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F 000	INITIAL COMMENTS A complaint investigation was conducted from 02/12/18 through 02/15/18. Immediate jeopardy was identified at: CFR 483.10 at tag F 580 at a scope and severity (J) CFR 483.25 at tag F 686 at a scope and severity (J). The tags F 580 and F 686 constituted Substandard Quality of Care. Immediate jeopardy began on 01/09/18 and was removed on 02./15/18. An extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		2/26/18

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

Electronically Signed | 03/04/2018

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff, Physician, Physician Assistant (PA), Wound Nurse Consultant interviews and record review, the facility failed to notify the physician of the resident's pressure ulcers on the resident's admission and failed to obtain treatment orders, resulting in the resident's delay in treatment from 1/9/18 till 1/12/18. The facility failed to get the physician approval before the initiation of pressure ulcer treatment. The facility failed to notify the physician of the Wound Nurse	F 580	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Resident #1 no longer resides in the	

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F 580	Continued From page 2 Consultant treatment orders for Resident #1's pressure ulcers. The facility failed to notify the physician of the worsening of the pressure ulcers and seek an order for treatment. Resident #1's sacral pressure ulcer was described as "quarter size" suspected deep tissue injury (purple or maroon area of discolored intact skin) on 01/09/18. It was described on 01/22/18 as an unstageable sacral pressure ulcer measuring 13.5 centimeter (cm) length, 12.5 cm width and 1.5 cm depth having excessive necrotic tissue appearing yellow/black in color and as deteriorated. Resident #1 was hospitalized with an infected stage 4 pressure ulcer requiring sharp debridement and antibiotic therapy. Immediate jeopardy began on 01/09/18 for Resident #1 when the facility failed to notify Physician #1 of the resident's pressure ulcers and failed to obtain treatment orders, resulting in the resident's delay in treatment from 1/9/18 till 1/12/18. On 01/12/18, the Treatment Nurse began implementing treatment orders without approval of the physician. The facility failed to notify the physician of the Wound Nurse Consultant treatment orders on 1/15/18 for Resident #1's pressure ulcers. The facility failed to receive approval of the physician before starting new pressure ulcer treatment on 1/16/18. The facility failed to notify the physician of the worsening of the pressure ulcers on 1/22/18 and seek an order for treatment. Resident #1's pressure ulcer worsened and he was hospitalized with an infected stage 4 pressure ulcer requiring sharp debridement and antibiotic therapy. Immediate jeopardy was removed on 02/15/18 when an acceptable credible allegation was provided. The facility remains out of compliance	F 580	facility. The nurses were unsure to call the Medical Director for treatment orders when the attending physician was unable to be reached. There was a lack of follow through by nursing to assure orders were received for treatment and a lack of oversight to identify and treat any worsening wound condition. The Treatment Nurse was removed from completing treatments 2/14/18 and retraining initiated. Floor staff will complete treatments beginning 2/14/18 until the Treatment Nurse's retraining is completed. A 100% audit of all current residents with a wound was completed by the Regional Clinical Consultant on 2/15/18 to verify physician and Responsible Representative notification of the wound was completed when discovered. Three instances lacked Responsible Party notification at the time of discovery. In those 3 instances, the wound was a surgical incision and the resident was deemed alert and oriented. One instance of delayed notification was noted. The Responsible Representative was contacted on 2/15/18 by the Unit Manager and given the history and current status of the wound. The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of all nursing assistants on reporting skin changes noted during care by completing	

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F 580	Continued From page 3 at a lower scope and severity of D (isolated with no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and that all staff have been in-serviced. The findings included: Resident #1 was admitted to the facility on 01/09/18 with cumulative diagnoses of Parkinson's disease, Peripheral Vascular Disease, Dysphagia and Benign Hypertrophic Prostrate, urinary retention with an indwelling urinary catheter. Review of Resident #1's admission orders dated 01/09/18 read he was ordered a skin assessment weekly every Wednesday and no treatment orders for a pressure ulcer. Review of Resident #1's admission nursing note dated 01/09/18 at 4:36 PM read there was a quarter sized open area on his right buttock which was described as brownish/dark in color with a slight odor and minimal serosanguinous drainage. There was no documented evidence that Physician #1 was notified. Review of Resident #1's Wound Assessment Report dated 01/09/18 read Resident #1 was admitted with an unstageable pressure ulcer to his right buttock measuring 3.5 centimeters (cm) length, 7.5 cm width and 0.5 cm depth. It was described as 40% eschar (dry, dark scab of dead skin) and 60% granulation (pink tissue containing capillaries formed around the wound edges). The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/09/18 with treatment orders pending.	F 580	a full body shower sheet and submitting the sheet to the Charge Nurse. The Staff Development Coordinator initiated an in-service on 2/14/18 to 100% of all licensed staff to complete admission/re-admission head to toe skin assessments and weekly head to toe skin assessments with documentation of the assessment in the electronic medical record. The in-service will include calling the physician for treatment orders for all wounds identified with the admission skin assessment. The in-service included what to do when a new skin issue is identified and notification to the MD for treatment orders, Responsible Representative, Treatment Nurse, and Unit Managers. All newly hired nursing staff will receive the appropriate education during orientation. No staff will work until the in-service is completed. Corrective action completed on 2/26/18. Utilizing a Wound Notification QI Audit Tool, the Unit Managers will review the Wound Communication Book to assure the physician and Responsible Representative has been notified of any new wound.Monitoring will occur Monday through Friday x 2 weeks then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month. The Weekend Supervisor will complete the audit on the weekend x 2. Using an Admissions Wound QI Tool, the Unit Managers will review all new admission/re-admission records to assure a skin assessment was completed on admission and any identified skin issues were addressed with	

