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	345357	A. BUILDING _____ B. WING _____	C 11/13/2020

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 11/09/13 through 11/13/20. Event ID# Y03Y11 One of the 4 complaint allegations was substantiated but did not result in a deficiency. Two of the 4 complaint allegations were substantiated resulting in deficiencies F584, F686, F810, and F880 . One of the 4 complaint allegations was not substantiated.	F 000		
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 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,	F 584		12/18/20

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

Electronically Signed | 11/30/2020

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F 584	Continued From page 1 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 and staff interviews, the facility failed to provide clean privacy curtains for 2 of 2 residents reviewed for a safe, clean, comfortable, and homelike environment (Resident #1 and Resident #4). 1. Resident #1 was admitted on 5/09/17. Resident #1's Minimum Data Set Assessment, dated 7/06/20, revealed she had severe cognitive impairment. An observation of the privacy curtain in Resident #1's room on 11/10/20 at 10:41 AM revealed about 10 different dirty spots of varied size from pencil eraser to nickel size. The spots were tan and brown in color. There was also a smear of dried debris, which appeared yellowish in color.	F 584	Resident #1 & Resident # 4 had their privacy curtain replaced. An audit of current resident□s privacy curtains was completed to ensure that they were clean and free of stains and debris. Any identified privacy curtains with stains were replaced at that time. Housekeeping staff were re-educated by the Housekeeping Director/Designee on ensuring that privacy curtains are inspected daily while the room is being cleaned. The Housekeeping Director/Designee will audit 20% of patient rooms five times a week for four weeks then monthly times one to ensure clean privacy curtains.	

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F 584	Continued From page 2 An interview with the Housekeeping Supervisor on 11/09/20 at 2:05 PM revealed housekeepers were supposed to look at the curtains daily as the rooms were cleaned and replace any that were dirty. An observation with the Administrator on 11/9/20 at 1:25 PM revealed the stains and debris were still on Resident #1's privacy curtain. During the observation the Administrator reported she had been unaware of the stains and debris on Resident #1's privacy curtain. She also stated the facility was currently out of replacement privacy curtains, and new ones had been ordered but were on backorder and she did not know when they would get them. 2. Resident #4 was admitted on 8/16/13. Resident #4's Minimum Data Set Assessment, dated 9/05/20, revealed she had severe cognitive impairment. An observation of the privacy curtain in Resident #4's room on 11/09/20 at 12:11 PM revealed a large dark stain on the lower portion of the curtain, which was dark brown in color. The dark stain covered approximately a 6 inch X 8 inch area. An interview with the Housekeeping Supervisor on 11/09/20 at 2:05 PM revealed the housekeepers were supposed to look at the curtains daily as the rooms were cleaned and replace any that were dirty. An observation with the Administrator on 11/9/20 at 1:25 PM revealed the large stain was still present on Resident # 4's privacy curtain. During	F 584	Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of Compliance Dec 18, 2020	

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F 584	Continued From page 3 the observation she stated she had been unaware of the stain on Resident 4's privacy curtain. She also stated the facility was currently out of replacement privacy curtains, and new ones had been ordered but were on backorder and she did not know when they would get them.	F 584		
F 686 SS=E	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. 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 record review, staff interviews and physician interview, the facility failed to complete an admission skin assessment, identify and provide treatment to right lateral foot, right medial side of the foot, left lateral foot wounds (Resident #4) and failed to provide treatment for left heel and calf pressure ulcers (Resident #5) for 2 of 2 residents reviewed for pressure ulcers. Findings included: 1. Resident #4 was admitted to the facility on 8/16/13 and most recently readmitted on 8/28/20	F 686	Resident # 4 & Resident # 5 had skin assessments completed and wound orders are being completed as ordered and some wounds have healed. . An audit of current residents was completed to ensure that nursing staff identified, completed skin assessments and provided treatments to residents with wounds. This was completed by the Director of Health Services/Designee.	12/18/20

