

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2021
NAME OF PROVIDER OR SUPPLIER GUILFORD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2041 WILLOW ROAD GREENSBORO, NC 27406	
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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 07/26/21 through 07/30/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SD7E11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and compliant survey was conducted on 07/26/21 through 07/30/21. 1 of 77 complaint allegations were substantiated resulting in deficiencies. 19 of 77 complaint allegations were substantiated without deficiencies. 57 of 77 complaint allegations were unsubstantiated. Event ID#SD7E11.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to provide the proper size brief causing a red skin irritation for 1 of 4 residents (Resident #39) reviewed for accommodation of needs. Findings included: Resident #39 was admitted to the facility on 8-23-18 with multiple diagnosis that included diabetes, muscle weakness and chronic	F 558	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following	8/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/26/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	<p>Continued From page 1 obstructive pulmonary disease.</p> <p>The quarterly Minimum Data Set (MDS) revealed Resident #39 was cognitively intact and required extensive assistance with one person for toileting. The MDS also revealed Resident #39 was occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>Resident #39's care plan dated 6-29-21 revealed he would remain free from skin breakdown due to incontinence and brief. The interventions for the goal were in part; clean peri-area with each incontinent episode.</p> <p>During an interview with Resident #39 on 7-26-21 at 2:23pm, the resident discussed his need for a 5x brief and explained the facility had run out of the size he required at the end June 2021. The resident stated he was provided a 3x brief to wear and was informed by staff the facility did not have any larger size. Resident #39 explained he had received a red area around his groin and the creases of his upper thigh from having to wear a smaller size brief. He stated the staff applied a cream to the areas and the redness was no longer present. The resident further stated the facility had received the larger size brief approximately a week ago (7-19-21).</p> <p>An observation of Resident #39's skin occurred on 7-26-21 at 2:25pm. The observation revealed no redness or open areas to the resident's upper thigh or groin area.</p> <p>During an interview with a nursing assistant (NA) #5 on 7-28-21 at 8:35am, the NA discussed the facility having difficulty receiving large briefs for some of the residents from the end of June 2021</p>	F 558	<p>plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated</p> <p>F558 Reasonable Accommodations needs</p> <p>1.How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #39 has proper size of brief available as of 07/22/2021 in Central Supply and his closet</p> <p>2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current bariatric patients audited to validate have correct size brief available by Central Supply Clerk 08/18/2021</p> <p>3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Admission Coordinator will be educated to notify Central Supply Clerk of a Bariatric patient admission by Director of Nursing or designee Completion August 26, 2021 Central Supply clerk will be educated to provide proper brief sizing to all new Bariatric patients and stock supply in room and Central Supply storage area by Director of Nursing or designee, Completion August 26, 2021 DON and or designee will audit each Bariatric patient weekly X 4, Bi-weekly X 1 month, and monthly X 1 for proper size availability in room and central supply</p>		

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F 558	<p>Continued From page 2</p> <p>until week of 7-19-21. NA #5 stated she was informed from management that the lack of supplies was caused by a change in suppliers. She explained Resident #39 wore a brief size of 5x and the facility only had 3x briefs available. She stated the 3x briefs were placed on Resident #39 and that she had noticed the brief was leaving a red mark in the creased areas of the resident's skin.</p> <p>NA #6 was interviewed on 7-28-21 at 8:40am. NA #6 explained the facility had run out of briefs larger than 3x at the end of June 2021 and that there were residents who required briefs larger than 3x. The NA said management had informed her the facility was changing supply companies and there may be a shortage of some supplies. She stated she did not have a choice but to place the 3x brief on the larger residents. The NA stated she had noticed reddened areas on Resident #39 where the brief was tight but said there was no skin breakdown noticed.</p> <p>The Central Supply staff member was interviewed on 7-27-21 at 3:55pm. The Central Supply staff member discussed the facility's change in supply company at the end of June 2021 and the inability to receive briefs larger than 3x. She stated she had sent an email to the new supplier and was informed the larger size briefs were not on the company's formulary so the facility would not be allowed to order the larger size briefs. She said she had informed management around the middle of June of the inability to order larger size briefs. The Central Supply staff member said the facility did not attempt to purchase the larger size briefs during the change in companies. She explained the facility had the larger size briefs added to the formulary approximately 2 weeks</p>	F 558	<p>storage area.</p> <p>4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of audits will be reviewed in Quarterly Quality Assurance Meeting X 1 for further problem resolution if needed.</p> <p>5. Completion date: August 26, 2021</p>		

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F 558	Continued From page 3 ago (7-12-21) and she was able to order the larger sizes. She stated the first shipment arrived a week ago (7-19-21). The former Director of Nursing (DON) was interviewed by telephone on 7-27-21 at 1:50pm. The former DON explained the facility had changed supply companies in June 2021 and the facility was unable to acquire briefs that were larger than 3x. She explained this had occurred from 7-1-21 and remained the case to at least 7-20-21. The former DON discussed the facility had received "some" from a sister facility but that there were not enough for all the residents who needed briefs larger than 3x. The Administrator was interviewed on 7-30-21 at 2:03pm. The Administrator discussed the facility's transition to a new supply company and commented the transition was difficult. He acknowledged the facility had run out of the larger brief sizes and some residents had to wear briefs that were too small. He also explained staff had tried to obtain larger briefs for the residents but were not able to obtain an adequate supply. The Administrator stated the larger briefs were now on formulary and able to be purchased.	F 558			
F 584 SS=E	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	F 584		8/26/21	

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F 584	<p>Continued From page 4</p> <p>homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(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.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§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</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident interview and staff interviews, the facility failed to (1) maintain walls, ceilings, doorknobs and resident furnishings in good repair for 6 of 15 rooms (Rooms 102, 206, 222, 225, 227 and 232) and (2) maintain a clean-living environment for 8 of 15</p>	F 584	<p>F584 Safe homelike environment</p> <p>1.How the corrective action will be accomplished for the residents found to be affected by the deficient practice. Facility failed to maintain walls, ceilings,</p>		

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F 584	<p>Continued From page 5</p> <p>rooms (Rooms 222, 225, 226, 227, 231, 232, 233 and 235) observed for environment.</p> <p>Findings included:</p> <p>1.Observation of hallways 100 and 200 revealed the facility failed to maintain walls, ceilings, doorknobs and resident furnishings in good repair for the following resident rooms:</p> <p>a. Observation of room 102 occurred on 7-26-21 at 12:15pm. The observation revealed the light cover by the resident's door was partially detached from the wall leaving an approximate 3 inch by 4-inch hole in the wall.</p> <p>A second observation was made on 7-30-21 at 11:00am with the Environmental Director and the Maintenance Director. The observation revealed the light cover by the resident's door was partially detached from the wall leaving an approximate 3 inch by 4-inch hole in the wall.</p> <p>The Maintenance Director was interviewed on 7-30-21 at 11:02am. The Maintenance Director stated he was not aware of the issue. He discussed any staff member can enter a work order through the computer system which he retrieved through the computer or his phone. The Maintenance Director said he had not received a work order for the light cover.</p> <p>b. Room 206 was observed on 7-27-21 at 12:05pm. The wall behind the resident's door was observed to have a hole measuring approximately 7 inches by 9 inches.</p> <p>A second observation was made on 7-30-21 at 11:05am with the Environmental Director and the</p>	F 584	<p>doorknobs, and resident furnishings in good repair in rooms 102, 206, 222, 225, 227, and 232. Repairs for these rooms will be completed by 8/26/2021.</p> <p>Facility failed to maintain a clean-living environment in rooms 222, 225, 226, 227, 231, 232, 233, and 235. Facility will clean and correct these areas effective 8/26/2021.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Maintenance Director, Maintenance Assistant, Environmental Director and Administrator will audit every room and note all problems that need to be corrected in the environment. Work orders will be entered into electronic referral/Reqqer system and Maintenance Dept or EVS will complete task accordingly. This will be completed by 8/26/2021.</p> <p>3. Measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur. Licensed Nurses and Department heads will be educated on the electronic referral system (Reqqer) to submit requests to notify Maintenance and Environmental Services departments to correct any areas of concern going forward. C.N.A's will be educated on notifying Licensed Nurse of areas noted that need correction. Any problems identified will be reported in stand-up meetings each morning. This will be completed by 8/26/2021.</p> <p>4. The monitoring procedure to ensure the plan of correction is effective, and that specific deficiency cited remains correct</p>		

