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	345149	A. BUILDING ______ B. WING ______	C 05/20/2015

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BRIAN CTR HEALTH & RETIREMENT	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		6-17-15

483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to follow-up on a missed appointment and failed to accurately transcribe discharge recommendations for activity restrictions for 1 of 6 sampled residents (Resident #4) reviewed for quality of care. Based on staff interview and record review the facility also failed to provide adequate antifungal treatment to 1 of 1 sampled residents (Resident #1) diagnosed with skin irritation and underlying infection. Findings included:

1. Resident #4 was discharged from an acute care hospital and admitted to the facility on 04/28/15. His hospital discharge diagnosis was documented as post-operative subdural hemorrhage. His facility admission diagnoses included Diabetes Mellitus, Hypertension, Cerebrovascular Disease with Hemiplegia. Further record review revealed an Admission Minimum Data Set (MDS) dated 05/05/15 which documented that the resident required extensive assistance for bathing, transfers and mobility. The resident was assessed as being moderately impaired cognitively.

F309

An immediate review by the rehab manager on June 20, 2015 of Resident #4's therapy record showed that he had not exceeded 2 pounds of weight lifted or 21% activity participation and did not include bending. This resident went for an ultrasound on 5/18/15 and was admitted to the hospital from the doctor's office.

Resident #1 was already discharged from the facility at the time of the survey. The facility was aware of the Lotrisone transcription error as a Medication Variance form was filled out and counseling was done with the nurse by the DON on 4/28/15.

All may be affected by the alleged deficient practices.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce B. McGuire — TITLE: Administrator — (X6) DATE: 6-19-15

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 1 A review of the hospital discharge recommendations for Resident #4 included limited activity--not bending, moving furniture or performing strenuous activity--to be cleared at a follow-up appointment for the post-subdural brain hemorrhage with neurosurgeon on 05/20/15. Resident #4 was scheduled to have a lower extremity ultrasound on 04/29/15 to follow-up on a Deep Vein Thrombosis (DVT) in 9/2014 and concerns of developing a new DVT. A review of the attending physician's admission orders, dated 05/01/15, for Resident #4 documented for physical therapy and occupational therapy with no deferred therapy or limitations noted. There was no order documented regarding a venous duplex ultrasound DVT test. A review of the resident's medical record showed no documentation of an appointment scheduled for a venous duplex ultrasound DVT test. Review of admission orders for resident #4 revealed Nurse #3 transcribed regular activity with physical and occupational therapy on 04/28/15. Review of resident # 4's ultrasound results revealed no ultrasound results from 04/29/15. During an interview conducted on 05/20/15 at 5:18 PM with Nurse #3 she stated she transcribed admission orders on Resident #4, indicated that she did not see any activity restriction from the neurosurgery discharge skilled nursing facility instructions and transcribed regular activity with physical therapy and occupational therapy for admission activity on Resident #4 on 02/28/15. Nurse # 3 continued by stating that she did not routinely read through discharge packets. During a 05/18/15 4:34 PM interview the Director of Nursing (DON) indicated that Resident #4, to	F 309	Audits were done of all charts by the DON. ADON, or Unit Manager to validate admission orders were transcribed correctly and follow up appointments had been scheduled as ordered. New admission charts are now audited by the team during the next morning meeting following admission. Needed follow-ups are noted and are reported on the next day. The DON has re-educated all Licensed Nurses regarding reading the discharge summary and transcribing physician's orders correctly to the physician's order sheet, MAR and TAR, and scheduling follow up appointments. The DON and ADON will monitor new admission charts 3 times per week for 12 weeks to validate accurate transcription of physician's orders and scheduling of follow up appointments. Opportunities identified as a result of these audits will be corrected at the time observed.	