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F 686	Continued From page 4 with diagnoses which included Huntington's disease and non-Alzheimer's dementia. The most recent Minimum Data Set dated 9/05/20 revealed Resident #4 had severe cognitive impairment and was coded as total dependence on staff for activities of daily living (ADL). Pressure ulcers identified during the look back period included 3 stage 1 pressure injuries and 3 stage 2 pressure ulcers. Review of Resident #4's hospital records dated 8/21/20 through 8/25/20 revealed Resident #4 had a stage 2 pressure ulcer on her right lateral foot, a stage 2 pressure ulcer on the dorsum of the medial side of the foot, and a small stage 2 on the left lateral foot. These wounds received an aquacel (absorptive) dressing change every 3 days per hospital orders. Resident #4's Admission nursing assessment dated 8/28/20 at 3:11 PM, completed by Nurse #1, revealed the skin assessment section was not completed and there was no indication the resident had a pressure ulcer. An interview with Nurse #1 on 11/09/20 at 3:20 PM revealed she did not remember if she had done Resident #4's admission assessment or if another nurse was supposed to have done it and she did not know why it had not been completed. Review of Resident #4's care plan, dated 9/01/19 identified her as at risk for impaired skin integrity related to dementia with significantly impaired cognition, Huntington's Chorea with spastic movements to all 4 extremities, impaired mobility, and incontinence. The goal was to have no skin breakdown through the next review date.	F 686	Licensed Nurses were re-educated by the Director of Health Services/Designee on completing skin assessments and providing physician ordered treatments for residents with wounds. The Director of Health Services/Designee will audit skin assessments for any resident admitted to ensure they are initiated and that the treatment is being provided to the resident as ordered by the physician. This will occur five times a week for four weeks then monthly times one. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of Compliance Dec 18, 2020	

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F 686	Continued From page 5	F 686		

Interventions included to assist with turning and repositioning frequently, braden (scale used to determine risk of pressure ulcer development) assessment per policy and as needed (prn), frequent checks for incontinence during rounds and prn, moisture skin prn, pillows for positioning as tolerated, specialty air mattress, treatments per order - refer to Treatment Administration Record (TAR) for current treatment order and use lift sheet for repositioning.

Review of the Treatment Administration Record (TAR) for August 2020 revealed no wound treatment orders for Resident #4 after her return from the hospital on 8/28/20.

Review of the Resident #4's September 2020 TAR revealed the following orders:
- Order dated 8/31/20 and discontinued on 9/20/20 stated to cleanse top of left foot with normal saline and pat dry, then apply medihoney lightly and cover with kerlix or island dressing daily.
- Order dated 8/31/20 and discontinued on 9/20/20 stated to cleanse right lateral foot with normal saline and pat dry, then apply medihoney and cover with kerlix or island dressing daily.
- Order dated 9/20/20 and discontinued on 9/23/20 to cleanse wounds on right foot and left foot with normal saline, dress with puricol and cover with foam and supportive dressing every 3 days.
- Order dated 9/23/20 and discontinued on 10/09/20 for mupirocin ointment applied to all wounds after cleansing with normal saline and covered with nonadherent pad and covered with rolled gauze.
- Order dated 9/23/20 and discontinued on 11/11/20 stated to apply skin prep to left foot

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F 686	Continued From page 6	F 686		

surrounding wound and over left foot 5th digit daily.

Review of the Physician orders revealed an order dated 8/31/20 to cleanse right lateral foot with normal saline and pat dry, then apply medihoney and cover with kerlix or island dressing daily. Further review revealed another order dated 8/31/20 to cleanse top of left foot with normal saline and pat dry, then apply medihoney lightly and cover with kerlix or island dressing daily.

Review of skin assessments for Resident #4 from 8/28/20 through 11/11/20 revealed 2 skin assessments dated 9/16/20 and 10/01/20.