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F 584	<p>Continued From page 6</p> <p>Maintenance Director. The observation revealed the wall behind the resident's door had a hole measuring approximately 7 inches by 9 inches.</p> <p>The Maintenance Director was interviewed on 7-30-21 at 11:07am. The Maintenance Director stated he was not aware of the issue. He stated he made daily rounds observing 4 rooms a day on the 100 and 200 halls. The Maintenance Director said he had not received a work order for the hole in the wall.</p> <p>c. During an observation of room 222 on 7-26-21 at 10:00am, the observation revealed the resident's nightstand did not have a handle present on the bottom drawer. The resident stated he had to use his fingers to pry the drawer open.</p> <p>During a second observation on 7-30-21 at 11:10am with the Environmental Director and the Maintenance Director. The observation revealed the resident's nightstand did not have a handle present on the bottom drawer.</p> <p>The Maintenance Director was interviewed on 7-30-21 at 11:12am. The Maintenance Director stated he was aware of the issue and he had the handles outside in his shed. He further commented he had not had time to correct the issue.</p> <p>d. Observation of room 225 occurred on 7-26-21 at 10:05am. The observation revealed the outlet cover by the resident window was broken exposing the outlet box and wires. The observation also revealed the resident's bathroom wall had the paint and dry wall peeling off exposing the sheet rock.</p>	F 584	<p>and/or in compliance with regulatory requirements.</p> <p>Department heads will do visualization of each patient's room in their assigned room list weekly for a period of 3 months, observing for any areas concerning walls, ceilings, doorknobs, and resident environment and cleanliness. Findings will be reported to Administrator, Maintenance Director, and Environmental Services Director. Work orders will be entered into electronic referral/ Reqqer system for Maintenance Dept or EVS to complete tasks accordingly.</p> <p>These audits will be presented to the Quarterly Quality Assurance and improvement meeting X1 to review for further problem resolution.</p> <p>5. Completion Date: August 26, 2021</p>		

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F 584	Continued From page 7 A second observation was not conducted due to resident care; however, the Environmental Director and the Maintenance Director were informed on 7-30-21 at 11:15am of the initial observation that included the outlet cover by the resident window was broken exposing the outlet box and wires. The observation also revealed the resident's bathroom wall had the paint and dry wall peeling off exposing the sheet rock. The Maintenance Director was interviewed on 7-30-21 at 11:16am. The Maintenance Director stated he was not aware of the issue but that he would assessing the room after resident care was completed. e. Room 227 was observed on 7-26-21 at 10:10am. The observation revealed the edge of the wall by the bathroom had exposed metal and the bathroom doorknob was loose making it difficult to open the door. A second observation was not conducted due to resident care; however, the Environmental Director and the Maintenance Director were informed on 7-30-21 at 11:17am of the initial observation that included the edge of the wall by the bathroom had exposed metal and the bathroom doorknob was loose making it difficult to open the door. The Maintenance Director was interviewed on 7-30-21 at 11:17am. The Maintenance Director stated he was not aware of the issue but that he would assessing the room after resident care was completed. f. An observation of room 232 was completed on	F 584			

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F 584	<p>Continued From page 8</p> <p>7-26-21 at 10:13am. The observation revealed a hole in the resident's ceiling above the window measuring approximately 4 inches by 2 inches.</p> <p>During a second observation on 7-30-21 at 11:20am with the Environmental Director and the Maintenance Director. The observation revealed a hole in the resident's ceiling above the window measuring approximately 4 inches by 2 inches.</p> <p>The Maintenance Director was interviewed on 7-30-21 at 11:22am. The Maintenance Director stated he was not aware of the issue and had not noticed the hole on previous inspections.</p> <p>2. Observation of hallway 200 revealed the facility failed to maintain a clean-living environment for the following resident rooms.</p> <p>a. Observation of rooms 222, 225, 227, 232 and 233 occurred on 7-26-21 at 10:15am. The observations revealed the resident's privacy curtains contained orange, brown and black marks on them.</p> <p>During a second observation on 7-30-21 at 11:20am with the Environmental Director and the Maintenance Director of rooms 222, 232 and 233, the observation revealed the resident's privacy curtains contained orange, brown and black marks on them.</p> <p>The Environmental Director was interviewed on 7-30-21 at 11:25am. The Environmental Director stated housekeeping assessed the privacy curtains weekly and was not sure why there were dirty privacy curtains hanging in resident rooms. He said he would have the problem fixed by the end of the day.</p>	F 584			

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F 584	Continued From page 9 b. During an observation of rooms 226, 231, 232 and 235 on 7-26-21 at 10:20am, the observation revealed the residents wall heating and air system contained dead bugs, crumbs and black circles inside and on the air vent. A second observation on 7-30-21 at 11:27am with the Environmental Director and the Maintenance Director of rooms 226, 231, 232 and 235, the observation revealed the residents wall heating and air system contained dead bugs, crumbs and black circles inside and on the air vent. The Environmental Director was interviewed on 7-30-21 at 11:30am. The Environmental Director stated housekeeping cleaned the wall heating and air vents every 2 weeks and could not say why the vents were dirty. The Maintenance Director was interviewed on 7-30-21 at 11:31am. The Maintenance Director stated the wall units were cleaned one time a year but that he looked at them daily. He said he realized there were objects in the vents, but he did not carry around his vacuum cleaner to clean the vents out. The Administrator was interviewed on 7-30-21 at 2:03pm. The Administrator discussed the vents being cleaned seasonally but that he expected them to be cleaned as needed if they were dirty. He also discussed the other concerns found and stated he would have them corrected.	F 584			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		8/26/21	

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F 658	<p>Continued From page 10</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on physician, staff interviews, facility, and hospital record review the facility failed to administer antibiotics as ordered by the physician for 1 of 7 residents reviewed for the provision of care according to professional standards. (Resident # 389)</p> <p>Findings included:</p> <p>Resident was admitted on 4/28/21 with diagnoses that included Parkinson disease, unstageable pressure ulcer to the sacral region, Stage 4 pressure ulcer to the sacral region, osteomyelitis of vertebra, lumbosacral region, progressive neurological disorder and unsteady on her feet.</p> <p>Review of the comprehensive admission minimum data set (MDS) dated 5/4/21 revealed the resident was assessed as moderately cognitively impaired. Resident # 389 required extensive to total assistance with one-two person physical assist for activities of daily living. Assessment indicated the resident was assessed as having unstageable pressure ulcer at admission.</p> <p>Review of the care plan dated 4/28/21 revealed the resident was care planned for pressure ulcer to sacrum area due to immobility. The care plan was updated on 5/25/21, indicating the resident had infection of the sacrum wound. The goals indicated the pressure ulcer will show signs of healing, and the resident would be free from</p>	F 658	<p>F658 Administer Antibiotics as ordered</p> <p>1.How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #389 no longer resides at facility as of 06/03/2021</p> <p>2.How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current residents who are receiving Antibiotics will be audited by Director of Nursing or designee to validate Antibiotic administered as ordered, completion date August 26, 2021.</p> <p>3.Measures to be put in place or systemic changes made to ensure practice will not re-occur: All Licensed Nurses will be educated by Director of Nursing or designee that all Antibiotics are to be administered as ordered, and if unable, Physician or Nurse Practitioner will be notified for further direction, completion August 26, 2021 Any Licensed Nurse who is not educated by August 26, 2021, will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation that all Antibiotics are to be</p>		

