiple times a day and was very aware of Resident #1's condition. She stated that she did not believe that the staff were consistently feeding Resident #1 because she would come to visit and "several" times have found unopened snacks and meal trays with the cover still over them and food untouched on his bedside table. An observation was made on 10/24/18 at 5:50 PM, Nursing Assistant (NA) #2 was observed to deliver Resident #1 his supper tray. NA #2 placed the tray on Resident #1's bedside table removed the cover and set the tray up. NA #2 was then observed to exit Resident #1's room and return to the meal cart and continued to deliver trays to other residents on the unit. An observation was made of Resident #1 on 10/24/18 at 5:55 PM. The supper tray had been removed from Resident #1's bedside table. An observation was made of Resident #1 on 10/24/18 at 6:04 PM. A dietary staff was observed to deliver another tray to Resident #1 and set it on his bedside table remove the cover and exit the room. A continuous observation was made of Resident	F 600	staff. New nursing staff will also receive this in-service during orientation. 4.The Director of nursing and/or member of administrative team will randomly select 2 rooms/residents to observe/monitor 2 x week for 1 month, then weekly x 2 months. Observations will be documented on a monitoring tool. In addition,The Director of Nursing will implement the plan of correction. The Director of nursing and/or licensed nurse will relay the results to Quality Assurance Performance Improvement Committee monthly for 3 months then quarterly for review and further recommendation to sustain compliance.	

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F 600	Continued From page 10	F 600		

#1 on 10/24/18 from 6:04 PM to 6:20 PM. Resident #1's supper tray remained on his bedside table. The spoon had been placed in the mashed potatoes but had not disturbed the gravy on top of the potatoes. Resident #1 had attempted to reach his glass of tea and spilled it all over the food, tray, and comforter that was covering him. The supper tray remained untouched and at 6:20 PM the staff entered Resident #1's room picked up the supper tray and placed it on the cart and returned the cart to the dietary department. The staff did not offer to assist or feed Resident #1 his supper tray.

An interview was made with NA #2 on 10/24/18 at 6:24 PM and again at 8:00 PM. NA #2 confirmed that she had delivered Resident #1 his supper tray. She also stated that this was her first time working on the unit where Resident #1 resided, and she was very unfamiliar with Resident #1. NA #2 was aware that Resident #1 needed to be assisted with his meals because she had been told by other staff members during report. NA #2 stated that when she delivered the tray to Resident #1 she placed the spoon in Resident #1's hand and he would not do anything, and she realized that food that was on the tray was the wrong consistency, so she returned the tray to the dietary department and they delivered the correct tray to Resident #1. NA #2 stated that when Resident #1 would not do anything with the spoon that she placed in his hand she assumed he did not want it and returned to the hall to deliver and assist the other residents on the unit. NA #2 stated she "stayed in the room a few seconds and he would not accept any food" so she moved on.

An observation was made of Resident #1's supper tray on 10/24/18 at 6:36 PM. The tray was

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F 600	Continued From page 11 on the meal cart in the kitchen waiting to be cleaned off. The plate of food was covered with the tea that Resident #1 spilled when trying to pick up the glass and the spoon remained stuck in the mashed potatoes but again the gravy was not disturbed that was on top of the potatoes. The Administrator was made aware that Resident #1 was not offered or assisted with his supper meal on 10/24/18 at 6:45 PM. An interview was conducted with Nurse #1 on 10/25/18 at 3:45 PM. Nurse #1 confirmed that she was responsible for Resident #1. She stated that she expected each resident that needed assistance to be assisted with their meals. She stated it was unacceptable to not offer and assist Resident #1 with his supper meal. An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 5:01 PM. The DON stated that she found it appalling and did not like that Resident #1 was not offered or assisted his supper meal on 10/24/18. The DON stated that NA #2 should have sat down with Resident #1 and attempted to feed him the correct supper tray and if he refused then she should have reported that to the nurse and documented it in the medical record. She added that she expected if NA #2 delivered the tray to Resident #1 then she should have stayed with him and attempted to feed him his supper. The DON stated that each resident had a Kardex that the NAs could review, and each NA also received report about their residents.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		11/22/18