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F 580	Continued From page 4 Review of Resident #1's Wound Assessment Report dated 01/09/18 read Resident #1 was admitted with an unstageable, due to suspected deep tissue injury, pressure ulcer to his sacrum measuring 3.5 cm length and 7.5 cm width. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/09/18 with treatment orders pending. Review of Resident #1's Wound Assessment Report dated 01/09/18 read Resident #1 was admitted with an unstageable pressure ulcer to his left buttock measuring 3.5 centimeters (cm) length, 7.5 cm width and 0.5 cm depth. It was described as 60% Eschar and 40% granulation. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/09/18 with treatment orders pending. Review of Resident #1's January 2018 Treatment Administration Record (TAR) included no treatment orders to his bilateral buttocks and sacrum from 01/09/18 through 01/12/18. Review of the electronic physician orders dated 01/12/18 at 11:10 AM revealed the Treatment Nurse entered the following new treatment orders to the electronic physician orders which auto-populated the Treatment Administration Record (TAR): bilateral buttocks and sacrum were to be cleansed with wound cleanser, patted dry and Calmoseptine ointment (analgesic, antiseptic, antipruritic, and skin protectant combination) was to be applied to the peri-wound with Silver Alginate (an antimicrobial, highly absorbent wound dressing with ionic silver) to the wound bed. It was to be covered with a protective foam dressing daily and as needed. There were	F 580	a treatment order, progress note, notification to the MD and RP was made, and notification was completed in the Wound Communication book. The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process. The Administrator will be responsible for implementing the plan of correction.	

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no written physician orders for this treatment (A written physician order requires the prescriber to acknowledge the order with his/her signature).

A telephone interview was conducted with Nurse #2 on 02/14/18 at 3:25 PM. Nurse #2 stated she admitted Resident #1 on 01/09/18 and completed his initial skin assessment and noted a small area on his sacrum. She stated she completed a wound communication form and gave it to the Treatment Nurse on 01/09/18 as she was leaving. Nurse #2 stated the physician had to be contacted for orders for every new or worsening pressure ulcer. She stated it was the responsibility of the Treatment Nurse to contact Physician #1 for treatment orders.

During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated she was not made aware of any pressure ulcers found on Resident #1 until 01/12/18. When questioned regarding the Wound Assessment Report she completed on 01/09/18 on Resident #1, the Treatment Nurse stated she must have dated the assessment incorrectly and it should have been dated 01/12/18. She stated she did not recall asking for treatment orders for Resident #1 on 01/09/18 as documented on the Wound Assessment Report dated 01/09/18. The Treatment Nurse stated she did not receive a wound communication form until 01/12/18. The facility provided no evidence of a wound communication form at the time of exit on 02/15/18. The Treatment Nurse stated when she found out about Resident #1's pressure ulcers on 01/12/18, she notified the Physician Assistant (PA) who gave her the original treatment orders entered in the electronic record dated 01/12/18 but she must have forgotten to write an original physician order. The Treatment Nurse stated she

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thought the PA could give her orders on Resident #1.

An Interview was conducted with the PA on 02/14/18 at 1:30 PM. The PA stated she did not give any treatment orders for Resident #1 because he was under the care of Physician #1 and it was an unacceptable medical practice to give orders or direction on Resident #1. She stated she did not recall the Treatment Nurse asking her for advice or orders regarding the worsening of Resident #1's pressure ulcers. The PA stated Resident #1 was being followed by the facility Wound Nurse Consultant.

Physician #1 was interviewed via Telephone on 02/13/18 at 3:50 PM. Physician #1 stated he was in office 01/09/18 through 01/12/18 and noted that the facility let him know that Resident #1 was admitted but he was unsure if there was a request for treatment orders. Physician #1 stated the request for treatment orders could have gotten lost but he would have expected the facility to contact him again if they had not received a reply for treatment to Resident #1's pressure ulcer.