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F 658	<p>Continued From page 11</p> <p>complications related to infections. Interventions included administration of treatment as ordered and monitoring for effectiveness.</p> <p>Administration of medication as ordered. Monitoring/ documenting and reporting any signs and symptoms of infection to physician. Monitoring nutrition status and providing supplements as needed.</p> <p>Physician orders dated 5/25/21 read in part "Bactrim DS Tablet 800-160 milligrams (MG) (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth two times a day for wound infection for 7 days. Cipro Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for wound infection for 7 days ".</p> <p>Review of the nurse practitioner (NP) note dated 5/25/21 revealed the resident was seen by the NP due to lethargy and alerted mental status as reported by the nurse. The note indicated the resident had an overall decline and failure to thrive. Venous Doppler (ultrasound diagnostic test) was ordered due to concerns for Deep vein thrombosis (DVT). Wound doctor to address worsening of sacral wounds.</p> <p>Review of wound doctor note dated 5/27/21 revealed the resident with Stage 4 pressure wound to the sacrum, Wound size - 10 X 8 X 1.4 centimeters (cm), Slough 20% and skin 80%, and wound deteriorated. Recommendations were to insert peripherally inserted central catheter (PICC) line, Vancomycin (antibiotic agent to treat infection) 1 gram (g) every 12 hours for 2 weeks. Meropenem (antibiotic agent to treat infection) 500 milligram (mg) every 8 hours for 2 weeks.</p>	F 658	<p>administered as ordered, and if unable, Physician or Nurse Practitioner will be notified for further direction. Director of Nursing or designee will audit all Antibiotics are to be administered as ordered, and if unable, Physician or Nurse Practitioner will be notified for further direction weekly X 4, Bi-weekly X 1 month, and monthly X 1. 4.How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of all audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. 5. Completion Date: 08/26/2021</p>		

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F 658	<p>Continued From page 12</p> <p>Review of the Medication administration record (MAR) for May 2021 revealed the resident was ordered: 1) Vancomycin 1 gram every 12 hours via PICC for x 2 weeks. (5/27/21 - 6/3/21). 2) Meropenem 500 milligrams (mg) every 8 hours via PICC x 2 weeks (5/28/21 - 6/1/21).</p> <p>Review of MAR for May 2021 revealed medication Vancomycin was documented as administered on 5/28/21 at 10 AM; on 5/29/21, 5/30/21 and 5/31/21 at 10 AM and 8 PM. Medication was not documented as administered on 5/28/21 at 8 PM. Medication Meropenem was documented as administered on 5/28/21 and 5/29/21 at 8 AM and 4 PM; and on 5/30/21 and 5/31/21 at 12:00 AM, 8 AM and 4 PM. Medication was not documented as administered on 5/28/21 and 5/29/21 at 12:00AM.</p> <p>Review of the MAR for June 2021 revealed Vancomycin and Meropenem were not documented as administered to the resident on 6/1/21 and 6/2/21.</p> <p>Review of the physician orders dated 6/3/21 read in part: Meropenem solution reconstituted 500 mg, use 500 mg intravenously every 8 hours for infection related to pressure ulcer of sacral region, unstageable for 9 days. Order also read in part: Vancomycin HCl solution reconstituted 1000 mg. Use 1000 mg intravenously every 12 hours related to pressure ulcer of sacral region, unstageable for 9 days.</p> <p>Nurse Practitioner note 6/1/21 revealed the resident had a wound to the sacrum that was infected. Resident on intravenous (IV) antibiotics. Note read in part "Vanc (vancomycin) trough level (labs) drawn today is WNL (within normal limits).</p>	F 658			

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F 658	<p>Continued From page 13</p> <p>Pt (resident) is still lethargic, confused today but does appear with mild improvement overall".</p> <p>Nurse Practitioner note 6/2/21 read in part "Pt (patient) currently being treated for sacral wound infection, pt on BID (twice a day) dressing changes, vancomycin and meropenem IV (intravenous) x 2 weeks, recent vanc (vancomycin) trough therapeutic. Pt still not feeling well, no real improvements. She has had this lethargy and weakness since admission but definitely worsened since wound infection. Pt has had profound bradykinesia (Slowness of Movement) since admission and has worsened somewhat. No other acute issues. Pt will follow up with wound doctor tomorrow. At this time, she is stable, VS (vital signs) stable and no other acute changes".</p> <p>Nurse Practitioner note 6/3/21 read in part "Pt (patient) does have a wound to her sacrum which is now infected and pt is on IV (intravenous) antibiotics. Today patient remains in stable condition, with mildly low BP (blood pressure) 90s/60s, HR (heart rate) 68, SpO2 (oxygen saturation) 98% RA (room air), RR (respiration rate) 16, Temp (temperature) 97. Pt continues with profound bradykinesia related to Parkinson's, unable to feed herself. Started her on (nutritional supplement) but she is having trouble providing any nutrition to herself. She is still on IV NS (normal saline) @ 50 ml/hr. (milliliters/hour). Pt was seen today by Wound doctor with wound care, who noted her wound with continued infection. It was discovered by nursing staff last night that patient did miss a few doses of vancomycin and meropenem due to computer outage and the order did not cross over from the paper charting. Pt is now c/o (complaining of)</p>	F 658			

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F 658	<p>Continued From page 14</p> <p>chest pain and hurts when she breathes in. She says she would like to go to the hospital. Due to patient's fragile condition, worsening sacral wound, and overall decline since admission, I discussed with her (family member) that I would like her to be evaluated in ER (emergency room) to ensure quick eval and treatment, possible sepsis".</p> <p>Hospital records review revealed that Resident # 389, arrived at the emergency room on 6/3/21 at 2:39 PM from the nursing home, for worsening sacral wound evaluation. It was reported she was hypotensive but appeared normotensive at admission. Since 5/27/21, patient received intravenous vancomycin and meropenem (broad-spectrum antibiotics), but according to staff, she missed all her doses on Tuesday and one dose on Wednesday due to computer malfunction. The facility's Nurse Practitioner and Wound Care Doctor assessed the patient and felt her wounds were not improving and required hospital evaluation. Upon assessment, the wound on sacrum showed small amount of bloody drainage, central necrotic tissues with granulation on margins. Bone probe test was positive. The laboratory data return without signs of sepsis or systemic infection. The MRI (imagine test) revealed mild osteomyelitis on coccyx area (bone infection). The hospital records did not indicate where the resident was discharged.</p> <p>During an interview on 7/28/21 at 3:20 PM, Nurse #5 stated sometime during end of May 2021; all resident's medication administration was recorded on paper due to computer system issue. The orders for Vancomycin and another antibiotic did get transcribed into the MAR when the system was working again. Nurse #5 stated the resident</p>	F 658			