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F 309	Continued From page 2 her knowledge, was not admitted with any activity restrictions, and that she would expect the hall nurses to accurately transcribe and clarify all orders and recommendations from discharge with the resident's doctor. She stated that her expectations were for the hall nurses to notify the doctors about any appointments missed by the residents. She revealed that Resident #4 had missed the recommended ultrasound appointment scheduled for 04/29/15. During an interview conducted with the medical doctor for facility on 05/19/15 at 12:38 PM she indicated she was not notified of Resident #4's missed Venous Duplex ultrasound on 04/29/15. She stated that she was not aware of admission neuro-surgery activity recommendations or any activity restrictions for Resident #4. She further revealed that she expected licensed (Registered nurses and licensed practical nurses) staff to correctly and accurately communicate and clarify residents' hospital discharge orders and recommendations from discharging surgeons as well as clarifying orders with her. 2. Resident #1 was admitted to the facility on 04/17/15 and discharged home on 05/09/15. The resident's documented diagnoses included panniculitis (inflammation of the fat and connective tissue that lies underneath the skin, often presenting with tender skin nodules), sepsis, and obesity.	F 309	The DON will report the results of the monitors to the Quality Assurance and Performance Improvement Committee at regular meetings for the next 6 months. The committee will evaluate the plan's effectiveness and make recommendations for ongoing compliance.	

Preparation, submission and implementation of the Plan of Correction does not constitue an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 3 A 04/17/15 hospital discharge summary listed lotrisone cream as a new medication which was to be applied topically every eight hours, after cleansing, to a rash and hypergranulated tissue in the neck fold and every eight hours, after using secura cleanser, to abdominal folds and the perineal areas with pads applied to keep skin folds separated. Nystatin cream was listed under continued medications to be applied topically daily to skin folds. Review of Resident #1's April 2015 treatment administration record (TAR) revealed the facility began the administration of the nystatin cream, but did not utilize the lotrisone cream upon admission. Review of the facility's grievance log revealed on 04/18/15 a family member was concerned because the resident was not receiving his skin creams as ordered. A 04/23/15 Nursing Daily Skilled Summary documented this same family member requested to see the facility's wound doctor in relation to Resident #1's skin condition. The note documented the family member was told the wound doctor was no longer in the building, but the nurse practitioner (NP) was sent to assess the resident. In a 04/23/15 progress note the NP assessed two ulcerated areas on Resident #1. However, the resident's panniculitis and skin treatment regimen were not addressed. Resident #1's 04/24/15 admission minimum data set (MDS) documented his cognition was intact, he required extensive assistance to being totally dependent on the staff for his activities of daily living, and he was receiving intravenous medications to treat his panniculitis. On 04/24/15 "Actual infection related to urinary tract and skin panniculitis" was identified as a	F 309		

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F 309	Continued From page 4 problem in Resident #1's care plan. Interventions to the problem included "Administer medications and/or treatments as ordered." On 04/24/15 "Non-pressure ulcer skin impairment: actual skin impairment r/t (in regard to) diabetes, morbid obesity with panniculitis" was identified as a problem in Resident #1's care plan. Interventions to the problem included "wound care as ordered." A 04/28/15 Medication Variance Report documented Resident #1 did not receive lotrisone cream due to a transcription error/omission from hospital discharge records. Review of the resident's April 2015 TAR revealed the lotrisone cream began to applied to the resident's neck, abdominal folds, and perineal area on 04/28/15. A 04/30/15 Wound Care Specialist Initial Evaluation documented Resident #1 had scaly plaques to his head/face, tinea cruris (superficial fungal infection) to his chest, seborrheic keratosis (benign skin growths) to his back, irritated dermatitis to his groin/buttock, and lichenification to his right and lower extremities. The specialist prescribed "Nizoral (antifungal) cream 2% bid (twice daily) under breasts and pannus with abds (pads) prn (as needed) for drying." A 04/30/15 physician order documented, "Clean under breast and abdominal folds with NS (normal saline). Apply nizoral ointment 2% BID." Review of the resident's April and May 2015 TARs revealed this order was not transcribed to the TARs until 05/05/15, and the resident did not receive the application of any nizoral cream before his discharge home. A 05/07/15 follow-up wound specialist note documented the lichenification of Resident #1's bilateral lower extremities remained unchanged, but the fungal infection of the chest and the	F 309		