Based on record review and interviews with the physician, physician assistant, Nurse #2 and Treatment Nurse, there was no evidence that the admitting nurse (Nurse #2) or the Treatment Nurse notified the physician of the condition of pressure ulcer and the need for treatment on 1/9/18. The resident did not receive assessment and treatment of the pressure ulcer from 1/9/18 till 1/12/18. Also there was no evidence that the treatment nurse got approval from the physician regarding the treatment orders that the treatment nurse initiated on the Treatment Administration

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Record (TAR) on 1/12/18.

Review of Resident #1's January 2018 TAR indicated documented initials that his treatment was completed with Calmoseptine and Silver Alginate to his sacrum on 01/13/18 and 01/14/18. There was no documented description of the appearance of his sacral pressure ulcer on 01/13/18 or 01/14/18.

There was no documentation that the pressure ulcer wound was ever assessed again after 01/09/18 until the Wound Nurse Consultant saw the area on 01/15/18.

Review of the Wound Nurse Consultant report dated 01/15/18 read Resident #1 had an unstageable pressure ulcer to his sacrum measuring 3.5 cm length, 7.5 cm width and 0.5 cm depth. It was described as having excessive necrotic tissue appearing yellow/black in color. There was noted mild serous drainage with no odor. The note indicated there was no debridement completed and new orders for Medi-honey (medical-grade honey products for the management of wounds), Calcium Alginate (wound dressing made with the ingredient alginate, a highly-absorbent substance that is extracted from brown seaweed) and a foam dressing daily and as needed.

During a telephone interview on 02/14/18 at 4:10 PM, the Wound Nurse Consultant stated she recently took over the wound care and treatments at the facility. She stated she first assessed Resident #1 on 01/15/18 and gave new orders for Medi-honey and Calcium Alginate to all areas on his sacrum. She stated it had been her experience in working with the Treatment Nurse

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that she wrote the new orders and contacted Physician #1.

During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated that she never saw the new order written in the Wound Nurse Consultant report on 01/15/18.

There was no evidence that the Treatment Nurse notified the physician of the Wound Nurse Consultant new orders or that the orders were implemented.

Resident #1's admission Minimum Data Set (MDS) dated 01/16/18 indicated severe cognitive impairment with no behaviors. He was coded requiring extensive assistance with bed mobility and total assistance with toileting and hygiene. Resident #1 was coded for an indwelling urinary catheter, always incontinent of bowel, and as admitted with two unstageable pressure ulcers.

Review of the electronic physician orders dated 01/16/18 at 1:06 AM, revealed the Treatment Nurse entered the following new treatment which auto-populated the TAR: cleanse Resident #1's unstageable wound to his sacrum with Anasept spray (gentle antimicrobial wound cleanser with broad-spectrum bactericidal properties) for odor control. Pat the area dry and apply Calmoseptine to the peri-wound then apply Calcium Alginate to the wound bed only. Cover with a foam dressing daily and as needed. There were no written physician orders for this treatment. There was no evidence that the physician approved the change in treatment.

During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated that, regarding the

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missing written order for treatment change on 1/16/18, the Wound Nurse Consultant gave her those orders on 01/15/18 but the Wound Nurse Consultant was responsible for writing her own treatment orders. The Treatment Nurse stated she only entered the new treatment order into the electronic medical record on 01/16/18 and never saw an original written order.

During a telephone interview on 02/13/18 at 3:10 PM, the Wound Nurse Consultant confirmed she had not spoken with Physician #1 regarding Resident #1's pressure ulcers.

Review of Resident #1's Wound Assessment Report dated 01/22/18 read Resident #1's unstageable pressure ulcer to his right buttock status deteriorated measuring 6.0 cm length, 6.0 cm width with no documented depth. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/22/18 with no new orders.

Review of Resident #1's Wound Assessment Report dated 01/22/18 read Resident #1's unstageable pressure ulcer to his sacrum was unchanged measuring 3.5 cm length, 7.5 cm width with no documented depth. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/22/18 with no new orders.

Review of Resident #1's Wound Assessment Report dated 01/22/18 read Resident #1's unstageable pressure ulcer to his left buttock status deteriorated measuring 7.5 cm length, 3.5 cm width and 0.3 cm depth. It was described as 60% Eschar, 30% slough and 10% granulation. There was noted moderate serous drainage with

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no evidence of infection. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/22/18 with no new orders.

Review of the Wound Nurse Consultant report dated 01/22/18 read Resident #1 had an unstageable pressure ulcer to his sacrum measuring 13.5 cm length, 12.5 cm width and 1.5 cm depth. It was described as having excessive necrotic tissue appearing yellow/black in color and as deteriorated. There was noted moderate serous purulent drainage with no odor. The note indicated there was no debridement completed and no new orders. The treatment was to continue with Medi-honey, Calcium Alginate and a foam dressing daily and as needed.

There was no evidence that the physician was notified of the deterioration of the pressure sores.