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F 658	<p>Continued From page 15</p> <p>had missed these medications for 2 days. Nurse #5 further stated this error was noticed by a night shift nurse and the nurse practitioner was notified.</p> <p>During an interview on 07/30/21 at 09:10 AM, Nurse #8 stated she was assigned to the resident end of May 2021 and early June 2021, when the facility was transitioning to a new company. Nurse #8 stated the computer system was down for couple of days and the residents MARs were documented on paper. The Nurse #8 stated the resident's antibiotic orders were new and transcribed on the old system and not in the new system. As a result, the medications were not moved over to the new system. Nurse #8 stated when medications on the MAR were crossed checked, these medications were not seen as it was in the old system and were overlooked. A night shift nurse had noticed this error and notified the physician. A new order of the medication was received; however, the resident had left to the hospital due to her deteriorating condition.</p> <p>During an interview on 7/29/21 at 6:30 AM, Nurse #6 stated when the facility was in the process of changing companies, the computer systems were down for few days (end of May 2021). The residents MARs were documented in paper. Nurse #6 stated she does not recollect the exact dates, but recollects the resident was on Vancomycin and another antibiotic due to her deteriorating wounds. Nurse #6 stated when she returned to work after 2 days, she noticed the resident's antibiotic medication was not included in the MAR on the new system. Nurse #6 stated she immediately notified the nurse practitioner and received new orders for the medication.</p>	F 658			

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F 658	<p>Continued From page 16</p> <p>During an interview on 7/27/21 at 10:47 and on 7/30/21 at 10:23 AM, Nurse Practitioner (NP) stated Resident # 389 was new on-set of Parkinson disease, had ataxic movement, was refusing to be turned or repositioning, and had a poor appetite. The resident's overall medical conditions were causing the wounds to deteriorate. The NP stated the resident was ordered antibiotics due to wound deterioration. NP stated on 5/29/30 when the facility had computer outage, the resident medications were printed and administered via paper charts. On 6/2/21, a nurse had noticed that the resident's antibiotics were not transcribed on the new system. NP stated she was notified, and new orders were given. NP stated on 6/3/31 the resident was having chest pain and pain while breathing. The resident was sent to the hospital for further evaluations of her wounds. NP stated she had seen the resident on 6/1/21 and 6/2/21 and the resident evaluation was based on the labs, which indicated her vancomycin tough was at therapeutic level and other labs were normal. NP further stated the resident may have missed 5 doses of antibiotics; however, this may not have caused any deterioration in conditions. The resident was having multiple medical issues, refusing repositioning, and turning, and poor po intake that were causing the wounds to worsen. Resident was in a declining process. NP indicated the nurses should follow the orders, administer medication as ordered, and notify physician when doses were missed.</p> <p>During a telephone interview on 7/29/21 at 2:30 PM, The Wound Doctor stated the resident's wound were not healing well due to deterioration of the resident's overall health and poor meal intake. The resident was on oral antibiotics. The</p>	F 658			

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F 658	<p>Continued From page 17</p> <p>Wound Doctor further stated the resident was ordered IV antibiotics as her wounds were deteriorating. The Wound Doctor stated when antibiotics dosage was missed it would potentially worsen the wounds, however for Resident #389, the resident's diagnosis of Parkinson's, osteomyelitis, and poor meal and fluid intake were also contributing factor for resident's poor wound healing process. The wound doctor stated staff should notify the physician when the physician orders were not followed, or medications were missed. The Wound Doctor further stated the resident was already receiving oral antibiotic, hence missing few doses would not cause any major issues for her wound healing.</p> <p>During a telephone interview on 7/30/21 at 2:14 PM, the Physician stated missing medication administration was a medication error. However, this happened during the transition time when the electronic medical record systems were changed from one system to another. The Physician stated the previous DON had printed the paper charts for administration. The physician further stated any medication missed was not good, however the resident was already deteriorating due to her medical condition, poor meal intake and her wounds were already infected. The physician stated usually the antibiotics would start working within 48 hours of administration and this would not have affected the resident's condition as the last doses were missed. The resident was sent to the hospital for further evaluation of the wounds. The Physician stated the NP or physician should be notified when medications were not administered as ordered.</p> <p>During an interview on 07/30/21 01:50 PM, the</p>	F 658			

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F 658	Continued From page 18 corporate nurse consultant indicated the facility's computer systems were down from 5/26/21 to 5/28/21. This was during transition phase from one company to another. The corporate nurse consultant further stated during the transition phase there was a change in system, change in personnel and medication had been missed.	F 658			
F 686 SS=G	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 observations, record reviews, staff interviews, Nurse practitioner and Wound Doctor interviews the facility failed to apply an air mattress to prevent skin impairment, transcribe wound treatment to the right heel and sacrum according to and, provide pressure ulcer care according to physician orders during a pressure ulcer observation for 1 of 6 residents (Resident #17) observed for pressure ulcers. Resident #17 was at risk for pressure ulcers and acquired 3 pressure ulcers (sacrum area, left heel, and right heel) since admission. The wounds to the left	F 686	F686 Treatment Pressure ulcer 1.How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident # 17 currently has an air mattress in place, validated by Director of Nursing August 17, 2021. Resident # 17 treatment orders validated transcribed correctly as of August 17,2021	8/26/21	

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F 686	<p>Continued From page 19</p> <p>heel and sacrum had some bloody drainage with maceration at observation. The resident was started on antibiotics due to infection to the wounds.</p> <p>Findings included:</p> <p>Resident #17 was admitted to the facility on 5/13/21 with diagnoses that included cervical disc disorder with myelopathy, chronic diastolic (congestive)heart failure, atherosclerosis of native arteries of other extremities with ulceration and diabetes mellitus type 2 with diabetic peripheral angiopathy without gangrene. Resident was not diagnosed with Peripheral vascular disease (PVD) and was not end of life.</p> <p>Review of the physician orders dated 5/13/21 revealed: Clopidogrel Bisulfate Tablet 75 milligrams (MG) -1 tablet by mouth one time a day, Lantus 100 UNIT/ML (milliliters) (Insulin Glargine) Inject 10 unit subcutaneously at bedtime and NovoLOG 100 UNIT/ML (Insulin Aspart) per sliding scale inject subcutaneously with meals.</p> <p>The comprehensive admission Minimum Data Set (MDS) dated 5/19/21 revealed the resident was moderately cognitively impaired. The resident required extensive to total assistance of one-person physical assist for activities of daily living. Resident #17 was assessed as at risk for pressure ulcers. Assessment indicated the resident did not have any pressure ulcers at the time of admission. The MDS indicated the resident had a pressure reducing device for bed and ointment/treatment were applied.</p> <p>Review of Nurse Practitioner note dated 5/19/21</p>	F 686	<p>by Director of Nursing. Resident # 17 pressure ulcer care validated to be administered per order August 17, 2021</p> <p>2.How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All residents with pressure ulcers will have orders validated that they are transcribed correctly, and all treatments validated that administered as ordered by Director of Nursing or designee, completion date August 26, 2021.</p> <p>3.Measures to be put in place or systemic changes made to ensure practice will not re-occur: All Licensed Nurses will be educated by Director of Nursing or designee that all Treatment orders will be transcribed correctly per wound evaluation and management summary provided by Wound MD, and treatment administered as ordered, and if unable, Wound MD will be notified for further direction, completion August 26, 2021 Any Licensed Nurse who is not educated by August 26, 2021, will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation that all Treatment orders will be transcribed correctly per wound evaluation and management summary provided by Wound MD, and treatment administered as ordered, and if unable, Wound MD will be notified for further</p>		