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F 656	Continued From page 12 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 13 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to implement care plan interventions for feeding a resident (Resident #1) and failed to implement care plan interventions for wound dressing changes (Resident #3) this affected 2 of 3 residents sampled for activities of daily living. The findings included: 1.Resident #1 was admitted to the facility on 04/26/18 with diagnoses that included dementia without behavioral disturbances, atrial fibrillation, anemia, and dysphagia. Review of the comprehensive minimum data set (MDS) dated 09/24/18 revealed that Resident #1 was severely impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member with eating and was receiving hospice care. Review of a care plan dated 10/02/18 read in part, Resident #1 has an activity of daily living (ADL) deficit related to advanced dementia and receives hospice services. The goal read, Resident #1 will have care needs met through the review date as evidence by his neat appearance. The interventions included, Resident #1 needed extensive assistance with all intake. Review of Resident #1's Kardex revealed that he required assistance with all intake.	F 656	1.On 10-24-18, Dietary manager delivered tray #3 to resident #1 with correct consistency. Nursing assistant assisted and attempted to feed resident which was declined by resident. On 10-24-18, the wound nurse removed dressing and assessed to ensure wound was not compromised for resident #3. Medical director and responsible party were notified of incorrect dressing placement for 2 days. The wound nurse assessed the area and applied new correct dressing. Inadequate staffing is the process that led to the deficient practice. 2. On 10-24-18, the hall nurses on duty checked to ensure residents requiring assistance, received assistance with meals. No other residents were affected by this deficient practice. On 10-24-18, the wound care nurse completed head to toe assessments on all residents with wounds. No other residents were noted to be affected. 3.Education for nursing staff started on 10 -26-18 by Administrator to include Neglect, ADL Care, and maintaining a sanitary and orderly interior. Education was continued by the Director of Nursing on 11-8-2018 regarding resident rights, abuse, neglect, dignity and when to change resident□s clothing/linen, and dining/serving. Staff was also in serviced	

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F 656	Continued From page 14 An observation was made on 10/24/18 at 5:50 PM, Nursing Assistant (NA) #2 was observed to deliver Resident #1 his supper tray. NA #1 placed the tray on Resident #1's bedside table removed the cover and set the tray up. NA #1 was then observed to exit Resident #1's room without assisting him with the meal. A continuous observation was made of Resident #1 on 10/24/18 from 6:04 PM to 6:20 PM. Resident #1's supper tray remained on his bedside table. The supper tray remained untouched and at 6:20 PM the staff entered Resident #1's room picked up the supper tray and placed it on the cart and returned the cart to the dietary department. The staff did not offer to assist or feed Resident #1 his supper tray. An interview was made with NA #2 on 10/24/18 at 6:24 PM and again at 8:00 PM. NA #2 confirmed that she had delivered Resident #1 his supper tray. NA #2 stated that when she delivered the tray to Resident #1 she placed the spoon in Resident #1's hand and he would not do anything, she assumed he did not want it and returned to the hall to deliver and assist the other residents on the unit, without assisting Resident #1 with his meal tray. NA #2 confirmed that she was aware Resident #1 needed assistance with his meals because she had been told that by the other staff. An interview was conducted with the MDS Nurse on 10/25/18 at 3:04 PM. The MDS Nurse stated that she was responsible for initiating and updating Resident #1's care plan. She added that the NA ' s are expected to review and follow the Kardex each shift they work. Resident #1 was care planned to need assistance with all intake and the nursing staff were expected to follow that	F 656	on 08-13-2018 regarding Kardex information and re-educated on 11-8-2018.Education will be complete by 11-22-18 for current nursing staff. New nursing staff will also receive this in-service during orientation to include kardex information and care plans. 4. The Director of nursing and/or member of administrative team will conduct random care plan and Kardex reviews on 2 residents 2 x a week for 1 month and then 2 residents weekly x 2 months. Observations will be documented on a monitoring tool. In addition, The Director of Nursing will implement the plan of correction. The Director of nursing and/or licensed nurse will relay the results to Quality Assurance Performance Improvement Committee monthly for 3 months then quarterly for review and further recommendation to sustain compliance.	

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Kardex and plan of care.

An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 5:01 PM. The DON stated that she found it appalling and did not like that Resident #1 was not offered or assisted his supper meal on 10/24/18. The DON stated that NA #2 should have followed the Kardex and care plan for Resident #1 and assisted him with his intake.

2. Resident #3 was admitted to the facility on 01/31/17 with diagnoses that included dementia, hypertension, anxiety, mood affective disorder, osteoporosis, and major depressive disorder.

Review of the quarterly minimum data set (MDS) dated 07/23/18 revealed that Resident #3 was moderately impaired for daily decision making and had no behaviors during the reference period. The MDS further stated that Resident #3 required extensive assistance with activities of daily living and indicated that she had no pressure ulcers.

Review of a care plan updated on 10/09/18 read in part, Resident #3 has the potential for pressure ulcer development related to needing assistance with mobility, incontinence, and poor intake. The goal read, Resident #1 would be free from any sign or symptoms of infection related to altered skin integrity and be free from any further pressure related skin issues. The interventions included: administer treatments as ordered and monitor for effectiveness.

Review of a physician order dated 10/11/18 read in part, cleanse right outer ankle wound with wound cleanser, pat dry, apply Santyl (type of

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ointment) and cover with foam dressing every day and as needed.

Review of the treatment administration record (TAR) dated 10/01/18 through 10/31/18 revealed that on 10/22/18 and 10/23/18 there were no initials indicating the daily treatment to Resident #3's right outer ankle had not been completed.