Review of Physician #1's progress notes dated 01/26/18 read Resident #1 had a 4.0 length with 4.0 cm width sacral pressure ulcer. The note read the pressure ulcer needed debriding and intense wound care. The plan read to consult the wound consultant for wound care. Additional orders included a Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP) and pre-albumin (marker of nutritional status and was used to help detect and diagnose protein-calorie malnutrition).

Review of Resident #1's January 2018 TAR indicated documented initials that his treatments were completed to his sacrum with Anasept spray and Calcium Alginate on 01/25/18, 01/26/18, 01/27/18 and 01/28/18.

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Review of the final wound culture dated 01/28/18 read Staphylococcus Aureus was present in Resident #1's sacrum. It was noted the results of the wound culture were faxed to Physician #1 on 01/28/18.

Review of nursing note dated 01/28/18 read Physician #1 was aware of the wound culture result and there were no new orders except Physician #1 stated would treat with Levaquin already ordered on 01/25/18 for pneumonia.

Review of a nursing note dated 01/29/18 read that on 01/28/18 at 9:30 PM, Resident #1's responsible party (RP) requested Resident #1 be sent to the hospital for intravenous (IV) antibiotics. Physician #1 was contacted and Resident #1 was transferred to the hospital as requested.

Review of the hospital admission summary dated 01/29/18 read Resident #1 was admitted with severe sepsis secondary to a urinary tract infection and an infected pressure ulcer. Bed-side debridement was completed on 01/29/18 of a stage 4 sacral pressure ulcer. It measured 10 cm length, 12 cm width and depth was down to the muscle. He was started on wound management and IV antibiotics. Resident #1 was discharged from the hospital on 02/09/18 to another facility.

During an interview on 02/15/18 at 12:05 PM the Director of Nursing (DON) stated there were no facility standing orders for the treatment of new or worsening pressure ulcers. She stated it was her expectation that whoever found a pressure ulcer would communicate it to the floor nurse who would then communicate it to the Treatment Nurse. The Treatment Nurse was then to notify

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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the resident's physician to obtain orders for treatment. The DON stated she did not know where the Treatment Nurse was getting the orders she implemented for Resident #1.

Physician #1 was interviewed via Telephone on 02/13/18 at 3:50 PM. Physician #1 stated he was responsible for his residents in the facility. He stated he was under the impression that Wound Nurse Consultant was also involved in the treatment of Resident #1's pressure ulcer. Physician #1 stated the facility did not notify him of the need of Resident #1 for treatment orders on admission and did not notify him of worsening of the pressure ulcers. Physician #1 stated it was his expectation that the facility would have re-attempted to contact him for treatment orders, notified him of worsening of the pressure ulcers and provided any treatments as ordered. Physician #1 stated the worsening of Resident #1's pressure ulcers was likely avoidable.

The Medical Director was interviewed via Telephone on 2/13/18 at 5:15 PM. The Medical Director stated he was unaware until recently of the new Wound Care Management providers that apparently replaced the previous providers two weeks ago. He stated he was under impression the Wound Nurse Consultant was following all residents with pressure ulcers. He stated there was a Physician Assistant (PA) at the facility Monday through Friday but Resident #1 was admitted under the services of Physician #1 and would not have been involved in giving treatment orders for Resident #1. He stated it was his expectation Physician #1 would have been contacted for treatment orders.

During an interview on 2/14/18 at 9:50 AM, the

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Administrator stated the facility had no standing orders for new or worsening pressure ulcers but rather the nurse was to notify the responsible physician each time for specific orders. She stated when an order is received from the attending physician, the Wound Nurse Consultant or the Physician Assistant, it was her expectation that the original order be written with the prescriber's signature then entered into the electronic medical record. The Administrator stated nothing should be entered into the electronic medical record unless there was a written order. The Administrator stated it was her expectation that residents be assessed timely for new or worsening pressure ulcer and the attending physician be notified timely.

The Administrator was notified of immediate jeopardy on 02/15/18 at 9:10 AM. The Administrator provided the following Credible Allegation:

Resident#1 no longer resides in the facility
The nurses were unsure to call the Medical Director for treatment orders when the attending physician was unable to be reached. There was a lack of follow through by nursing to assure orders were received for treatment and a lack of oversight to identify and treat any worsening wound condition.

The Treatment Nurse was removed from completing treatments 2/14/18 and retraining initiated. Floor staff will complete treatments beginning 2/14/18 until the Treatment Nurse' retraining is completed.

A 100% audit all current residents with a wound

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was completed by the Regional Clinical Consultant on 2/15/18 to verify physician and Responsible Representative notification of the wound was completed when discovered. 3 instances lacked Responsible Party notification at the time of discovery. In those 3 instances, the wound was a surgical incision and the resident was deemed alert and oriented. One instance of delayed notification was noted. The Responsible Representative was contacted on 2/15/18 by the Unit Manager and given the history and status of the wound.