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F 686	<p>Continued From page 20</p> <p>revealed the resident prior to admission had chronic wounds to sacrum and heels. These wounds were recently healed. Note indicated the resident would need to have her heels always elevated, and skin prep applied. Air mattress recommended due to her frequent skin breakdown. Recommendations were to cleanse, wash and dry both feet and apply Vaseline liberally.</p> <p>Review of the physician orders dated 5/19/21 read in part "Air mattress due to skin breakdown. Float heels on pillows while in bed." Orders also indicated the following med</p> <p>Review of the Wound Doctor notes dated 5/27/21 revealed the following: 1) Left heel -unstageable deep tissue injury (DTI): Wound measurement 3.5 X2.5 X not measurable centimeters (cm). Treatment indicated was skin prep apply once a day x 30 days. Gauze roll nonsterile apply once a day x 30 day. Recommendations included offloading the wound and reposition by facility protocol. 2) Sacrum - Stage 3 Pressure ulcer: Wound measurement 4 x 3.1 x 0.1 cm. granulation tissue 100%. Treatment indicated was Alginate calcium apply once daily x 30 days. Gauze island applied once daily x 30 days. Recommendations were off loading wound, reposition per facility protocol and group 2 mattress. Note indicated the factors complicating healing was type 2 Diabetes Mellitus.</p> <p>A review of the care plan revised on 6/1/20 revealed the resident was care planned for actual skin impairment to sacrum site #1, and site #2 left heel with the potential for more skin impairments. The goal was for the resident to have no further</p>	F 686	<p>direction, completion August 26, 2021 Director of Nursing or designee will audit 10% of each unit for Treatment orders will be transcribed correctly per wound evaluation and management summary provided by Wound MD, and treatment administered as ordered, and if unable, Wound MD will be notified for further direction weekly X 4, Bi-weekly X 1 month, and monthly X 1.</p> <p>4.How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed.</p> <p>5. Completion August 26, 2021</p>		

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F 686	<p>Continued From page 21</p> <p>evidence of skin impairment. Interventions included keeping skin clean and dry, providing peri care with incontinent care and weekly skin assessments.</p> <p>Review of the Wound Doctor notes dated 6/3/21 revealed the following</p> <p>1) Left heel unstageable DTI: Wound measurement 4 X 2.5 X not measurable cm.</p> <p>2) Sacrum - Stage 3 Pressure ulcer: Wound measurement 6 x 3.6 x 0.1 cm. Granulation tissue 70%. Wound deteriorated. Note also indicated the factors complicating healing was type 2 Diabetes Mellitus. Surgical excisional debridement procedure done to the sacrum wound on 6/3/21.</p> <p>Review of the Nurse Practitioner note dated 6/3/21 revealed the resident had developed 2 new wounds since admission. These were old wounds that have reopened. The resident seen by the Wound doctor for pressure ulcer to sacrum and to left heel deep tissue injury. The note read in part "pt. (resident) still does not have air mattress. Will discuss with DON (Director of Nursing). She will require an air mattress due to her fragile skin and high risk for pressure wounds and skin breakdown. No other acute issues. She has no acute complaints."</p> <p>Review of the Wound Doctor notes dated 6/17/21 revealed:</p> <p>1) Left heel unstageable DTI: Wound measurements - 8 X 4 X not measurable cm. Wound deteriorated.</p> <p>2) Sacrum - Stage 3 Pressure ulcer: Wound measurements- 4. x 3.9x 0.8 cm. granulation tissue 90%. Wound improved.</p> <p>3) Right heel unstageable DTI: Wound</p>	F 686			

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F 686	<p>Continued From page 22 measurements- 1 x 0.8 X not measurable cm.</p> <p>Review of the Wound Doctor notes dated 6/24/21 revealed: 1) Left heel unstageable DTI: Wound measurement 5.2 X 4.5 X not measurable cm. Wound improved. 2) Sacrum - Stage 3 Pressure ulcer: Wound measurement 3.2 x 3 x 0.2 cm. granulation tissue 90%. Wound improved. 3) Right heel unstageable DTI: Wound measurement 1.4 x 1 X not measurable cm. No change in wound.</p> <p>Review of the Wound Doctor notes dated 7/1/21 revealed: 1) Left heel unstageable DTI: wound measurement 5.5 X 4 X not measurable cm. Wound improved. 2) Sacrum - Stage 3 Pressure ulcer: Wound measurement 3 x 1.8 x 0.2 cm. granulation tissue 90%. Wound improved. 3) Right heel unstageable DTI: Wound measurement 1.1 x 0.9 X not measurable cm. Wound -improved.</p> <p>Review of the Wound Doctor notes dated 7/9/21 revealed 1) Left heel unstageable DTI: wound measurement 5 X 3 X not measurable cm. Wound improved. 2) Sacrum - Stage 3 Pressure ulcer: Wound measurement 3 x 1.8 x 0.2 cm. granulation tissue 90%. Wound improved. 3) Right heel unstageable DTI: Wound measurement 1.4 x 0.9 X not measurable cm. No change in wound.</p> <p>Review of the Wound Doctor notes dated 7/15/21</p>	F 686			

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F 686	<p>Continued From page 23</p> <p>revealed</p> <p>1) Left heel unstageable DTI: wound measurement 4.5 X 2.5 X not measurable cm. Wound deteriorated.</p> <p>2) Sacrum - Stage 3 Pressure ulcer: wound measurement 2.5 x 1.6 x 0.2 cm. granulation tissue 90%. Wound improved.</p> <p>3) Right heel unstageable DTI: wound measurement 5.5 x 5 X not measurable cm. Wound deteriorated.</p> <p>Review of the physician orders dated 7/21/21 read in part "Bactrim DS Tablet 800-160 milligrams (MG) (Sulfamethoxazole-Trimethoprim) - Give 1 tablet by mouth every 12 hours for heel infection for 7 Days".</p> <p>Review of the nurse practitioner note dated 7/21/21 revealed the resident was seen by the nurse practitioner as follow up on bilateral heels wounds. The dressing was changed. Both heels draining with foul odor. Note indicated the resident was started on antibiotics due to worsening of the wounds, foul smell, and drainage. Resident's right heel with DTI had no open areas. Left heel with open area, DTI, drainage and foul odor and tender to touch. Note revealed the resident was not in any pain.</p> <p>Review of the wound doctor notes dated 7/22/21 revealed:</p> <p>1) Left heel unstageable DTI: wound measurement 5 X 2.1 X not measurable centimeters (cm). Wound deteriorated.</p> <p>Treatment - Leptospermum honey apply once a day x 23 days. Gauze rolls nonsterile apply once a day x 23 day. Recommendations included offloading wound and reposition by facility</p>	F 686			

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F 686	<p>Continued From page 24</p> <p>protocol.</p> <p>2) Sacrum - Stage 3 Pressure ulcer: wound measurement 2.5 x 1.5 x 0.2 cm. granulation tissue 100%. Wound improved. Treatment - Leptospermum honey apply once a day x 23 days. Gauze rolls nonsterile apply once a day x 30 day. Alginate calcium apply once daily x 9 days. Recommendations included offloading wound, reposition per facility protocol.</p> <p>3) Right heel unstageable DTI: wound measurement 5 x 5 X not measurable cm. Wound improved. Treatment - Betadine apply once a day x 17 days. Gauze roll nonsterile apply once a dayx17 days. Recommendations included offloading wound and reposition by facility protocol.</p> <p>A review of a Treatment administration record (TAR) revealed the following:</p> <p>1) Cleanse left heel with normal saline, apply Medi honey and cover with dry dressing every day shift wound care (order date 7/22/21).</p> <p>2) Cleanse area to sacrum, apply Medi honey and cover with dry dressing every day shift for wound care (order date 7/22/21). The TAR did not include Alginate Calcium as indicated in the Wound doctor treatment notes</p> <p>3) Cleanse right heel with normal saline, apply Medi honey and cover with dry dressing every day shift for wound care (order date 7/22/21). The Wound Doctor note indicated Betadine apply once a day x 17 days. Gauze roll nonsterile apply once a day x 17 day. This was not indicated on the TAR</p> <p>. During an interview on 7/28/21 at 7:47 AM, Nurse #3 stated she was assisting the Wound Doctor during the weekly rounds. Nurse #3 stated the Wound Doctor's treatment orders were</p>	F 686			