An interview was conducted with Nurse #1 on 10/24/18 at 6:00 PM. Nurse #1 confirmed that she was the nurse that was responsible for Resident #3 on 10/23/18. She stated that she did not complete the wound dressing to Resident #3's right outer ankle because there was a lot going on and she did not have time to complete the dressing change. She stated she was the only nurse on the units that day and there was just not enough time to do everything she needed to do.

An interview was conducted with Nurse #3 on10/24/18 at 6:06 PM. Nurse #3 confirmed that she was responsible for Resident #3 on 10/22/18 and indicated that she was the only nurse on the units that day. Nurse #3 stated that she had not completed the dressing change to Resident #3's right outer ankle because she did not have time. Nurse #3 stated that when she was the only nurse on the units it was very hard to get everything completed and she had 2 readmissions that she had to work on in addition to her other duties and she just did have time to complete the dressing change as ordered.

An interview was conducted with the MDS Nurse on 10/25/18 at 3:04 PM. The MDS Nurse stated that she was responsible for initiating and updating Resident #3's care plan. She added that the Nurses are expected to review and follow the

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F 656	Continued From page 17 care plan each shift they work. Resident #3 was care planned for wound care and the nurses should follow the care plan and provide the treatment as ordered. An interview was conducted with the DON on 10/25/18 at 5:01 PM. The DON stated that the Nurses were expected to follow the Resident #3 plan of care and provide wound care as ordered.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interview the facility failed to feed a dependent resident (Resident #1) and failed to provide showers as scheduled (Resident #4 and #8) this affected 3 of 3 residents sampled for activities of daily living. The findings included: 1.Resident #1 was admitted to the facility on 04/26/18 with diagnoses that included dementia without behavioral disturbances, atrial fibrillation, anemia, and dysphagia. Review of the comprehensive minimum data set (MDS) dated 09/24/18 revealed that Resident #1 was severely impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #1 required extensive assistance of 1 staff member with	F 677	1. On 10-24-18, Dietary manager delivered tray #3 to resident #1 with correct consistency. Nursing assistant assisted and attempted to feed resident which was declined by resident. On 10-25-18, residents #4 and #8 received showers. Inadequate staffing is the process that led to the deficient practice. 2. On 10-24-18, the hall nurses on duty checked to ensure residents requiring assistance, received assistance with meals. No other residents were affected by this deficient practice. On 10-25-18, hall nurses on day shift duty conducted room rounds for current residents, to ensure that everyone had on clean clothes, clean linen, recently groomed, and if showered per shower	11/22/18

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F 677	Continued From page 18 eating and was receiving hospice care. Review of a care plan dated 10/02/18 read in part, Resident #1 has an activity of daily living (ADL) deficit related to advanced dementia and receives hospice services. The goal read, Resident #1 will have care needs met through the review date as evidence by his neat appearance. The interventions included, Resident #1 needed extensive assistance with all intake. An interview was conducted with Resident #1's family member on 10/24/18 at 11:15 AM. The family stated she visited the facility multiple times a day and was very aware of Resident #1's condition. She stated that she did not believe that the staff were consistently feeding Resident #1 because she would come to visit and would find unopened snacks and meal trays with the cover still over them and food untouched on his bedside table. An observation was made on 10/24/18 at 5:50 PM, Nursing Assistant (NA) #2 was observed to deliver Resident #1 his supper tray. NA #1 placed the tray on Resident #1's bedside table removed the cover and set the tray up. NA #1 was then observed to exit Resident #1's room and return to the meal cart and continued to deliver trays to other residents on the unit. An observation was made of Resident #1 on 10/24/18 at 5:55 PM. The supper tray had been removed from Resident #1's bedside table. An observation was made of Resident #1 on 10/24/18 at 6:04 PM. A dietary staff was observed to deliver another tray to Resident #1 and set it on his bedside table remove the cover and exit the	F 677	schedule. Each resident was found in good appearance Staff was in serviced starting on 11-8-2018 by Director of Nursing regarding shower schedules and skin assessment sheets. 3.Education will be complete by 11-22-18 for current nursing staff. New staff will receive this in-service during orientation. Education will cover when resident showers and skin assessments. 4.The Director of nursing and/or member of administrative team will randomly select 2 rooms/residents to observe/monitor 2 x week for 1 month, then weekly x 2 months. Observations will be documented on a monitoring tool. In addition, The Director of Nursing will implement the plan of correction. The Director of nursing and/or licensed nurse will relay the results to Quality Assurance Performance Improvement Committee monthly for 3 months then quarterly for review and further recommendation to sustain compliance.	

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room.

A continuous observation was made of Resident #1 on 10/24/18 from 6:04 PM to 6:20 PM. Resident #1's supper tray remained on his bedside table. The spoon had been placed in the mashed potatoes but had not disturbed the gravy on top of the potatoes. Resident #1 had attempted to reach his glass of tea and spilled it all over the food, tray, and comforter that was covering him. The supper tray remained untouched and at 6:20 PM the staff entered Resident #1's room picked up the supper tray and placed it on the cart and returned the cart to the dietary department. The staff did not offer to assist or feed Resident #1 his supper tray.