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F 309	Continued From page 6 application to promote skin healing. She reported the family member was referring to treatments the resident received while hospitalized. The administrator commented she explained the nursing home had to provide treatment prescribed by the primary physician, medical director, and wound care specialist. At 10:40 AM on 05/19/15 RCS #2, who cared for Resident #1 on first shift, stated she used aloe vera wipes when providing incontinent care, and applied barrier ointment to the resident's buttocks and groin due to redness and irritation. She reported she was not sure what medicated creams the nurses were applying, but recalled a family member complaining that nursing was not applying these creams like she knew they were supposed to. At 11:10 AM on 05/19/15 the director of nursing (DON) stated, according to a 04/28/15 Medication Variance Report, Resident #1 did not receive the lotrisone treatment documented in the hospital discharge summary. She reported this was not acceptable. She also commented if the nursing staff had confusion about the wound specialist's 04/30/15 nizoral order, then they should have contacted the specialist or primary physician for a clarification order. Otherwise, she stated, she expected the staff to apply the nizoral cream BID to help with the fungal irritation under Resident #1's breasts.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		6/17/15

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F 314	Continued From page 7 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to change pressure ulcer dressings for 1 of 3 residents (Resident #6) reviewed for pressure ulcers. Findings included: Resident #6 was admitted to the facility on 05/12/2015 after hospitalization for the evaluation and treatment of sepsis secondary to Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia. Diagnosis history included: Tachycardia, pressure ulcers, urinary tract infection and diabetes mellitus, type 2. A compete Minimum Data Set (MDS) had not yet been completed at the time of the survey, but a Brief Interview for Mental Status (BIMS) assessment, completed on 5/15/2015, indicated that Resident #6 was cognitively intact. Hospital discharge orders, dated 5/12/2015, stated the follow treatment was to be done daily to 7 areas including Resident #6's right stump, healing stage IV to left plantar foot, left heel, left lateral lower leg, healing stage IV to right ischium, and stage IV to sacrum: Clean daily with normal saline. Apply Elta silver gel ¼" thick and Mepilex. On 5/13/15, hospital discharge orders were transcribed as a telephone order and stated that the left plantar foot, left heel, left lateral heel, sacral, and ischial areas were to be cleansed with	F 314	F314 The DON ensured the completion of the dressing change for resident #6 on 5/19/2015 and daily as ordered thereafter. A medication variance was completed for the treatments not completed as ordered. Residents requiring wound treatments may be affected by the alleged deficient practice. The DON and ADON completed an audit of all residents with physician ordered wound treatments to verify treatment was provided as ordered by 6-15-15. The DON and ADON re-educated all Licensed Nurses regarding the timely completion of treatments according to the physician's orders including accurate documentation of completed treatments by 6-15-15. The DON and ADON will observe 3 nurses per week for 12 weeks providing wound care and will validate these treatments were completed according to the physician's orders. Opportunities identified as a result of these audits will be corrected at the time observed.	

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F 314	Continued From page 8 normal saline and that Elta silver gel should be applied ¼" thick and Mepilex. On 5/14/15, new telephone orders were written to change the pressure ulcer dressing changes to cleanse with normal saline and apply hydrogel and dry dressing every other day for the left plantar foot, lateral ankle, and lateral shin. The orders for the sacrum, left ischium, coccyx, and right ischium were also changed in the same telephone order to cleans with normal saline and apply Silvadene and dry dressing every day. In an interview with Resident # 6 at 9:42 AM on 5/19/2015, he stated that his pressure ulcer dressings had not been changed since Saturday, 5/16/2015 and had only been changed one other time prior to Saturday since he was admitted to the facility on 5/12/2015. A review of the treatment administration record on 5/19/2015 at 9:45 AM revealed that dressing changes had been signed off on 5/14/2015, 5/15/2015, 5/16/2015, 5/17/2015, and 5/18/2015 for the sacrum, left ischium, coccyx, and right ischium. No treatments had been documented prior to 5/14/2015 although there were admission orders for treatments starting on 5/12/2015. An observation of Resident #6's wound care on 5/19/2015 at 12:30 PM revealed one large sacral wound, one coccyx wound, one right ischium wound, and one left ischium wound. Prior to the surveyor entering the resident ' s room, Nurse # 2 had already pulled the privacy curtain, placed the resident on his right side, lowered the head of the bed, was gloved, and had removed the previous wound dressing and had it rolled up under the bed pad or chuck. The treatment supplies were	F 314	The DON will report the results of the audits to the QAPI committee at each regular meeting for 6 months. The committee will evaluate the effectiveness of the plan and make recommendation for continued compliance.	