Resident #4's skin assessment dated 9/16/20 at 1:29 PM, written by Nurse #2, revealed a stage 4 pressure ulcer on the left top of foot, a pressure ulcer deep tissue injury on the left pinky toe, a stage 2 pressure ulcer on the right top of foot (additional notation indicated this was an existing wound first identified on 6/23/20), and a stage 3 pressure ulcer on the right top of foot (additional notation indicated this was an existing wound first identified on 6/23/20).

Resident #4's skin assessment dated 10/01/20 at 7:50 PM, written by Nurse #2, revealed a comment to see wound management for detailed assessment of residents wounds.

An interview with Nurse #1 on 11/09/20 at 10:45 AM revealed if the Treatment Nurse was out, the nurse assigned to that resident was responsible for ensuring the resident received wound care.

An interview with the Treatment Nurse on 11/11/20 at 2:25 PM revealed she had been out

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F 686	Continued From page 7	F 686		

on leave during part of August and September and she was aware that skin assessments and treatments had not been done in a timely manner. She further stated Resident #4's wounds were currently healing. She also stated that skin assessments should have been performed on admission and weekly. The Treatment Nurse also stated that wound care should have been provided. She stated the floor nurses were responsible for wound care if there was no treatment nurse available.

An interview with the Nurse Practitioner Wound Consultant dated 11/10/20 at 7:35 AM revealed when she had first seen Resident #4 on 9/23/20, the resident had 4 pressure wounds. She also stated she had seen the resident weekly since 9/23/20 and her wounds were improved, and some had healed.

An interview with the Physician on 11/13/20 at 12:58 PM revealed Resident #4 had multiple comorbidities and he did not think that lack of wound care for a few days had made a significant difference in her wounds.

An interview with Director of Nursing (DON) #1 and Director of Nursing (DON) #2 on 11/10/20 at 2:45 PM revealed they were aware of some concerns related to admission assessments and wound care. They stated every admission should have a head to toe skin assessment to ensure a resident does not have a skin issue. After the initial assessment, the skin is monitored as needed and weekly by the nurses using an assessment tool. A weekly skin assessment is scheduled for each resident as a reminder for the nurse to complete. The DONs validated that weekly skin assessments were not completed as

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F 686	Continued From page 8	F 686		

scheduled for Resident #4. They also recognized that Resident #4 did not receive wound care as needed. They further stated they were working to resolve these issues and ensure all residents were assessed on admission and received wound care as appropriate.

An interview with the Administrator on 11/13/20 at 11:13 AM revealed she was aware there were some residents who had not received skin assessments on admission and wound care as needed. She stated she was working to get the necessary processes in place to ensure proper resident care.

2. Resident #5 was admitted to the facility on 9/18/20, discharged to the hospital on 9/24/20 with diagnoses which included diabetes mellitus and end stage renal disease.

The most relevant Minimum Data Set dated 9/24/20 revealed Resident #5 had severe cognitive impairment and was coded as extensive assistance to total dependence for activities of daily living (ADL). Pressure ulcers identified during the look back period included 1 stage 2 pressure ulcer that was coded a present upon admission or reentry and 1 unstageable pressure ulcer present upon admission or reentry.

Review of Resident #5's hospital discharge instructions dated 9/18/20 revealed Resident #5 had a nonhealing wound of the left lower extremity and a left heel wound.

Resident #5's Admission nursing assessment dated 9/18/20 at 9:50 PM, completed by Director of Nursing (DON) #2, revealed the skin assessment section stated the resident had no

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alterations in her skin and there were no comments.

An interview with Nurse #1 on 11/09/20 at 10:45 AM revealed if the Treatment Nurse was out, the nurse assigned to that resident was responsible for ensuring the resident received wound care.

An interview with Nurse #3 on 11/10/20 at 12:17 PM revealed she performed Resident #5's skin assessment on admission and documented her wounds in her nursing progress note. She further stated she was new and had not known she was supposed to enter wound care orders for Resident #5. Nurse #3 stated in the absence of the Treatment Nurse, the nurse assigned to that hall was responsible for performing wound care. She also stated she performed wound care based on orders entered in the electronic health record which were located on the Treatment Administration Record (TAR).