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F 686	<p>Continued From page 25</p> <p>transcribed in the system by her. Related to the difference in the orders transcribed, to the orders in the Wound Doctor's recommendations, she indicated it was how the physician had stated while the physician was assessing the resident. Betadine was not transcribed for right heel DTI, instead Medi honey was transcribed. Alginate calcium was not transcribed for sacrum wound.</p> <p>During a telephone interview on 7/27/21 at 1:37, the previous Director of Nursing (DON) stated she was working for the facility from 4/12/21 to 7/20/21. The previous DON stated the resident was treated for wounds and seen by the Wound Doctor. The Wound Doctor was followed by a nurse who would transcribe the physician orders into the system. The DON further stated the medical record staff would print a copy of the Wound Doctor's notes and provide it to her. DON indicated that she would cross check to see if the orders were transcript correctly and per Wound Doctor's notes.</p> <p>During an interview on 7/30/21 at 1:43 PM, Corporate nurse consultant stated the verification of the wound doctor's order should be done once the physician orders were transcribed by the system by rounding nurse. Nurse consultant confirmed she had not verified the orders last week.</p> <p>During an interview and observation on 7/26/21 at 12:38 PM, the resident stated she had pressure ulcers on both her heels and on her back. The resident stated that staff were treating the wounds. Resident further stated the staff repositioned her frequently and kept her feet floated. Resident was observed on an air mattress. Resident heels were floated on pillows.</p>	F 686			

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F 686	<p>Continued From page 26</p> <p>On 7/27/21 at 11:30am, the resident's wound dressings were observed with the nurse practitioner. The resident was observed lying in bed on an air mattress. The resident's feet were noted to be floating off a pillow and the bandages on both feet were dated "7-26-21". Observed the resident's sacrum with the nurse practitioner and noted the dressing on the resident's sacrum was intact and dated "7-26-21".</p> <p>Wound care was observed with Nurse #2 on 7/27/21 at 1:55 PM. Nurse kept clean field and performed hand hygiene. Observation of Left and Right Heels: Nurse #2 removed gauze and a dressing of Vaseline gauze from right heel. Right heel was noted to be closed with no drainage, but skin was boggy and white. The left heel was noted to have the Vaseline gauze and a piece a foam. Left heel was noted to have bloody drainage with maceration around the edges. Treatment: Nurse #2 washed the wounds with normal saline, applied Medi honey and a dry gauze dressing but also had 2 pieces of foam. Sacrum: Removed dressing which was a foam border dressing that was clean, no remanence of a treatment applied to wound. Wound bed and surrounding skin were clean, some bloody drainage with maceration in the center. Treatment: Nurse #2 washed with normal saline, applied Medi honey and a piece of foam then covered with a gauze border dressing. Nurse #2 did not apply Alginate calcium to the wound.</p> <p>During an interview on 7/27/21 at 2:00 PM, Nurse #2 stated she only applies the foam dressing to the heels if she feels they are needed but the order called for a dry dressing. She also acknowledged there was not an order for foam to</p>	F 686			

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F 686	<p>Continued From page 27</p> <p>the resident's sacrum but applied foam anyway. Nurse #2 also denied knowing what the yellow gauze was on the resident's heels but stated it was not the correct dressing.</p> <p>During an interview on 7/28/21 at 1:15 PM, Nurse Aide (NA)# 3 stated she was frequently assigned to the resident. The resident was alert and oriented and able to verbalize her needs. NA stated when she begins her shift, the resident was usually repositioned to her side by the outgoing NA. The resident was repositioned to center when breakfast was served so that she could consume her meals. The resident after her ADL care during mid-morning was repositioned to the side and later around lunch when family visited the resident was transferred to the wheelchair. The resident's feet were floated using pillows. Pillows are placed on both bed and wheelchair. NA #3 stated the resident was repositioned every 2 hours.</p> <p>During an interview on 7/27/21 at 10:47 AM. Nurse Practitioner stated the resident had peripheral vascular disease, diabetes and was immobile. The resident used a mechanical lift for transfer. Nurse practitioner further stated based on resident's medical condition, the resident was at a high risk for developing pressure wounds. Nurse Practitioner indicated prior to admission the resident had wounds to the sacrum area and both her heels. These wounds were healed at admission. The resident's sacrum wound had developed on 5/27/21. The Nurse practitioner stated on 6/3/21 when she was assessing the resident, she had noticed that the resident was not lying on an air mattress. Nurse practitioner further stated that she had a conversation with the previous Director of Nursing and the</p>	F 686			

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F 686	<p>Continued From page 28</p> <p>resident's mattress was changed. The resident was seen by the wound doctor and both DTI of left and right heel and stage 3 sacrum were assessed. Nurse Practitioner stated the resident's feet were kept floating of a pillow for pressure relief. Nurse Practitioner stated the resident's wounds need to be dressed daily as ordered by the wound doctor for healing.</p> <p>During a telephone interview on 7/29/21 at 2:30 PM, the Wound Doctor stated the resident had wounds to the sacrum and both heel, which were healed prior to admission. The resident had contributing factors like diabetes mellitus type 2 and other medical conditions that would put the resident at risk for pressure ulcers. The Wound Doctor indicated the resident's feet were floated with pillows to help with pressure relief. The Wound Doctor stated the foam placed with the dressing would help with keeping the wound dry. The Wound Doctor further stated that Betadine was ordered for the right heel to keep the wound dry and help with wound healing. He indicated the Medi honey would not help dry the wound and could deteriorate the wound. The Wound Doctor stated Vaseline gauze should not be used to the heels as it would not keep the wounds dry and cause maceration. The Wound Doctor further stated the Vaseline gauze would cause the wound to deteriorate. The wound doctor was also made aware that Alginate calcium was not used while dressing the sacrum wound. The Wound Doctor stated Alginate calcium would assist in keeping the wound dry and help with speeding wound healing. The Wound Doctor indicated the resident's wounds were healing. The Wound Doctor further indicated that by nurses not following his orders the resident's wounds could deteriorate. The Wound Doctor stated the nurses</p>	F 686			

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F 686	Continued From page 29 should be following his orders for wound treatment for proper healing of the resident's wounds.	F 686			
F 693 SS=D	<p>Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)</p> <p>§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to follow physician's orders for 1 of 3 residents reviewed for tube feeding (Resident #139).</p> <p>Findings included: Resident #139 was admitted to the facility on</p>	F 693	<p>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:</p> <p>Resident #139 observed during Tube feeding to validate correctly administered by Regional Nurse Consultant in am on</p>	8/26/21	