Preparation, submission and implementation of the Plan of Correction does not constitue an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

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F 314	Continued From page 9 set up both on the small bed side night stand and on resident's bed next to the sacral wound. The resident was then asked when the last time his ulcer dressing was changed? He replied that his last ulcer dressing change was done on Saturday, 05/16/15. Nurse #2 replied that some of the ulcer dressings were changed daily and the others were changed every other day, which were all initialed on the TAR. The nurse could not explain what type of ulcers the resident had, their location, size, who changed the dressing last, or even if she had changed a dressing herself. During the dressing change and wound observation the nurse said she had just previously cleaned the sacral wound with normal saline and was in the process of applying a silver Sulfadiazine cream onto the ulcers. While the nurse was applying the Sulfadiazine cream, the sacral, coccyx, and two ischium wounds were observed to be pink to beefy red, without drainage, and all had a foul odor. After applying the cream, Nurse #2 covered the ulcers with a dry dressing. She was then asked to see the old dressing which was rolled up under the bed pad. The nurse unrolled the bed pad which revealed an old dirty brown to black foul smelling dressing. The nurse was then asked to turn over the old dressing to look at the other side. When she did, it showed a black marker hand written date of 05/16/15 written on it. The nurse did not respond when the date was pointed out to her. In an interview on 5/19/15 with Nurse #3, the nurse who had initialed on Resident # 6's TAR that the treatments had been completed on 5/17/15 and 5/18/15, she stated she did not get a chance to get to his treatment and passed it on to the nurse relieving her on the 11-7 shift. She stated that she was not able to describe the	F 314		

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F 314	Continued From page 10 resident's ulcers because she had never done his treatments despite signing off on the TAR that she had. Nurse #3 stated that she understood that she should not have initialed the TAR unless she had actually done the treatments. Staff interview with Nurse #2 on 05/20/15 at 9:51 AM revealed that Resident #6's coccyx, 2 ischium, and sacrum ulcer dressing changes were ordered to be changed daily and the leg ulcers dressing changes should be every other day (QOD). The nurse said the last dressing change she did on Resident#6 was on 05/14/15 when the wound doctor last saw the resident. When asked why the resident ' s ulcer dressing changes were not done from 05/16/16 to 05/19/15, she said, that was a good question. She said if the dressing was not done on one shift, it should have been passed onto the next shift to do. Nurse #2 was asked why 9 shifts went by and still no one changed the resident's dressings and she said, it was not acceptable, and not the expectation of the facility, and that she was unhappy when she saw the brown to black dressing covered with exudate on 05/19/15. On 5/20/15 at 12:30 PM the Director of Nursing (DON) stated admitting nurses are responsible for the initial skin assessments for residents and that the wound doctor, accompanied by Nurse #2 rounded on residents with wounds each Thursday. She stated that if residents were admitted with wound treatment orders, they would be transcribed as a phone order and verified with the facility physician and it would be the expectation that they would be implemented upon verification. The DON stated that most wound treatments were done on the 7-3 or 3-11 shifts, but that treatments could be done on 11-7 if they	F 314		