Review of Resident #5's nursing progress note dated 9/18/20 at 10:23 PM read in part multiple wounds on her body included a left heel wound and left lower leg wound.

Review of Resident #5's care plan, with a problem start date of 9/18/20 identified a problem which included her as at risk for further impaired skin integrity related to unstageable pressure ulcer on her left heel. The goal was to have no further skin breakdown through the next review. The interventions included to assist with turning and repositioning frequently, braden assessment per policy and as needed, diet as ordered, report any signs of skin breakdown (sore, tender, red, or broken areas), treatment as ordered, and weekly body audit.

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F 686	Continued From page 10	F 686		

Review of the Treatment Administration Record (TAR) for August 2020 revealed no wound treatment orders for August 18, 19, 20, and 21.

Review of the Treatment Administration Record (TAR) for August 2020 revealed an order dated 9/22/20 to clean heel with normal saline and apply a wet to dry dressing daily for Resident #5.

An interview with the Treatment Nurse on 11/11/20 at 2:25 PM revealed she had been out on leave during part of August and September and she was aware that wound treatments had not been done in timely manner. She further stated Resident #5 had been sent out to the hospital on 9/24/20. The Treatment Nurse also stated that wound care should have been provided. She stated the floor nurses were responsible for wound care when no treatment nurse was available.

An interview with the Physician on 11/13/20 at 12:58 PM revealed Resident #5 had multiple comorbidities and he did not think that lack of wound care for a few days had made a significant difference in her wounds.

An interview with Director of Nursing (DON) #1 and Director of Nursing (DON) #2 on 11/10/20 at 2:45 PM revealed they were aware of some concerns related to admission assessments and wound care. They recognized that Resident #5 did not receive wound care as needed. They further stated they were working to resolve these issues and ensure all residents received wound care as appropriate.

An interview with the Administrator on 11/13/20 at

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F 686	Continued From page 11 11:13 AM revealed she was aware there were some residents had not wound care as needed. She stated she was working to get the necessary processes in place to ensure proper resident care.	F 686		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a 2 handled sippy cup and built-up utensils to 1 of 1 resident reviewed for assistive devices (Resident #2). Findings included: Resident #2 was admitted to the facility on 1/25/19 with most recent readmission dated 9/16/20 with diagnoses which included dysphagia and unspecified protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) dated 7/06/20 revealed Resident #2 had severely impaired cognition and was coded as supervision or extensive assistance for activities of daily living. Resident #2 was coded as supervision with eating. An observation of Resident #2 on 11/10/20 at 8:18 AM revealed she did not have a 2 handled	F 810	Resident # 2 had the built-up utensil order added to her menu card. An additional order was placed to ensure enough adaptive equipment is available for resident use. An audit of current resident□s orders for adaptive equipment was completed to ensure that they were on the menu card. Any identified discrepancies were addressed at that time. Dietary staff were educated by the Dietary Director/Designee on reading menu tickets to ensure that all adaptive equipment is placed on their food tray prior to leaving the kitchen. Nursing staff were educated by the Director of Health Services/Designee on reviewing the resident□s menu ticket to ensure all adaptive equipment is on the food tray prior to serving to the resident.	12/18/20