An interview was made with NA #2 on 10/24/18 at 6:24 PM and again at 8:00 PM. NA #2 confirmed that she had delivered Resident #1 his supper tray. She also stated that this was her first time working on the unit where Resident #1 resided and she was very unfamiliar with Resident #1. NA #2 stated that when she delivered the tray to Resident #1 she placed the spoon in Resident #1's hand and he would not do anything, and she realized that food that was on the tray was the wrong consistency, so she returned the tray to the dietary department and they delivered the correct tray to Resident #1. NA #2 stated that when Resident #1 would not do anything with the spoon that she placed in his hand she assumed he did not want it and returned to the hall to deliver and assist the other residents on the unit. NA #2 stated she "stayed in the room a few seconds and he would not accept any food" so she moved on.

An observation was made of Resident #1's supper tray on 10/24/18 at 6:36 PM. The tray was

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on the meal cart in the kitchen waiting to be cleaned off. The plate of food was covered with the tea that Resident #1 spilled when trying to pick up the glass and the spoon remained stuck in the mashed potatoes but again the gravy was not disturbed that was on top of the potatoes.

The Administrator was made aware that Resident #1 was not offered or assisted with his supper meal on 10/24/18 at 6:45 PM.

An interview was conducted with Nurse #1 on 10/25/18 at 3:45 PM. Nurse #1 confirmed that she was responsible for Resident #1. She stated that she expected each resident that needed assistance to be assisted with their meals. She stated it was unacceptable to not offer and assist Resident #1 with his supper meal.

An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 5:01 PM. The DON stated that she found it appalling and did not like that Resident #1 was not offered or assisted his supper meal on 10/24/18. The DON stated that NA #2 should have sat down with Resident #1 and attempted to feed him the correct supper tray and if he refused then she should have reported that to the nurse and documented it in the medical record. She added that she expected if NA #2 delivered the tray to Resident #1 then she should have stayed with him and attempted to feed him his supper.

2. Resident #4 was admitted to the facility on 01/15/15 with diagnoses that included Parkinson's disease, dementia with Lewy body (form a dementia), mood affective disorder, major depressive disorder, hypertension, chronic kidney disease, and others.

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Review of the quarterly minimum data set (MDS) dated 09/03/18 revealed that Resident #4 was severely impaired for daily decision making and had long and short-term memory problems. The MDS also revealed that Resident #4 required total assistance of one staff member with bathing and had no rejection of care during the assessment reference period.

Review of the shower schedule for Resident #4 revealed that her scheduled shower days were Monday and Thursday on 1st shift.

Review of the facility's shower sheets for Resident #4 from 10/01/18 through 10/25/18 revealed the following:
10/01/18: No shower
10/02/18: Received a shower
10/04/18: Received a shower
10/08/18: No shower
10/11/18: Received a shower
10/15/18: No shower
10/18/18: Received a shower
10/22/18: No shower
10/25/18: Received a shower

An observation was made of Resident #4 on 10/24/18 at 12:30 PM. Resident #4 was resting in bed with eyes open and was alert. Resident #4 was noted to have a slight body odor to her. Resident #4's family member was at bedside and had just provided incontinent care to her.

An interview was conducted with Resident #4's family member on 10/24/18 at 12:44 PM. The family member stated that she visited the facility every day and most days multiple times during the day. She added that Resident #4 was

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scheduled to get a shower on Monday and Thursday on 1st shift and that was fine with her if she got those scheduled showers. The family member stated that Resident #4 was not consistently receiving her showers. The family member stated she has asked the staff to please take Resident #4 to the shower and just wash her real good and then return her to the bed and she would provide the rest of the personal care she needed so the staff could move on to the next resident but that was not happening either. The family member added that Resident #4 had not received her shower on Monday 10/22/18 so it had been a week and that was why she had the slight body odor to her. The family member stated she had asked the staff to please make sure that Resident #4 received her shower that was scheduled on 10/25/18.

An interview was conducted with Nursing Assistant (NA) #3 on 10/25/18 at 3:26 PM. NA #3 stated that the shower scheduled was kept in a book at the nurse's station and each day she worked she would check the schedule to see which residents were scheduled for a shower on that day. NA #3 confirmed that she was taking care of Resident #4 on 10/08/18, 10/15/18, and 10/22/18 and confirmed that she had not showered Resident #4 because they were short staffed, and she did not have the time to do so. NA #3 stated that she reported to the nurse on the hall which she could not recall which nurse that she was unable to complete Resident #4's shower on those days. NA #3 stated that if she was unable to take Resident #4 to the shower she did try to give her a good bed bath but sometimes that was not possible.