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F 314	Continued From page 11 were not done on the previous shift. She stated that her expectation would have been that Resident #6's wounds would have been treated per the physician's orders upon admission and each day as ordered. It was not her expectation that Resident #6 was admitted on 5/12/15 and did not have his dressings changed until 5/14/15 and then not changed again between 5/16/15 and 5/19/15. She stated that she would expect that the nurses would not sign off on a treatment on the TAR until after the treatment had been administered and not before. The DON also stated that a corresponding note should be written in the resident's chart once a treatment had been completed.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		6/17/15

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F 356	Continued From page 12 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility failed to post nursing staffing for 4 consecutive days and failed to include census information in nursing staffing postings for staff, residents, and visitors in the nursing facility. Findings included: At 6:20 AM on 5/18/2015, an observation of the posted nursing staffing revealed that nursing staffing had not been posted since 5/13/2015 and the census information was not included in the posting. At 2:15 PM on 5/18/2015 an observation of the posted nursing staffing revealed that it had been updated to reflect staffing on 5/18/2015, however, there was still no resident census listed. In an interview with the Director of Nursing (DON) on 5/20/15 at 12:30 PM, she stated that the Assistant Director of Nursing (ADON) was the person who posted the daily nurse staffing in the facility, but that she would be the person responsible for the posting if the ADON was not there. She reported that she understood that the staffing was supposed to be posted separately for the skilled nursing floor and the assisted living	F 356	The ADON took immediate corrective action for the alleged deficient practice by posting the missing census data on the staffing sheet on 5//20/15. The alleged deficient practice has a the potential to affect all residents. A new staffing posting sheet was developed and implemented to include the facility's daily census by 6-15-2015. The ADON was re-educated by the DON to include the facility's daily census on the staffing posting sheet by 6-15-15. The Administrator, DON, and Weekend Managers are monitoring the staffing posting sheet daily for 2 weeks, then 3 times per week for 10 weeks. Opportunities identified as a result of these audits will be corrected at the time observed. The Administrator will report on the results of the monitoring to the QAPI committee at each regular meeting for 6 months. The committee will evaluate and make further recommendations as needed.	

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F 356	Continued From page 13 floor and that the information that should be included in the posted was the nursing disciplines, hours scheduled, and daily resident census. The DON stated that it would be her expectation that the staffing was posted daily at the beginning of the day. At 3:35 PM on 5/20/15, the ADON stated that she was the person responsible for posting the staffing each day and that she usually posted the staffing the first thing in the morning upon arriving to work. She reported that the DON and/or weekend nursing staff would do the postings if she were not there and that should would find it unusual not to have the postings done for 4 or 5 days. The ADON stated that the nursing disciplines and hours scheduled to work was the information included in the postings, but the resident census was not listed on the staff postings.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F441 Resident #5 remains without signs and symptoms of wound infection. Nurse#1 received immediate one-on-one education on 5/18/15 by the Director of Nursing regarding infection control techniques including cleaning scissors prior to use in wound care. The scissors have been cleaned and stored properly. All residents receiving wound care requiring scissors to cut needed supplies may be affected by this alleged deficient practice.	6/17/15

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F 441	Continued From page 14 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, nursing staff failed to follow the facility policy to clean scissors for 60 seconds of contact with alcohol and place on a clean corner of the setup before use while providing wound treatment for 1 of 4 residents (esident #5). Findings included: Review of facility "Infection Prevention Manual for Long Term Care" dated 2012, read in part under "Wound Care Procedures for Major Wound" section II stated: 1. Cut the tape with your clean scissors. 2. Clean the scissors with 60 seconds of contact	F 441	The DON arranged an inservice by a KCI representative on 6/3/15 regarding infection prevention techniques with wound care including cleaning scissors prior to use. All Licensed Nurses were required to attend. The DON or ADON will observe a wound treatment by each nurse who does wound treatments to verify acceptable infection prevention techniques are being utilized by 6-15-15. The DON or ADON will randomly observe 3 dressing changes weekly for 12 weeks. Opportunities identified as a result of these audits will be corrected at the time observed. The DON will report the results of the audits to the QAPI team during every regular meeting for the next 6 months. The committee will evaluate and make further recommendations as indicated.	

