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	345505	A. BUILDING _____ B. WING _____	C 11/10/2021

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F 000	INITIAL COMMENTS An onsite revisit was conducted on 11/08/2021 through 11/10/2021. Tags F580 and F657 were corrected as of 11/10/2021. However, new tags were cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. 3 of the 20 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident, and Physician Assistant interviews, the facility failed to follow physician orders for a surgical wound dressing change for 1 of 1 resident (Resident #3) and failed to change a wound vacuum-assisted closure device as ordered for 1 of 1 resident (Resident #4) reviewed for wound care. The findings included: 1a. Resident #3 was admitted to the facility on 8/24/21. The resident diagnoses included fracture	F 684	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 plan of correction constitutes the facility□s allegation of compliance. All alleged	11/29/21

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

Electronically Signed | 11/29/2021

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F 684	Continued From page 1 of T11-T12 vertebra, cerebral infarction and generalized muscle weakness. The admission Minimum Data Set (MDS) dated 8/30/21 indicated Resident #3 was severely impaired and required extensive assistance with bed mobility. A Physician order 10/15/21 indicated cleanse lower back wound with Normal saline. Pack open areas with wet to dry and cover with dry dressings daily. Leave open to air for 1 hour. Resident #3's care plan revised 10/21/21 indicated she had a non-pressure related potential/actual impairment to skin integrity of the right lower back related to surgical wound. The goal was Resident #3 would not have complications related to surgical incision. Resident #3's wound dressing to lower back was observed on 11/8/21 at 2:01 pm. Nurse #2 took off old dressing, cleaned with normal saline, applied wet dressing and covered with dry gauze with adhesive. Nurse #2 did not leave the wound open to air for 1 hour as per physician orders. During a follow up interview on 11/8/21 at 2:15 pm, Nurse #2 stated she had not noticed the last part of the physician order that stated, "leave open to air for 1 hour." She revealed she had changed the wound more than once since Resident #3 was transferred to the 300 hallway and had not left the wound open to air for 1 hour when she changed the dressing. During an interview on 11/9/21 at 9:49 am with Nurse #3, she revealed she had changed Resident #3's lower back dressing more than	F 684	deficiencies cited have been or will be corrected by the date or dates indicated. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1 is currently receiving wound care as per physician order. Resident #2 is no longer in the center. How the facility will identify other residents having the potential to be affected by the same deficient practice; " Current Residents in the center with wound care orders have the potential to be affected. The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur; " Licensed nurses will be educated by the DON/designee on following physician orders for wound care treatments as ordered/ scheduled and complete required documentation in the Treatment Administration Record. " Any nurse who did not receive the education by the compliance date will be removed from the schedule until completed. " Orientation for new nurses will include following physician orders for wound care including wound vacs. How the facility plans to monitor its performance to make sure that solutions are sustained; " DON /designee will complete observation audits of residents wound care treatments (to include wound vacs) to ensure treatment is complete as	

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F 684	Continued From page 2 once and did not leave the wound open to air for 1 hour. She stated she had not noticed the section that stated, "leave open to air for 1 hour." An interview was conducted on 11/9/21 at 1:48 pm with facility Physician Assistant (PA). The PA revealed the wound dressing order dated 10/15/21 was received from orthopedics' office and he signed off on it. He stated he expected nursing staff to follow the wound dressing order and leave the wound open to air for 1 hour before redressing the wound. Attempts to interview wound physician were unsuccessful. During an interview on 11/10/21 at 11:36 am with the Director of Nursing (DON), she indicated nursing staff were to follow physician orders as written. She stated Nurse #2 and Nurse #3 should have left Resident #3's wound open to air for 1 hour after removing the old dressing before redressing the wound. 1b. Resident #4 was admitted to the facility on 6/28/21 with diagnoses that included abdominal wound with cellulitis. Her admission Minimum Data Set (MDS) dated 7/4/21 indicated she was cognitively intact and was independent with toileting and personal hygiene. She had a surgical wound and received wound care. A Care Plan dated 6/29/21 focused on an infection of the abdominal wall with goal to be free from complications related to infection. Interventions included medication as ordered, monitor and report signs of infection to doctor. Review of Resident #4 physician's orders	F 684	scheduled per physician order and documented appropriately on Treatment Administration Record. These audits will be performed 5 residents weekly x 2 weeks, 3 residents weekly x 2 weeks ,1 resident weekly x 4 weeks, then 1 resident monthly x1. " The results of the audits will be reported to the QAPI committee quarterly for further discussion and review. Once the QAPI Committee determines the problem no longer exists, audits will be conducted on a random basis. Date of compliance is November 29, 2021	

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revealed the following orders regarding the wound vacuum-assisted closure (VAC):
Wound VAC Change every Tuesday, Thursday, Saturday on night shift ordered 7/1/21 and discontinued 7/2/21
Wound VAC Change every Monday, Wednesday, Friday on night shift ordered 7/5/21 and discontinued 7/8/21
Wound VAC Change every Tuesday, Thursday, Saturday on night shift ordered 7/8/21 and discontinued 7/24/21
Wound VAC Change every Monday, Wednesday, Friday on night shift ordered 7/26/21 and discontinued 8/3/21
Cleanse with hypochlorite solution and pack twice daily ordered 8/3/21 and discontinued 8/6/21
Wound VAC Change every Monday, Wednesday, Friday on day shift ordered 8/9/21 and discontinued 9/22/21

Review of the Treatment Administration Record (TAR) and nursing Progress Notes revealed the treatments were completed as ordered for the month of July 2021.