An interview was conducted with Nurse #1 on

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10/25/18 at 3:45 PM. Nurse #3 stated that she did recall the NAs reporting to her that showers were not being completed but could not recall which specific residents. She added that when the NAs reported to her that they were unable to complete showers she would ask the next shift to complete them, but she was not sure if that was happening or not.

An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 5:01 PM. The DON stated that when she arrived at the facility a few months ago she quickly realized that showers were not being done and she had implemented the shower sheets and the nurses must sign off on the shower sheet after the shower had been completed. The DON stated that she was now holding both the NAs and the Nurses accountable when showers were not being completed as scheduled. She added that they have incorporated preferences into the shower schedule, so each resident was receiving what they wanted on the days that they wanted them. The DON further stated that she fully expected the staff to complete the showers for each resident as they were scheduled and to document the shower on the shower sheet and have the nurses sign off on them.

3. Resident #8 was readmitted to the facility on 02/14/18 with diagnoses that included dementia, heart failure, muscle weakness, and chronic pain.

Review of the quarterly Minimum Data Set (MDS) dated 07/23/18 revealed Resident #8 had moderate impairment in cognition and required extensive staff assistance with bathing. Further review revealed he displayed no rejection of care during the 7-day assessment period.

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Review of Resident #8's care plans, last revised on 05/18/18, revealed a plan in place to address his need for assistance with activities of daily living due to a self-care performance deficit related to dementia. Interventions included for staff to provide Resident #8 with extensive assistance with bathing/showering and use Selsun blue shampoo to wash his hair on shower days.

Review of the facility's bathing sheets for the period 09/05/18 to 10/25/18 revealed Resident #8 received 6 out of 16 scheduled showers on 09/05/18, 09/17/18, 09/27/18, 10/01/18, 10/15/18, and 10/18/18.

On 10/25/18 at 10:12 AM Resident #8's Family Member (FM) voiced concerns he was not receiving his showers as scheduled. The FM explained Resident #8 was supposed to receive 2 showers per week on Monday and Thursday but had not received one in over a week.

On 10/25/18 at 11:30 AM Resident #8 was observed up in his wheelchair sitting in the main dining room with a disheveled appearance and slight body odor.

An interview with Nurse Aide (NA) #3 on 10/25/18 at 3:26 PM revealed the shower schedule was kept in a book at the nurse's station and each day she worked she would check the schedule to see which residents were scheduled for a shower. NA #3 confirmed she provided care to Resident #8 and if she was not able to provide him with a shower on his scheduled day it was because they were short staffed and she did not have the time to do so. NA #3 stated she reported to the nurse on the hall when she was unable to provide

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F 677	Continued From page 25 Resident #8 with shower on those days. NA #8 added when she was unable to take Resident #8 to the shower she did try to give him a bed bath but sometimes that was not possible. An interview was conducted with Nurse #1 on 10/25/18 at 3:45 PM. Nurse #3 stated that she did recall the NAs reporting to her that showers were not being completed but could not recall which specific residents. She added when the NAs reported to her that they were unable to complete showers she would ask the next shift to complete them, but she was not sure if that was happening or not. An interview was conducted with the Director of Nursing (DON) on 10/25/18 at 5:01 PM. The DON stated when she arrived at the facility a few months ago she quickly realized that showers were not being done and she had implemented the shower sheets and the nurses must sign off on the shower sheet after the shower had been completed. The DON stated she was now holding both the NAs and the Nurses accountable when showers were not being completed as scheduled. She added they have incorporated preferences into the shower schedule, so each resident was receiving what they wanted on the days that they wanted them. The DON further stated that she fully expected the staff to complete the showers for each resident as they were scheduled and to document the shower on the shower sheet and have the nurses sign off on them.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		11/22/18

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F 686	Continued From page 26 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to apply the correct treatment to a pressure ulcer and failed to complete the pressure ulcer treatment as ordered (Resident #3) and failed to replace a dressing to a pressure ulcer when the dressing became dislodged (Resident #2) this affected 2 of 3 residents sampled for pressure ulcers. The findings included: 1.Resident #3 was admitted to the facility on 01/31/17 with diagnoses that included dementia, hypertension, anxiety, mood affective disorder, osteoporosis, and major depressive disorder. Review of the quarterly minimum data set (MDS) dated 07/23/18 revealed that Resident #3 was moderately impaired for daily decision making and had no behaviors during the reference period. The MDS further stated that Resident #3 required extensive assistance with activities of daily living and indicated that she had no pressure ulcers.	F 686	1.The dressing was removed from resident #3 10/24/18 by the wound nurse and assessment was completed to ensure wound was not compromised and it was found to not be. A new dressing was replaced. The MD and responsible party were notified. Resident #2 wound was assessed by the nurse and a dressing was applied. Inadequate staffing and nursing misinterpretation of treatment orders are the processes that led to the deficient practice. 2. The Wound nurse completed head to toe assessments on all residents with wounds to ensure they were not affected 10-24-18 during wound rounds and no other residents were noted to be affected. Nurse #2 was given hands on re-training by wound nurse on 11-1-2018. Training consisted of reading orders correctly to ensure correct treatments are in place and return demonstration of dressing changes.	