The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of all nursing assistants on reporting skin changes noted during care by completing a full body shower sheet and submitting the sheet to the Charge Nurse. The Staff Development Coordinator initiated an in-service on 2/14/18 to 100% of all licensed staff to complete admission/re-admission head to toe skin assessments and weekly head to toe skin assessments with documentation of the assessment in the electronic medical record. The in-service will include calling the physician for treatment orders for all wounds identified with the admission skin assessment. The in-service included what to do when a new skin issue is identified and notification to the MD for treatment orders, Responsible Representative, Treatment Nurse, and Unit Managers. All newly hired nursing staff will receive the appropriate education during orientation. No staff will work until the in-service is completed.

Utilizing a Wound Notification QI Audit Tool, the Unit Managers will review the Wound Communication Book to assure the physician and Responsible Representative have been notified of

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any new wound. Monitoring will occur Monday through Friday x 2 weeks then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month. The Weekend Supervisor will complete the audit on the weekend x 2. Using an Admissions Wound QI Tool, the Unit Managers will review all new admission/re-admission records to assure a skin assessment was completed on admission and any identified skin issues were addressed with a treatment order, progress note, notification to the MD and RP was made, and notification was completed in the Wound Communication book. The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns.

The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process.

This Administrator will be responsible for implementing the credible allegation of removal on 2/15/18.

The credible allegation was verified on 02/15/18 at 5:00 PM as evidence by staff interviews on regarding notification of new pressure ulcers or worsening of pressures and actions to take immediately when a newly in-house acquired pressure ulcer identified or worsened. Review of on-going in-service records revealed licensed and unlicensed staff present at the facility received training and staff who did not have the in-servicing would be in-serviced prior to working on the floor.

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F 686	Continued From page 16	F 686		
F 686 SS=J	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 staff, physician, physician assistant, Wound Nurse Consultant interviews and record review, the facility failed to obtain physician orders to immediately initiate the treatment of a pressure ulcer on admission of Resident #1 resulting in delay in treatment, failed to obtain physician orders before starting treatment of pressure ulcer, failed to assess for worsening of a pressure ulcer, failed to prevent the worsening of a pressure ulcer and follow Wound Nurse Consultant's orders of a resident admitted with a pressure ulcer (Resident #1), and failed to consistently provide treatment to the pressure ulcer. Resident #1 was hospitalized with an infected stage 4 pressure ulcer requiring debridement and Intravenous antibiotics. The facility also failed to assess for the development of a facility acquired pressure ulcer (Resident #2), failed to immediately initiate treatment of a facility acquired pressure ulcer resulting in delay in	F 686	Resident #1 and Resident #2 no longer reside in the facility. There was a lack of communication between care providers; nursing staff were not consulting the doctor before they initiated treatment. There was confusion if there was a standing order or protocol or not. Also, there was a treatment not being provided as ordered due to the failure of the treatment nurse to complete treatments as ordered by the physician. The Treatment Nurse was removed from completing treatments 2/14/18 and retraining initiated. Floor staff will complete treatments beginning 2/14/18 until the Treatment Nurse□s retraining is completed. The Charge Nurse will be responsible for providing wound	2/26/18

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F 686	Continued From page 17 treatment, failed to obtain physician orders before starting treatment of pressure ulcer (Resident #2). Resident #2 had a stage 4 pressure ulcer requiring debridement and intravenous antibiotics. This was for 2 (Resident #1 and Resident #2) of 4 residents reviewed for pressure ulcers. Immediate jeopardy began on 01/09/18 for Resident #1 when he came in with a pressure ulcer on 1/09/18 and received no pressure ulcer treatment until 1/12/18. The facility provided no evidence of standing orders for pressure ulcer treatments. On 01/12/18, the Treatment Nurse began implementing treatment orders without approval of the physician. Resident #1 was seen by the Wound Nurse Consultant on 01/15/18 and her orders were not followed. There was no documented evidence of Resident #1's receiving pressure ulcer treatments from 01/09/18 through 01/12/18, 01/16/18, 01/18/18, 01/19/18, 01/23/18 and 01/24/18. The outcome for Resident #1 was the worsening of a pressure ulcer resulting in hospitalization with an infected stage 4 pressure ulcer requiring sharp debridement and antibiotic therapy. Resident #2 was admitted without any pressure ulcers on 01/01/18. Resident #2 developed a pink area on his sacrum on 01/09/18 with no evidence of interventions until 01/13/18. The Treatment Nurse began implementing treatment orders without approval of the physician. The outcome for Resident #2 was hospitalization on 01/27/18 with a stage 4 pressure requiring sharp debridement and antibiotic therapy. Immediate jeopardy was removed on 02/15/18 when an acceptable credible allegation was provided. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with	F 686	treatments in the event the Treatment Nurse is absent from work or assigned other duties. A 100% of all current residents residing in the facility received a head to toe skin audit that was initiated on 2/13/18 and was completed on 2/14/18 by the Unit Managers x 2, Staff Development Coordinator, and Director of Nursing to identify any unreported skin concerns. Three new concerns were identified, the attending provider was notified and treatment initiated as ordered by the attending provider and documented on the Treatment Administration Record, entered into the Wound Communication Book, and the Responsible Representative was notified. The Wound Communication Book will be maintained at each nursing station and used as a communication tool between the floor nurses and the Treatment Nurse. The Charge Nurse documents all new skin concerns in the communication book and the Treatment Nurse will review the Wound Communication Book daily to ensure any new skin issues are addressed completely. A 100% audit of Treatment Administration Records were reviewed with physician□s orders for the past 30 days by the Unit Managers x 2 and the Staff Development Coordinator on 2/15/18 to verify all treatments on the TAR have corresponding physician□s order and the order was transcribed as ordered.	