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F 810	Continued From page 12 sippy cup or built-up utensils on her tray. Further observations revealed she spilled food and fluids on her clothes and the table during her meal. An observation of Resident #2 on 11/10/20 at 12:39 PM revealed she had a 2 handled sippy cup with liquid in it. No built-up utensils were observed. Further observations of Resident #2 revealed she ate cake with her fingers and she was noted to have spilled food on her clothes and table. Review of Occupational Therapy (OT) daily treatment note dated 10/13/20 revealed recommendations for Resident #2 to have a sippy cup and built-up utensils with meals to increase her grasp and coordination. An interview with the Therapy Director on 11/13/20 at 11:10 AM revealed Resident #2 had been evaluated by Occupation Therapy (OT) on 10/13/20. She further stated the dietary communication for the 2 handled sippy cup and built-up utensils had been entered into the electronic record and the kitchen was supposed to ensure those items were on the resident's tray at every meal. A review of the menu card on Resident #2's lunch tray on 11/10/20 at 12:39 PM revealed she was to have a 2 handled sippy cup on her tray. A review of Resident #2's physician's orders revealed an order for her to have a sip cup with handles and built-up utensils. An interview with Nursing Assistant (NA) #1 on 11/12/20 at 11:21 AM revealed she normally worked on the hall where Resident #2 resided	F 810	Facility staff will audit 4 resident meal trays five times a week for four weeks then monthly times one to ensure adaptive equipment is placed on the resident meal tray. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of Compliance Dec 18, 2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 11/13/2020

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F 810	Continued From page 13 and usually set up her meal trays. She stated she had seen a 2 handled sippy cup on the resident's tray and had never seen built-up utensils on her meal trays. An interview with the Dietary Manager on 11/10/20 at 8:51 AM revealed she was aware sometimes residents do not get the assistive devices on their trays. She further stated sometimes the kitchen runs out of adaptive equipment and doesn't have any to put on the resident's trays. An interview with the Administrator on 11/13/20 at 11:13 AM revealed she was unaware of any concerns related to assistive devices for Resident #2 and she was unaware the kitchen sometimes ran out of the ordered assistive devices.	F 810		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		12/18/20

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F 880	Continued From page 14	F 880		

staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 15 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure a nurse aide performed hand hygiene following incontinence care and prior to repositioning the resident's head and touching clean bedding for 1 of 1 resident (Resident #1). These failures occurred during a COVID-19 pandemic. Findings included: Resident #1 was observed on 11/10/20 at 10:40 AM as Nursing Assistant (NA) #2 and NA #3 provided incontinence care. The resident was observed to have been incontinent of urine. Then while wearing the same gloves and without performing hand hygiene, NA # 2 lifted the resident's head, repositioned the pillow under Resident #1's head, placed a pillow under the resident's right calf, and pulled the sheet and blanket up over the resident. An interview with NA#2 on 11/10/20 at 11:00 AM revealed she didn't know why she had not removed her gloves and performed hand hygiene prior to touching the resident's hair, pillows, sheet and blanket. An interview with the Director of Nursing (DON) on 11/10/20 at 1:43 PM revealed she was	F 880	Nurse aide# 2 was re-educated on hand hygiene and successfully completed a return demonstration to the Infection Preventionist/designee The facility realizes that all residents have the potential to be affected by these practices. A Root Cause Analysis was completed on Hand Hygiene to aid with education. Nurse Aides will be re-educated on hand washing and infection control by the Infection Preventionist or Director of Nursing by December 6, 2020. In addition, hand hygiene is a part of orientation, annual education and competencies requiring return demonstration from the nursing staff. Any staff on leave will complete upon return. Infection Preventionist/Designee will audit nurse aides while providing incontinent care on residents to ensure they are following proper hand hygiene techniques. This will occur five times a week for four weeks then monthly times one. Identified issues will be addressed at time of discovery.	

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F 880	Continued From page 16 unaware that NA#2 had not removed the soiled gloves, performed hand hygiene, and donned clean gloves prior to touching the resident and her bedding. She stated the NA should have removed her gloves, performed hand hygiene, and put on new gloves prior to repositioning. An interview with the Administrator on 11/13/20 at 11:13 AM revealed she was unaware of any concerns related to hand hygiene. She also stated she did not know why the NA had failed to perform hand hygiene between tasks.	F 880	Audit results along with a Root Cause Analysis of any identified issues will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and need for additional education. Date of Compliance Dec 18, 2020	