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F 686	Continued From page 27 Review a physician order dated 10/09/18 read in part, cleanse right buttock with wound cleanser, pat dry, and apply hydrocolloid (type of dressing) every 3 days and as needed. Review of a physician order dated 10/11/18 read in part, cleanse right outer ankle wound with wound cleanser, pat dry, apply Santyl (type of ointment) and cover with foam dressing every day and as needed. Review of the facility ' s wound log dated 10/13/18 revealed that Resident #3 developed a Stage 2 pressure ulcer to her right buttock on 10/09/18 and a Stage 3 pressure ulcer to her right outer ankle on 10/11/18. Review of the treatment administration record (TAR) dated 10/01/18 through 10/31/18 revealed that on 10/21/18 the treatment to Resident #3 ' s right buttock and right outer ankle were completed by Nurse #2. The TAR further revealed that on 10/22/18 and 10/23/18 there were no initials indicating the daily treatment to Resident #3 ' s right outer ankle had not been completed. An observation was made of Resident #3 ' s wound care on 10/24/18 at 12:23 PM. The Wound Nurse (WN) washed her hands and removed the old dressing from Resident #3 ' s right buttock and after changing her gloves cleaned the wound with wound cleanser, patted it dry and applied a hydrocolloid dressing as ordered. The wound appeared to be healed and the skin was intact and the WN indicated she would replace the dressing for protection to the area. The WN then washed her hands and began the treatment to Resident #3 ' s right outer ankle, the dressing that was in place was dated	F 686	3.In-services for licensed staff were started on 11-8-2018 by DON. The education provided was on accountability of nurses, to ensure all wounds are addressed even while wound nurse is in the building, and to complete all treatment administration records prior to end of shift. Nurses were educated on conducting weekly skin assessments and the process for notification of Medical Director, and family if impairment is observed. Education will continue until each current nurse receives. Education will be complete by 11-22-18 for current nursing staff. New nursing staff employees will receive in-service material during orientation. Education was provided to nursing assistants by Director of Nursing on 08/2018 and re-education was given on 11-8-2018. Education included turning and repositioning as directed by care plans and observation of skin during daily care, reporting any skin issues to nurses via shower sheets. Education will be complete by 11-22-18 for current nursing staff. A posting for a full-time wound nurse has been posted on a job site as of 11-15-18 by the Human Resources Director. Vohra wound care Physician company contacted on 11-2-18 by the Administrator to facilitate a contract for evaluating, and treating resident wounds as indicated. Until contract is in place, specific wound care concerns will be sent out to be seen by Carolina wound Clinic. 4.The night shift nurse will audit treatment	

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F 686	Continued From page 28 10/21/18 and contained no staff initials. The WN removed the dressing and discovered that the dressing that was in place was calcium alginate which was not the ordered treatment. Th WN again changed her gloves and cleaned the right outer ankle with wound cleanser, patted the wound dry, and applied Santyl and covered the area with a foam dressing as ordered. An interview was conducted with Nurse #2 on 10/24/18 at 5:30 PM. Nurse #2 confirmed that she was the nurse that changed the dressing to Resident #3 ' s right outer ankle on 10/21/18 and recalled placing calcium alginate and a foam dressing. Nurse #2 stated that she may have mis read the order but that it was an error on her part and she should have applied the Santyl as ordered. Nurse #2 stated that she was new to the wound position on the weekends and was still learning and she would have to double check her orders now to make sure she was applying the correct treatment to the correct wound. An interview was conducted with Nurse #1 on 10/24/18 at 6:00 PM. Nurse #1 confirmed that she was the nurse that was responsible for Resident #3 on 10/23/18. She stated that she did not complete the wound dressing to Resident #3 ' s right outer ankle because there was a lot going on and she did not have time to complete the dressing change. She indicated that on 10/23/18 she had a resident that fell, blood work that had to be drawn, and intravenous antibiotic that needed to be administered and she just did not have time to complete the dressing. She stated she was the only nurse on the units that day and there was just not enough time to do everything she needed to do.	F 686	administration records for 2 residents 2 nights per week for 2 months then weekly for 1 month to determine compliance and turn into DON. The Director of nursing and/or licensed nurse will randomly audit 2 resident□s nursing documentation of wound care, and conduct wound rounds with wound nurse on those 2 residents per week x 2 months and then weekly x 1 month. Impairments will be addressed immediately according to treatment plan. Observations will be documented on a monitoring tool. The Director of nursing will implement the Plan of Correction. The Director of nursing and/or licensed nurse will relay the results to Quality assurance Performance improvement committee monthly for 3 months for review and further recommendation to sustain compliance.	