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F 686	Continued From page 18 the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and that all staff have been in-serviced. The findings included: 1. Resident #1 was admitted to the facility on 01/09/18 with cumulative diagnoses of Parkinson's Disease, Peripheral Vascular Disease, Dysphagia and Benign Hypertrophic Prostrate with an indwelling urinary catheter. Review of Resident #1's admission orders dated 01/09/18 read he was ordered a skin assessment weekly every Wednesday, a multi-vitamin daily. There were no admitting lab-work and no treatment orders for pressure ulcers. Review of Resident #1's admission nursing note dated 01/09/18 at 4:36 PM read there was a quarter sized open area on his right buttock which was described as brownish/dark in color with a slight odor and minimal serosanguinous drainage. There was an eraser size area to his coccyx. There was no documented evidence that the physician or treatment nurse was notified. Review of Resident #1's Wound Assessment Report dated 01/09/18 read Resident #1 was admitted with an unstageable pressure ulcer to his right buttock measuring 3.5 centimeters (cm) length, 7.5 cm width and 0.5 cm depth. It was described as 40% eschar (dry, dark scab of dead skin) and 60% granulation (pink tissue containing capillaries formed around the wound edges). The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/09/18 with treatment orders pending.	F 686	The Wound Consultant will begin writing her own treatment orders as of 2/14/18 while in the facility after her assessment of the wound. The Wound Consult Report will be reviewed with the provider. All orders will be transcribed by the Treatment Nurse or Charge Nurse. The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of all nursing assistants on reporting skin changes noted during care by completing a full body shower sheet and submitting the sheet to the Charge Nurse. The Charge Nurse will observe the resident□s skin, notify the physician for treatment orders, transcribe the order to the Treatment Administration Record, initiate the treatment, and notify the Responsible Representative. The Charge Nurse will enter the resident and the skin issue in the Wound Communication Book for the Treatment Nurse to review and follow. The completed shower sheet will be given to the Unit Manager to verify all phases of the process have been completed. The Staff Development Coordinator initiated an in-service on 2/14/18 to 100% of all licensed staff to complete admission/re-admission head to toe skin assessments and weekly head to toe skin assessments with documentation of the assessment in the electronic medical record. The in-service included what to do when a new skin issue is identified and notification to the MD, Resident Representative, Treatment Nurse, and Unit Managers. The Charge Nurse will	

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F 686	Continued From page 19 Review of Resident #1's Wound Assessment Report dated 01/09/18 read Resident #1 was admitted with an unstageable due to suspected deep tissue injury pressure ulcer to his sacrum measuring 3.5 cm length and 7.5 cm width. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/09/18 with treatment orders pending. Review of Resident #1's Wound Assessment Report dated 01/09/18 read Resident #1 was admitted with an unstageable pressure ulcer to his left buttock measuring 3.5 centimeters (cm) length, 7.5 cm width and 0.5 cm depth. It was described as 60% Eschar and 40% granulation. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/09/18 with treatment orders pending. A telephone interview was conducted with Nurse #2 on 02/14/18 at 3:25 PM. Nurse #2 stated she admitted Resident #1 on 01/09/18 and completed his initial skin assessment and noted a small area on his sacrum. She stated she completed a wound communication form and gave it to the Treatment Nurse on 01/09/18 as she was leaving. She stated she did not recall if the Treatment Nurse assessed Resident #1 on 01/09/18 because he was admitted at the end of first shift and the Treatment Nurse usually left around 3:00 PM. Nurse #2 stated she was not aware of any standing orders for the treatment of pressure ulcers but rather the physician had to be contacted for orders. She stated it was the responsibility of the Treatment Nurse to contact the physician. Regarding the missing treatment on 01/24/18, Nurse #2 stated she provided Resident #1 his treatment on 01/24/18 but forgot	F 686	observe the resident□s skin, notify the physician for treatment orders, transcribe the order to the Treatment Administration Record, initiate the treatment, and notify the Responsible Representative. The Charge Nurse will enter the resident and the skin issue in the Wound Communication Book for the Treatment Nurse to review and follow. The completed shower sheet will be given to the Unit Manager to verify all phases of the process have been completed. All newly hired nursing staff will receive the appropriate education during orientation. No staff will work until the in-service is completed. Corrective action completed on 2/26/18. The Medical Director, Physicians and Physician Assistants were all re-educated on 2/14/18 by the Staff Development Coordinator regarding the physician order process. All physicians understand that if we are unable to locate the attending physician or the physician assistant, the Medical Director is responsible for giving the facility staff orders for the resident. This includes wound care orders. Otherwise, all physicians and their extenders are responsible for giving orders for their residents. Utilizing a Treatment Record Administration QI Audit Tool, the Unit Managers or Staff Development Coordinator will review 100% of all treatment records to assure the treatments have been completed and signed off by the staff. Monitoring will	