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F 693	<p>Continued From page 30</p> <p>07/20/21 with diagnoses that included hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side, memory deficit, dysphagia, and atherosclerotic heart disease of native artery.</p> <p>Review of the admission Minimum Data Set dated 7/27/21 revealed Resident #139 had severe impairment in cognition and required total staff assistance for all activities of daily living. Further review revealed Resident #139 had impairment on one side for functional range of motion.</p> <p>Review of the active physician orders for Resident #139 revealed enteral orders dated 7/21/21 that revealed Jevity 1.5 Cal 237 milliliter (ML) carton bolus to be given four times a day. The order indicated to administer at 9:00 am, 1:00 pm, 5:00 pm, and 9:00 pm via gastric tube.</p> <p>During a medication administration observation on 7/27/21 at 09:40 AM, Nurse #2 stated she was not going to give resident #139 the enteral bolus feed (Jevity) per the Medication Administration Record (MAR). Nurse #2 stated the reason she was not going to give it was because the family member did not want the resident to have it if she ate 100% of her meal. Nurse #2 indicated this was something that she normally would do if the resident ate 100% of her meal. When asked if there were instructions to hold in the order, Nurse #2 stated "No, but I am using my nursing judgment".</p>	F 693	<p>8/17/2021. Resident #139 Tube feeding order changed 8/17/2021 1527 pm per MD orders to include "Hold tube feeding if resident eats more than 50% of meal" Resident discharged home on 08/20/2021.</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice :</p> <p>Director of Nursing or designee reviewed all residents receiving Tube Feeding orders to validate receiving Tube feeding per MD orders and all residents tube feeding administration observed to validate administered per MD order, completion August 26, 2021.</p> <p>Measures to be put in place or systemic changes made to ensure practice will not re-occur: All Licensed Nurses will be educated by Director of Nursing or designee that all Tube feedings must be administered per order, and if unable Physician or Nurse Practitioner will be notified for further direction, completion August 26, 2021 Any Licensed Nurse who is not educated by August 26, 2021, will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation that all "Tube feedings must be administered per order, and if unable Physician or Nurse Practitioner will be notified for further direction", Completion</p>		

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F 693	Continued From page 31	F 693	August 26, 2021 Director of Nursing or designee audit "all residents receiving Tube Feeding orders to validate receiving Tube feeding per MD orders and all residents tube feeding administration observed to validate administered per MD order weekly X 4, Bi-weekly X 1 month, and monthly X 1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed.		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility's medication error rate was greater than 5% as evidenced by 10 medication errors out of 29 opportunities. There were medication errors for 1 of 4 residents (Resident #139) during medication pass observations. The medication error rate was 34.48%. Review of physician orders for Resident #139 included the following medications: " Cyanocobalamin Tablet 1000 Micrograms (MCG). Give 1 tablet via Gastric Tube (GT) one time a day (9:00 am) for	F 759	F759 Free of Medication errors 1.How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident # 139 has an MD order stating ALL Medications per GTUBE, do not cocktail medications, crush and give 1 at a time per GTUBE effective 08/17/2021. 2.How corrective action will be accomplished for those residents having	8/26/21	

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F 759	<p>Continued From page 32 supplement.</p> <p>" Diltiazem Hydrochloride Tablet 60 Milligram (MG.) Give 1 tablet via GT three times a day (9:00 am, 2:00 pm, 9:00 pm) for atrial fibrillation.</p> <p>" Metoprolol Tartrate Tablet 50 MG. Give 1 tablet via GT every 12 hours (9:00 am, 9:00 pm) for hypertension.</p> <p>" Telmisartan Tablet 80 MG. Give 1 Tablet via GT one time a day (9:00 am) related to essential hypertension.</p> <p>" Oxybutynin Chloride Syrup 5 MG/5 ML. Give 5 milliliters (ML) via GT one time a day (9:00 am) for overactive bladder.</p> <p>" Multiple Vitamin Liquid. Give 5 ml via GT one time a day (9:00 am) for supplement. Give 1 tablet via GT one time a day every Mon, Wed, Fri for thyroid.</p> <p>" Hydralazine Hydrochloride Tablet 25 MG. Give 1 tablet via GT three times a day (9:00 am, 2:00 pm, 9:00 pm) related to essential hypertension.</p> <p>" Eliquis Tablet 2.5 MG (Apixaban). Give 1 tablet via GT two times a day (9:00 am, 6:00 pm) related to hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side.</p> <p>" Cholecalciferol Tablet 1000 UNIT. Give 1 tablet via GT one time a day (9:00 am) or supplement.</p> <p>" Calcium Citrate + D Tablet 315-200 MG-UNIT (Calcium Citrate-Vitamin D). Give 1 tablet via GT one time a day (9:00 am) for supplement.</p> <p>During observations of a medication pass on 7/27/21 at 9:40 am, Nurse #2 indicated Resident #139 took her medications crushed and by mouth. Nurse #2 was observed to measure 5 ML syrup and 5 ML liquid in medicine cups. She also crushed eight tablets. All of the medications were</p>	F 759	<p>the potential to be affected by the same deficient practice: Director of Nursing or designee will audit all residents receiving Tube Feeding for Administering per MD orders, completion 08/26/2021</p> <p>3.Measures to be put in place or systemic changes made to ensure practice will not re-occur All Licensed Nurses will be educated by Director of Nursing or designee that all residents with Tube feedings will have medications administered per order, and if unable Physician or Nurse Practitioner will be notified for further direction, completion August 26, 2021 Any Licensed Nurse who is not educated by August 26, 2021, will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation that all residents with Tube feedings will have medications administered per order, and if unable Physician or Nurse Practitioner will be notified for further direction, during orientation. Completion August 26, 2021 Director of Nursing or designee will audit all residents with Tube feedings will have medications administered per order weekly X 4, Bi-weekly X 1 month, and monthly X 1.</p> <p>4.How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of all audits will be reviewed at</p>		

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F 759	Continued From page 33 then mixed with apple sauce into a medicine cup. Nurse #2 was observed to administer the medications to Resident #139 by mouth. Review of records revealed there were no physician orders or progress notes to indicate Resident #139 could take medications by mouth. In an interview on 7/30/21 at 11:40 AM, the Nurse Practitioner (NP) stated she expected the nurses to follow physician's orders for GT medication administration and was not aware of nurses giving medications by mouth if the orders indicate to give via GT. In an interview on 7/30/21 at 2:30 pm, the Medical Director stated the nurses can sometimes give medications to residents with a GT crushed and given by mouth if the resident had passed a swallow evaluation with Speech Therapy. The Medical Director also stated medication orders can be changed if appropriate.	F 759	Quarterly Quality Assurance Meeting X 1 for further resolution if needed. 5. Completion Date: August 26, 2021		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		8/26/21	

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F 812	<p>Continued From page 34</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews and record review the facility failed to label and date stored food items in the walk-in freezer, discard foods with expired use by date in the walk-in refrigerator, ensure bread products were labeled so staff knew how long the bread could be utilized and discard food in 1 of 2 nourishment refrigerators reviewed for food storage (100 - hallway).</p> <p>Findings included:</p> <p>1) Observations of foods stored in the kitchen's walk-in freezer on 7/26/21 at 9:20 AM with the Dietary Manager (DM) revealed the following:</p> <p>a. An opened bag containing food that looked like omelets. There was no label or date on the bag. The Dietary Manager indicated the bag contained cheese omelets. DM was unsure when the bag was opened. She indicated any opened bags should be labeled and dated.</p> <p>b. There were 4 bags of food stored under the freezer compressor unit. The bags contained food and had ice inside them. The DM stated the bags contained pancakes that were usually used for breakfast. She further stated these bags should not be placed under the freezer compressor unit.</p>	F 812	<p>F812</p> <p>1.How corrective action will be accomplished for those residents found to have been affected: Facility failed to label and date stored food items in the walk-in freezer, discard foods with expired use by date in the walk-in refrigerator, ensure bread products were labeled so staff knew how long bread will be utilized and discard food in 1 of 2 nourishment refrigerators (100 hall). All items were discarded, labeled, and dated immediately, July 26, 2021</p> <p>2.How the facility will identify other residents having the potential to be affected by the same deficient practice: All Dining Services employees were in-serviced July 27, 2021, and continued bi-weekly regarding proper procedures for discarding expired food items, labeling, and dating items and storing food items when received [7-29-2021;8-10-2021;8-23-2021]. Check log placed in nourishment room. Nourishment rooms are checked and signed twice daily in the morning and evening as of August 1, 2021.</p> <p>3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not</p>		