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An interview was conducted with Nurse #3 on10/24/18 at 6:06 PM. Nurse #3 confirmed that she was responsible for Resident #3 on 10/22/18 and indicated that she was the only nurse on the units that day. Nurse #3 stated that she had not completed the dressing change to Resident #3 ' s right outer ankle because she did not have time. Nurse #3 stated that when she was the only nurse on the units it was very hard to get everything completed and she had 2 readmissions that she had to work on in addition to her other duties and she just did have time to complete the dressing change as ordered.

An interview was conducted with the WN on 10/25/18 at 2:00 PM. The WN stated that she worked part time at the facility and worked Tuesday, Wednesday, and Thursday as the wound nurse. She stated that she measured the wounds weekly and performed the treatments on the days that she was in the facility. The WN indicated that if she was pulled to work the medication cart then the wound treatments would be the responsibility of the hall nurse. She indicated that she was pulled to the medication cart a lot, 1-2 days per week and that limited what she was able to do in regard to healing wounds. The WN stated that she had trouble getting the nurses to complete their treatments and she had done lots of in-services to the staff about the importance of completing the treatments as ordered. She added that a lot of times when she would come to work on Tuesday the wounds would have no dressing over them or the dressing would be dated the week prior when she completed them. She added that she has reported this to the Director of Nursing (DON) and they were now going to starting disciplinary action on the staff that did not completed their

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dressing changes as ordered. The WN stated that on 10/23/18 she was supposed to be completing the dressing changes, but she was pulled to the medication cart, so each hall nurse was responsible for completing their dressing changes.

An interview was conducted with the DON on 10/25/18 at 5:01 PM. The DON stated that if the WN was not working or was pulled to the medication cart the hall nurses were expected to complete the wound dressings as ordered. She added that what she discovered since she has been at the facility was that the hall nurses were not knowledgeable about wounds, so they just differed them to the WN and were not completing the treatments as ordered. The DON stated that she was aware that the treatments had not been completed for the last 2 days and she was holding those staff members accountable. The DON stated that she expected the staff to complete the wound treatments as ordered.

2.Resident #2 was readmitted to the facility on 07/19/17 with diagnoses that included diabetes, kidney injury, dysphagia, insomnia, and hypertension.

Review of the quarterly minimum data set (MDS) dated 10/01/18 revealed that Resident #2 was cognitively intact and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #2 had no pressure ulcers.

Review of a physician order dated 10/08/18 read in part, clean left buttock open area with wound cleanser, pat dry, apply calcium alginate (type of dressing), cover with a foam dressing every 2

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days and as needed.

An observation of wound care for Resident #2 was made on 10/24/18 at 11:57 AM. The Wound Nurse (WN) washed her hands and went to remove the old dressing but there was no dressing covering the wound to Resident #2 ' s left buttock wound. The WN cleaned the open area with wound cleanser, patted the wound dry and applied the calcium alginate and covered it with foam dressing. The dressing was dated and signed by the WN. The WN added that "this happens all the time, that this wound had no dressing over it."

An interview with Resident #2 was made on 10/24/18 at 12:05 PM. Resident #2 stated that if the dressing came off sometimes the staff would replace it and sometimes they would not. She stated that she always told the WN if was working that it needed to be replaced but if she was not working then a lot of times the dressing did not get replaced until the WN returned to work.

An interview was conducted with Nurse #4 on 10/24/18 12:16 PM. Nurse #4 confirmed that she was responsible for Resident #2 on 10/24/18 and she was not aware that her left buttock dressing had come off. She stated that none of the staff had reported to her that it needed to be replaces or she would have gone and replaced the dressing. Nurse #4 stated that she would have wanted to know that the dressing was off, so she could protect the wound from further breakdown.

An interview was conducted with Nursing Assistant (NA) #4 on 10/24/18 at 3:53 PM. NA #4 confirmed that she had taken care of Resident #2 on 10/24/18 and stated that when she toileted

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Resident #2 between 8:00 AM and 9:00 AM the dressing was intact to her buttock but she stated it may have come off in the toilet or in her brief but she "really did not pay attention." NA #4 stated that the nurse on the hall or the WN change her dressing so if the dressing was gone they would just replace it, she confirmed that she had not reported to Nurse #4 that the dressing had come off or that it needed to be replaced.