A nursing progress note written by Nurse #4 dated 7/8/21 documented healthy tissue to wound bed with some redness and blisters around the wound. Hydrocolloid dressing was placed about the wound.

A progress note written by Nurse #4 dated 8/3/21 indicated an increase in necrotic tissue to Resident #4's wound bed. The surgical center was called, and an appointment was made for the following day. The surgeon gave an order for wet to dry dressings (gauze with cleansing solution to remove dead tissue) to be placed overnight.

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A progress note written by Nurse #4 dated 8/4/21 indicated Resident #4 went to her appointment at the surgical center and returned with an order to continue wet to dry dressings for two days then replace wound VAC.

Review of the TAR and nursing Progress Notes for August 2021 had no documentation indicating the wound VAC change was completed for the dates 8/18/21 and 8/30/21.

A physician's progress note dated 8/20/21 revealed no issues with Resident #4's abdominal wound or wound VAC.

During an interview on 11/8/21 at 12:30 PM, Resident #4 indicated the wound VAC was not changed due to not having supplies at times. The resident further stated staff said they were ordered, but the supplies did not come when they were supposed to and the wound VAC changes were delayed.

During an interview on 11/8/21 at 4:20 PM, the facility physician revealed Resident #4's wound care orders came from the surgical center. He recalled the wound did not worsen during her stay and did not become reinfected. He was not aware of any issues with the wound VAC not getting changed.

During an interview on 11/9/21 at 9:15 AM, Nurse #4 recalled issues with the wound VAC not getting changed on night shift and weekends. The order was changed to day shift on Monday, Wednesday, Friday because of this. She indicated it improved for a while but was still an issue during Resident #4's stay. She further revealed she discussed this with her unit

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manager and previous Director of Nursing (DON).

During an interview on 11/9/21 at 10:16 AM, Nurse #1 recalled issues with wound VAC not getting changed due to not having supplies. If this occurred, she would call the doctor to get an order for alternate treatment.

During an interview on 11/9/21 at 11:05 AM, Nurse #3 was assigned to work with Resident #4 on 8/18/21. She stated if she had changed the wound vac, she would have documented it on the TAR.

During an interview on 11/9/21 at 3:10 PM, the Director of Nursing (DON) did not recall issues with Resident #4's wound VAC not getting changed. She revealed nursing staff was educated on wound VAC changes through a video in orientation. She indicated if a nurse did not know how to change the wound VAC, they should have come to her with questions.

During an interview on 11/9/21 at 3:50 PM, the Administrator did not recall issues with Resident #4's wound VAC not getting changed.

During an interview on 11/10/21 at 1:00 PM, the Surgical Center Nurse referenced documentation from 8/3/21 indicating Nurse #4 called the center stating the wound VAC had not been changed for a week and she was concerned about odor. The surgical center nurse further stated Resident #4 was seen at the surgical center the next day with a new order to apply hypochlorite solution for three days then reapply the wound VAC. She explained the notes indicated the wound was healing slowly, no odor was present, and the blisters and redness had resolved.

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F 684	Continued From page 6 Attempts to interview the surgical center doctor were made 11/10/21 at 9:30 AM, 9:45 AM, 1:00 PM with no return call. During an interview on 11/10/21 at 1:45 PM, Nurse #6 recalled working with Resident #4 on 8/30/21. She revealed she did not change the wound VAC because she did not have time. She revealed no one on day shift changed the wound VAC and she was unsure if she passed it along to the oncoming nurse.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent a resident from rolling off the bed during care which resulted in a right frontal hematoma and laceration, and right periorbital swelling from a fall and hospitalization for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #3). The findings included: Resident #3 was admitted to the facility on 8/24/21. The resident diagnoses included fracture of T11-T12 vertebra, cerebral infarction and	F 689	Past noncompliance: no plan of correction required.	11/29/21

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generalized muscle weakness.

Resident #3's care plan dated 8/25/21 indicated she was at risk for falls related to gait/balance problems and psychoactive drug use. Interventions included: anticipate and meet needs, call light within reach and encourage the resident to use it, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.

The admission Minimum Data Set (MDS) dated 8/30/21 indicated Resident #3 was severely impaired and required extensive assistance with bed mobility. She was coded for one-person physical assist with bed mobility.

An incident note written by Nurse #1 dated 9/26/21 indicated Resident #3 was rolled onto her side getting linen changed and went over the other side of the bed. She had a hematoma on right eyebrow and eyelid and laceration to right forehead.