Preparation, submission and implementation of the Plan of Correction does not constitue an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

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F 441	Continued From page 15	F 441		

with alcohol and place on a clean corner of your setup. An additional note states: "Clean technique" is used. Care must be taken to prevent contamination of the supplies and surfaces used in wound care."

Resident #5 was admitted to the facility on 03/25/15 with cumulative diagnoses including: stress fracture of the hip, degenerative joint disease (DJD), infected prosthesis of left hip, and status post infection and debridement (I & D) with a wound vacuum assisted closure (VAC).

During observation of a surgical wound VAC change-out and dressing change on 05/18/15 at 10:30 AM, Nurse #1was observed cleaning the outer edge of resident #5's left hip surgical wound with skin prep, then cutting gray wound packing foam with scissors taken out of her pocket. Nurse #1 was then observed packing the gray wound packing foam into resident #5's surgical wound with the gray wound packing foam that was cut with un-clean scissors.

During an interview with Nurse #1 on 05/18/15 at 2:00 PM, the nurse stated that she cleaned her personal scissors with "soap and water in the resident's bathroom", prior to Resident #5's surgical wound treatment, and placed them in her pocket. Nurse #1 stated, "The only thing I ever put in my pocket are my scissors."

During an Interview with Nurse #2 on 05/19/15 at 10:40 AM, the nurse stated that in a wound treatment she would expect the following process:

1. Keep the treatment cart stocked with scissors, tape, saline, staple remover kits, and germicidal cleaner for personal equipment like

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F 514	Continued From page 17 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to maintain complete and accurate treatment administration records (TARs) for 2 of 6 sampled residents (Resident #1 and #6) as evidenced by completed treatments which were not initialed off on the TARs and treatments which were initialed off on the TARs but never completed. Findings included: 1. In an interview with Resident # 6 at 9:42 AM on 5/19/2015, he stated that his pressure ulcer dressings had not been changed since Saturday, 5/16/2015 and had only been changed one other time prior to Saturday since he was admitted to the facility on 5/12/2015. A review of Resident# 6's treatment administration record (TAR) on 5/19/2015 at 9:45 AM revealed that dressing changes had been signed off on 5/14/2015, 5/15/2015, 5/16/2015, 5/17/2015, and 5/18/2015 for the sacrum, left ischium, coccyx, and right ischium. In an interview on 5/19/15 with Nurse #3, the nurse who had initialed on Resident # 6's TAR that the treatments had been completed on 5/17/15 and 5/18/15, she stated she did not get a chance to get to his treatment and passed it on to the nurse relieving her on the 11-7 shift. She stated that she was not able to describe the resident's ulcers because she had never done his treatments despite signing off on the TAR that	F 514	F514 Resident #6 immediately received wound treatment as ordered on 5-19-15 and the treatment was then documented properly on the Treatment Administration Record. Resident #1 had already been discharged from the facility at the time of the survey. The DON completed a Medication Variance for the inaccurately documented treatments for resident #6 on 5-17-15 and 5-18-15. Nurse #3 received disciplinary action on 5-19-15 from the DON regarding the inaccurate documentation identified for 5-17- and 5-18-15. All residents requiring wound treatments may be affected by the alleged deficient practice. The DON and ADON completed an audit of all residents with physician ordered wound treatments to verify treatment was provided as ordered and documented accurately by 6-15-15.	