An interview was conducted with the WN on 10/25/18 at 2:00 PM. The WN stated that she worked part time at the facility and worked Tuesday, Wednesday, and Thursday as the wound nurse. She stated that she measured the wounds weekly and performed the treatments on the days that she was in the facility. The WN indicated that if she was pulled to work the medication cart then the wound treatments would be the responsibility of the hall nurse. She indicated that she was pulled to the medication cart a lot, 1-2 days per week and that limited what she was able to do in regard to healing wounds. The WN stated that she had trouble getting the nurses to complete their treatments and she had done lots of in-services to the staff about the importance of completing the treatments as ordered. She added that a lot of times when she would come to work on Tuesday the wounds would have no dressing over them or the dressing would be dated the week prior when she completed them. She added that she has reported this to the Director of Nursing (DON) and they were now going to starting disciplinary action on the staff that did not completed their dressing changes as ordered. The WN stated that on 10/23/18 she was supposed to be completing the dressing changes, but she was pulled to the medication cart, so each hall nurse

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F 686	Continued From page 33 was responsible for completing their dressing changes. She added that if the dressing came off the hall nurses need to place a protective covering over the wound until she could get to the wound to prevent further breakdown. An interview was conducted with the DON on 10/25/18 at 5:01 PM. The DON stated that if the WN was not working or was pulled to the medication cart the hall nurses were expected to complete the wound dressings as ordered. She added that what she discovered since she has been at the facility was that the hall nurses were not knowledgeable about wounds, so they just differed them to the WN and were not completing the treatments as ordered. The DON stated that if the dressing came off the hall nurse should place a protective dressing over the wound until the WN could get to it or just go ahead and provide the ordered treatment but it was not acceptable to leave a wound uncovered.	F 686		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		11/22/18

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F 725	Continued From page 34 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to provide sufficient nursing staff to ensure residents received assistance with meals, bathing and wound care/treatments. This affected 5 of 8 sampled residents (Residents #1, #2, #3, #4, and #8). Findings included: This tag is cross-referenced to: 1. 483.12 (F600): Based on observations, record review, family, and staff interview the facility neglected to feed a dependent resident for 1 of 3 residents sampled for activities of daily living (Resident #1). 2. 483.24 (F677): Based on observations, record review, family, and staff interview the facility failed to feed a dependent resident (Resident #1) and failed to provide showers as scheduled (Resident #4 and #8) this affected 3 of 3 residents sampled	F 725	1. Current residents identified in the 2567 were addressed related to each specific citation. Resident #1 received tray #3 and staff attempted to feed but resident declined. Resident #2- dressing was assessed and reapplied by wound nurse on 10-24-18. Resident #3 □wound nurse removed dressing, assessed area and placed correct dressing on 10-24-18. Residents #4 & #8 □both residents received showers on 10-25-18. Inadequate staffing is the process that led to the deficient practice. 2. Affected residents associated with each deficient practice were addressed, and no others were found to be affected. 3.A bonus structure for current staff was developed by the Administrator and Director of Nursing (in addition to required overtime) to fill shifts on the schedule until new staff is hired and trained. A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 35 for activities of daily living. 3. 483.25 (F686): Based on observations, record review, and staff interview the facility failed to apply the correct treatment to a pressure ulcer and failed to complete the pressure ulcer treatment as ordered (Resident #3) and failed to replace a dressing to a pressure ulcer when the dressing became dislodged (Resident #2) this affected 2 of 3 residents sampled for pressure ulcers. During an interview on 10/25/18 at 11:45 AM Nurse Aide (NA) #5 indicated she had only been employed for less than a week and they had worked short-staffed that entire time with only 3 to 4 NAs scheduled to provide resident care. NA #5 stated she often felt rushed and it wasn't always possible to get resident care provided as often as needed such as incontinence care or showers. During an interview on 01/25/18 at 1:52 PM the Wound Nurse (WN) stated staffing had been an issue since she started her employment and was often was pulled to work as a hall nurse instead of providing wound care for residents. She added when she was not scheduled to work or was pulled to cover a medication cart, it was not uncommon for wound treatments or dressing changes to not get done. During an interview on 10/25/18 at 5:01 PM the Director of Nursing (DON) confirmed she was responsible for the scheduling of staff. The DON acknowledged staffing was challenged due to not	F 725	mentorship program was developed by the administrator and Director of nursing to increase retention of new staff members. The staff was notified on 11-8-18 of these new incentives by the Director of Nursing and the programs started on 11-8-18. The facility continues to advertise for current open positions. Open positions are currently posted on Indeed. 4. The Director of Nursing and/or Administrator will monitor the nursing schedule a minimum of 3 times a week x 1 month, to ensure sufficient staffing is in place and will notify the staffing coordinator if additional assistance is needed. The Administrator/Director of Nursing/Human Resource Director will communicate needs to place additional ads for any open positions needed in the future. Observations will be documented on a monitoring tool. The Director of Nursing will implement the Plan of Correction. The Director of Nursing and/or Human resource Director will relay the status of current open positions to the Quality Assurance Improvement Committee monthly x 3 months for review and further recommendation to sustain compliance.	

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F 725	Continued From page 36 having enough staff and as a result, she was pulled to cover a medication cart on various shifts at least 3 to 4 days per week. She added they recently filled all available positions on the night shift (7:00 PM to 7:00 AM), hired a nurse for the day shift (7:00 AM to 7:00 PM) who would be starting orientation and planned to continue with the hiring process until all open positions were filled.	F 725		