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F 812	<p>Continued From page 35</p> <p>During an interview on 7/28/21 at 12:06 PM, the Culinary Director stated all food products that were opened should be labeled and dated. No food should be placed right under the freezer compressor unit.</p> <p>2) Observations of the kitchen's walk-in refrigerator on 7/26/21 at 9:20 AM, with the DM, revealed an aluminum pan with raw meat on the bottom shelf. The pan was labelled as "6/27/21 - 6/31/21". The DM stated the pan contained chicken thighs.</p> <p>During an interview on 7/28/21 at 12:06 PM, the Culinary Director stated that all products that have been defrosted and thawed in the refrigerator, which includes raw meat should be dated and used within 7 days.</p> <p>3) Observations of the kitchen's dry storage area on 7/26/21 at 9:15AM, with the DM, revealed the bread rack had 2 open bags containing 4 hotdog buns each, 3 opened bags containing 4- 5 hamburger buns each, and an unopened loaf of bread. None of the products had a use by date.</p> <p>During an interview on 7/26/21 at 9:15 AM, Dietary Manager stated the facility does not purchase any fresh bread. All breads purchased were frozen. DM indicated the breads were removed from the freezer and should be used within 7 days. Dietary Manager stated there should be date on the rack indicating when the product was removed from the freezer and the use by date.</p> <p>During an interview on 07/28/21 12:03 PM, the Culinary Director indicated the facility does not purchase fresh bread on regular basis. All bread</p>	F 812	<p>recur:</p> <p>A sanitation inspection conducted by DM daily, as of August 1, 2021, Culinary Regional once in August and will be twice monthly to ensure compliance with corrective actions. Any deficient practice identified though the inspections will result in reeducation and/or disciplinary action as indicated. All new hires received in-service education from the Dietary Services Manager on proper procedures on discarding expired food, labeling, and dating items when received and opened.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting X1 for any further resolution if needed.</p> <p>5. Completion Date: August 26, 2021</p>		

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F 812	<p>Continued From page 36</p> <p>purchased were kept frozen until needed. The breads when removed from the freezer should be used within 7 days of thawing. She stated bread rack should be labeled with the date when the product was removed and a use by date.</p> <p>4) Review of the policy related to food brought by family/visitor read in part "Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item, current date/time, and the use by date. "</p> <p>Observations of the nourishment refrigerator (100 hallway) on 7/26/21 at 9:30AM with the DM revealed a black plastic container with food labeled "6/18/21" and a plastic food container labeled "7/22/21". There was no resident's name on these containers. The nourishment refrigerator also contained 2 take out boxes in a grocery bag with no date or label on it. There was also an opened 32-ounce juice bottle (prune juice) that was half empty with no label or date.</p> <p>During an interview on 7/26/21 at 9:30AM, DM stated the nurses on the unit should date the food containers that were brought in by the family for the resident. The container should also contain the resident's name. The food should be discarded by the date on the food container, which was usually 3 days from the date the food was brought in.</p> <p>During an interview on 7/28/21 at 12:06 PM the Culinary Director stated the nursing should label the resident's food brought in by family. The food should be consumed within 3 days. The dietary staff or manager when refilling the nourishment refrigerator with snacks, should discard any food</p>	F 812			

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F 812	Continued From page 37 that has no label or food that was in the refrigerator for more than 3 days.	F 812			
F 880 SS=E	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§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:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, 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;</p> <p>§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;</p>	F 880		8/26/21	

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F 880	<p>Continued From page 38</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 record review, observation, staff interviews and physician interview, the facility failed to implement their infection control policies and procedures for personal protective equipment (PPE) when a nursing assistant (NA) #3 failed to don gloves, gown or eye protection when she entered a resident room who was on</p>	F 880	<p>F880 Infection Control</p> <p>1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. CNA#3 was given re-education by Regional Nurse Consultant on</p>		

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F 880	<p>Continued From page 39</p> <p>enhanced droplet precautions. The failure occurred during the COVID19 pandemic.</p> <p>Findings included:</p> <p>Review of the facility's "COVID-19 Infectious Disease Preparedness and Response Plan Training" dated June 2021 revealed in part; enhanced droplet-contact precautions the employee should wear a face mask, gown, goggles/face shield when entering a resident room. Always follow standard precautions and avoid being closer than 6 feet if possible.</p> <p>An observation of room 102 on 7-26-21 at 12:30pm, revealed a droplet-contact isolation sign on the door with an isolation caddy hanging from the door containing gloves, gowns, sanitary wipes and face shields. Nursing assistant (NA) #3 was observed entering room 102 without donning gloves, gown or face shield. Once the NA entered the room, she picked up the resident's wash cloth and bath basin without donning gloves, proceeded to the bathroom where she washed out the bath basin and placed the washcloth into a bag. NA #3 then exited the room, applied hand sanitizer and walked to the meal cart.</p> <p>NA #3 was interviewed on 7-26-21 at 12:35pm. The NA stated she was not aware the resident in room 102 was on droplet-contact isolation precautions and said she did not see the isolation caddy hanging from the door or the sign on the door. NA #3 stated she had received COVID19 training to include the use of PPE and isolation precautions in June 2021. The NA said, "I just entered the room without paying attention."</p> <p>An interview with the Administrator occurred on</p>	F 880	<p>07/26/2021 on donning and doffing of PPE when entering an Enhanced Droplet Contact Precaution room to deliver a meal tray</p> <p>2.How the facility will identify other residents having the potential to be affected by the same deficient practice . All residents have the potential to be affected by the alleged deficient practice .</p> <p>3.The measures put into place or systemic changes made to ensure that the deficient practice will not recur. All C.N.A's will be educated by Director of Nursing or designee on 1) ensuring that proper donning of PPE when entering an Enhanced droplet contact Precaution room to deliver a meal tray 2) The buddy system to help the C.N.A's pass trays during mealtimes. The buddy system involves one staff member will hand the tray to the CNA that has already donned PPE for that room, by Director of Nursing or designee, completion date 08/26/2021. Any C.N.A who is not educated by August 26, 2021, will not be allowed to work until education received.</p> <p>All new hire C.N.A's will be educated by Staff Development nurse, or Director of nursing or designee during orientation on 1) ensuring that proper donning and doffing of PPE when entering an Enhanced droplet contact Precaution room to deliver a meal tray2) The buddy system to help the C.N.A's pass trays during mealtimes. The buddy system involves one staff member will hand the tray to the CNA that has already donned PPE for that room.</p> <p>An audit will be completed by Director of</p>		

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F 880	Continued From page 40 7-30-21 at 2:03pm. The Administrator discussed a lack of education and training with staff due to not having a Staff Development Coordinator or Director of Nurses was the root cause of infection control breeches. He explained both positions were to be filled by the end of August 2021. The facility's Medical Director was interviewed by telephone on 7-30-21 at 2:32pm. The Medical Director discussed the training staff had regarding PPE usage and precautions. He stated the incident with NA #3 should not have occurred and the spread of the COVID19 virus was greater when the proper PPE was not utilized.	F 880	Nursing or designee on three C.N.A's during a meal service daily Monday through Friday x 1 week, three times a week x 3 weeks, bi-weekly X 2, and monthly x 1. 4.How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the audits will be reviewed at Quarterly Quality Assurance meeting for further problems resolution if needed X 1. 5.Completion date 08/26/2021	