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F 441	Continued From page 16 stethoscopes and scissors. 2. To use a germicidal agent to clean personal equipment. 3. To not put personal equipment like scissors in your pocket, but to keep cleaned scissors on top of treatment cart in the clean field. During an interview with the Nurse Practitioner on 05/18/15 at 12:20 PM, revealed that it was her expectation that all nurses' personal equipment to be cleaned before and after use according to the facility policy. During an interview with the ADON on 05/19/15 at 4:45 PM, revealed that it was her expectation that nurses' private scissors must be cleaned with sanitation wipes prior to use, and that un-clean scissors should never be used or placed on a clean field. During an interview with the DON on 05/18/15 at 12:30 PM, she revealed that it was her expectation that all staff nurses' personal equipment to be cleaned with a germicide before and after each use, per facility protocol.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514		6/17/15

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F 514	Continued From page 18 she had. Nurse #3 stated that she understood that she should not have initialed the TAR unless she had actually done the treatments. On 5/20/15 at 12:30 PM the Director of Nursing (DON) stated admitting nurses are responsible for the initial skin assessments for residents and that the wound doctor, accompanied by Nurse #2 rounded on residents with wounds each Thursday. She stated that if residents were admitted with wound treatment orders, they would be transcribed as a phone order and verified with the facility physician and it would be the expectation that they would be implemented upon verification. The DON stated that most wound treatments were done on the 7-3 or 3-11 shifts, but that treatments could be done on 11-7 if they were not done on the previous shift. She stated that her expectation would have been that Resident #6's wounds would have been treated per the physician's orders upon admission and each day as ordered. It was not her expectation that Resident #6 was admitted on 5/12/15 and did not have his dressings changed until 5/14/15 and then not changed again between 5/16/15 and 5/19/15. She stated that she would expect that the nurses would not sign off on a treatment on the TAR until after the treatment had been administered and not before. The DON also stated that a corresponding note should be written in the resident's chart once a treatment had been completed. 2. Resident #1 was admitted to the facility on 04/17/15 and discharged home on 05/09/15. The resident's documented diagnoses included	F 514	The DON re-educated all Licensed Nurses regarding the timely completion of treatments according to the physician's orders including accurate documentation of completed treatments by 6-15-15. The DON or ADON will audit the MAR and TAR 3 times per week for 12 weeks to validate accurate documentation. Opportunities identified as a result of these audits will be corrected at the time observed. The DON will report the results of the monitors to the QAPI committee at regular meetings for the next 6 months. The committee will evaluate the plan's effectiveness and make recommendation for ongoing compliance	

Preparation, submission and implementation of the Plan of Correction does not constitue an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

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sacral/buttocks pressure ulcer, panniculitis (Inflammation of the fat and connective tissue that lies underneath the skin, often presenting with tender skin nodules), sepsis, and obesity.

A 04/23/15 physician order initiated the cleansing of the top crease of Resident #1's buttocks with normal saline (NS) and the application of vaseline gauze at the crease daily.

Review of the resident's April 2015 and May 2015 treatment administration records (TARs) revealed the cleansing and application of vaseline gauze to Resident #1's buttock crease was not initialed off as completed on 04/24/15 through 04/26/15, 04/29/15, 04/30/15, and 05/07/15.

A 04/30/15 physician order documented, "Clean under breast and abdominal folds with NS. Apply Nizoral ointment 2% BID (twice daily).

Review of the resident's April 2015 and May 2015 TARs revealed this order was not transcribed to the TARs until 05/05/15. This treatment was not initialed off on 05/05/15 through 05/09/15 as having been completed.

At 3:10 PM on 05/18/15 Nurse #3, who cared for Resident #1 on second shift, stated to her knowledge the resident received all the wound treatments and antifungal creams as ordered.

At 10:00 AM on 05/19/15 Nurse #2, the first shift unit coordinator who cared for Resident #1, stated to her knowledge the resident received all the wound treatments and antifungal creams as ordered.

At 11:34 AM on 05/19/15 the director of nursing

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F 514	Continued From page 20 (DON) stated the TARs were the facility's official record of administered treatments. She reported once staff completed treatments they initialed them off on the TARs. She commented staff were not supposed to initial treatments off on the the TARs until the treatments were completed because they might get sidetracked and forget to return to the residents to provide those treatments. According to the DON, if treatments were refused by residents, the staff circled their initials on the front of the TARs and documented an explanation of the back of the TARs.	F 514		