Resident #3's post fall assessment dated 9/26/21 indicated she had a fall during bed linen change. She had a history of falls. The assessment indicated immediate action taken to prevent further falls was extra staff during rolling resident.

During an interview on 11/9/21 at 9:10 am, Nursing Assistant #1 (NA #1) indicated she was changing resident #3's linen when she fell off the bed. She turned Resident #3 away from her so that she could take off the linen and she rolled out of bed hitting her head. She tried to hold onto Resident #3, but she slipped and hit the floor. She verbalized she had been trained to turn the resident toward her if she was providing care by

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herself.

An interview on 11/9/21 at 10:26 am with Nurse #1 revealed she was the primary nurse for Resident #3 when she fell off the bed on 9/26/21. She indicated she became aware of the fall after NA #1 called for assistance from Resident #3's doorway. When she walked into the room Resident #3 was on the floor, she was bleeding from forehead and had swelling around her right eye. She was sent to the Emergency Department (ED) for evaluation.

During an interview on 11/10/21 at 11:36 am with the Director of Nursing (DON), she indicated Resident #3 fell while being turned in bed. One NA was positioning Resident #3 when she fell. The DON stated NA #1 should have turned Resident #3 toward her instead of away from her. She stated NA #1 had been trained to turn the resident toward the staff instead of away from the staff when utilizing one-person physical assist. The DON indicated Resident #3's care plan was updated on 9/27/21 to 2-person physical assist with bed mobility to include rolling and repositioning.

An ED consult note dated 9/26/21 revealed Resident #3 was seen at the ED on 9/26/21 for a fall. Resident #3 had a right frontal hematoma and laceration, and right periorbital swelling.

A hospital Physician note dated 10/1/21 revealed Resident #3 was discharged from inpatient on 10/1/21. The discharge diagnosis was subdural hematoma. She was evaluated for a fall from bed on 9/26/21 and admitted through 10/1/21. Computerized Tomography (CT) scan of head/C-spine revealed 3 mm subdural

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hematoma, right temporal parietal region with soft tissue swelling/hematoma overlying the right frontal and periorbital region. No skull or cervical fractures were noted. General surgery, neurosurgery and trauma were consulted for subdural hematoma with no surgical intervention needed. The hospital physician note also indicated there was no focal deficit and mental status was at baseline.

An interview was conducted on 11/10/21 at 12:00 pm with the Administrator. She stated NA#1 should have turned Resident #3 toward her because she was providing care by herself. She stated all the nursing staff were retrained, after Resident #3's fall, on turning residents toward staff if utilizing one-person physical assist. The Administrator indicated the facility had completed a plan of correction related to the fall.

The facility's corrective actions implemented after the accident to prevent a reoccurrence included the following:
1. Resident #3 was transferred to the hospital post fall on 9/26/21 for evaluation.
2. Resident #3's care plan was revised on 9/27/21 to include two-person assist with turning and positioning and on 10/1/21 to include fall mats at bedside.
3. On 9/29/21 NA #1 was provided with education related to ensuring you turn the patient toward you, not away from you during care
4. On 9/29/21 education to nurses and nursing assistants was provided to ensure you turn a person toward you, not away from you when using one person assist during turning and repositioning
5. Staff educated if any resident is noted with abnormal or involuntary movements, they are to

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make resident two person assist until evaluated
6. Any nurse or nursing assistant who did not receive the education by the compliance date will be removed from schedule until completed. All new nursing staff would receive education during the orientation process.
7. QAPI committee met on 10/1/21 to review findings from 9/26/21 and education. POC was finalized.
8. DON/designee will perform audits of 5 random staff members to ensure they turn residents toward them during care. The audits will be performed daily x2 weeks, 3x a week for 2 weeks, weekly x4 weeks, then monthly x1.
9. DON is responsible for daily monitoring of audits and will report to Administrator daily in morning meetings any residents found to have abnormal movements. Administrator will report results to QAPI monthly x3 for compliance/changes if needed to the plan.

On 11/10/21 the facility's Plan of correction was validated by the following: Audits conducted by the facility were reviewed and were found to be completed according to the plan of correction. Auditing started 10/1/21 and was expected to be completed by 12/15/21. All nurses and nursing assistants were educated on turning and repositioning. The training content stated, "Will ensure you turn a person toward you not away from you when using one person assist during turning and repositioning according to Mosby's textbook for long term care nursing assistants, 8th edition chapter 15 Body Mechanics page 198." Facility Administrator conducted the initial training and Staff Development Coordinator(SDC) was responsible for tracking and training those who had not been trained. The SDC trained new nurses/nursing assistants as well as agency

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F 689	Continued From page 11 nurses/nursing assistants. SDC stated she was responsible for training new hires and turning/positioning training was part of the new employee orientation. On 11/8/21 at 2:01 pm nursing staff were observed turning Resident #3 using two - person assist as indicated in her care plan revised 9/27/21. During survey a nursing assistant was observed turning a resident toward the NA when utilizing one-person assist according to the in-service material. Interviews were conducted with nurses and nursing assistants who verbalized they had received training related to turning residents toward staff personnel if using one person assist.	F 689		