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F 686	Continued From page 20 to initial the TAR. During an interview on 2/14/18 at 11:10 AM, Nursing Assistant (NA) #1 stated on 01/09/18 she assisted Nurse #2 with Resident #1's skin assessment and Nurse #2 noted a small area on his bottom. She stated Nurse #2 completed a wound communication form and gave it to the Treatment Nurse before she left for the day. NA #1 stated Resident #1 was always cooperative with his care, gotten up daily and laid back down after lunch. During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated she was not made aware of any pressure ulcers found on Resident #1 until 01/12/18. When questioned regarding the Wound Assessment Report she completed on 01/09/18 on Resident #1, the Treatment Nurse stated she must have dated the assessment incorrectly and it should have been dated 01/12/18. She stated she did not recall asking for treatment orders for Resident #1 on 01/09/18 as documented on the Wound Assessment Report dated 01/09/18. The Treatment Nurse stated she did not receive a wound communication form until 01/12/18. The facility provided no evidence of a wound communication form at the time of exit on 02/15/18. The Treatment Nurse stated when she found out about Resident #1's pressure ulcers on 01/12/18, she notified the PA who gave her the original treatment orders entered in the electronic record dated 01/12/18 but she must have forgotten to write an original physician order. The Treatment Nurse stated she thought the PA could give her orders on Resident #1. In an Interview was conducted with the PA on 02/14/18 at 1:30 PM. The PA stated she did not	F 686	occur Monday through Friday x 2 weeks then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month. Utilizing a Wound Assessment Manager (WAM) QI Audit Tool, the Staff Development Coordinator will complete a record review to verify all wounds are documented in the WAM to assure all parts of an assessment for 100% of wounds have been completed weekly. Monitoring will occur weekly x 8 weeks, then monthly x 1. Using an Admissions Wound QI Tool, the Unit Managers will review all new admission/re-admission records to assure a skin assessment was completed on admission and any identified skin issues were addressed with a treatment order, progress note, notification to the MD and Resident Representative was made, and notification was completed in the Wound Communication book. The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns. The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process. This Administrator will be responsible for implementing the plan of correction.	

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give any treatment orders for Resident #1 because he was under the care of Physician #1 and it was an unacceptable medical practice to give orders or direction on Resident #1. She stated she did not recall the Treatment Nurse asking her for advice or orders regarding the worsening of Resident #1's pressure ulcers. The PA stated Resident #1 was being followed by the facility Wound Nurse Consultant.

Review of the 48-Hour Baseline Care Plan dated 01/10/18 read Resident #1 was admitted with pressure ulcers. Interventions included pressure ulcer care, pressure reducing mattress to the bed and wheel-chair.

Review of Resident #1's January 2018 Treatment Administration Record (TAR) included no treatment orders to his bilateral buttocks and sacrum from 01/09/18 through 01/12/18.

Review of the electronic physician orders dated 01/12/18 at 11:10 AM was conducted. The Treatment Nurse entered the following new treatment orders which auto-populated the TAR: bilateral buttocks and sacrum were to be cleansed with wound cleanser, patted dry and Calmoseptine ointment (analgesic, antiseptic, antipruritic, and skin protectant combination) was to be applied to the peri-wound with Silver Alginate (an antimicrobial, highly absorbent wound dressing with ionic silver) to the wound bed. It was to be covered with a protective foam dressing daily and as needed. There were no written physician orders for this treatment.

Review of Resident #1's January 2018 TAR indicated documented initials that his treatment was completed with Calmoseptine and Silver

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Alginate to his sacrum on 01/13/18 and 01/14/18.

Review of the Wound Nurse Consultant report dated 01/15/18 read Resident #1 had an unstageable pressure ulcer to his sacrum measuring 3.5 cm length, 7.5 cm width and 0.5 cm depth. It was described as having excessive necrotic tissue appearing yellow/black in color. There was noted mild serous drainage with no odor. The note indicated there was no debridement completed and new orders for Medi-honey (medical-grade honey products for the management of wounds), Calcium Alginate (wound dressing made with the ingredient alginate, a highly-absorbent substance that is extracted from brown seaweed) and a foam dressing daily and as needed.

There was no Wound Assessment Report completed for Resident #1 the week of 01/15/18 through 01/19/18. This was the responsibility of the Treatment Nurse.

Review of the written physician orders dated 01/15/18 read Prostat (nutritional supplement used in improving wound healing through nutritional support) and Medpass (fortified nutritional shake that provides supplement calories and protein) were initiated by the Registered Dietician.

Review of the electronic physician orders dated 01/16/18 at 1:06 AM, revealed the Treatment Nurse entered the following new treatment which auto-populated the TAR: cleanse Resident #1's unstageable wound to his sacrum with Anasept spray (gentle antimicrobial wound cleanser with broad-spectrum bactericidal properties) for odor control. Pat the area dry and apply Calmoseptine

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to the peri-wound then apply Calcium Alginate to the wound bed only. Cover with a foam dressing daily and as needed. There were no written physician orders for this treatment.

Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum with Calmoseptine and Silver Alginate on 01/16/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/16/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments 01/16/18.

During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated that, regarding the missing written order for treatment change on 1/16/18, the Wound Nurse Consultant gave her those orders on 01/15/18 but the Wound Nurse Consultant was responsible for writing her own treatment orders. The Treatment Nurse stated she only entered the new treatment order into the electronic medical record on 01/16/18 and never saw an original written order.

During a telephone interview on 02/14/18 at 4:10 PM, the Wound Consultant Nurse stated she recently took over the wound care and treatments at the facility. She stated she first assessed Resident #1 on 01/15/18 and gave new orders for Medi-honey and Calcium Alginate to all areas on his sacrum. She stated it had been her experience in working with the Treatment Nurse that she wrote the new orders. She stated it was her expectation that the order she gave to the Treatment Nurse on 01/15/18 would have been written and implemented.

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Resident #1's admission Minimum Data Set (MDS) dated 01/16/18 indicated severe cognitive impairment with no behaviors. He was coded requiring extensive assistance with bed mobility and total assistance with toileting and hygiene. Resident #1 was coded for an indwelling urinary catheter, always incontinent of bowel, and as admitted with two unstageable pressure ulcers. The Care Area Assessment (CAA) dated 01/16/18 read Resident #1 was admitted with multiple wounds and remained at risk for the development of additional skin impairments. The CAA indicated a care plan would be developed.

Review of Resident #1's care plan dated 01/16/18 read he had an unstageable pressure ulcer to his sacrum. Interventions included the following: provide timely incontinence care, measure the wound at least weekly, report any decline in wound status to physician, administer treatments as ordered and document.

Review of Resident #1's January 2018 TAR indicated documented initials that his treatment was completed to his sacrum with Calmoseptine and Silver Alginate on 01/17/18.

Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum with Calmoseptine and Silver Alginate on 01/18/18. Review of the daily schedule assignment sheet indicated the floor nurses were responsible for their own treatments on 01/18/18. Nurse #1 was assigned to complete Resident #1's treatment on 01/18/18.

During a telephone interview on 02/12/18 at 11:30 AM, Nurse #1 stated she completed the

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treatment on 01/18/18 but must have forgotten to initial the TAR.

Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum with Calmoseptine and Silver Alginate on 01/19/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/19/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments on 01/19/18.

Review of Resident #1's January 2018 TAR indicated documented initials that his treatment was completed to his sacrum with Anasept spray and Calcium Alginate on 01/20/18 and 01/21/18.

Review of Resident #1's Wound Assessment Report dated 01/22/18 read Resident #1's unstageable pressure ulcer to his right buttock status deteriorated measuring 6.0 cm length, 6.0 cm width with no documented depth. There was no additional documented description of the pressure ulcer on his right buttock. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/22/18 with no new orders.

Review of Resident #1's Wound Assessment Report dated 01/22/18 read Resident #1's unstageable pressure ulcer to his sacrum was unchanged measuring 3.5 cm length, 7.5 cm width with no documented depth. There was no additional documented description of the pressure ulcer to his sacrum. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/22/18 with no new orders.

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Review of Resident #1's Wound Assessment Report dated 01/22/18 read Resident #1's unstageable pressure ulcer to his left buttock status deteriorated measuring 7.5 cm length, 3.5 cm width and 0.3 cm depth. It was described as 60% Eschar, 30% slough and 10% granulation. There was noted moderate serous drainage with no evidence of infection. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/22/18 with no new orders.

Review of the Wound Nurse Consultant report dated 01/22/18 read Resident #1 had an unstageable pressure ulcer to his sacrum measuring 13.5 cm length, 12.5 cm width and 1.5 cm depth. It was described as having excessive necrotic tissue appearing yellow/black in color and as deteriorated. There was noted moderate serous purulent drainage with no odor. The note indicated there was no debridement completed and no new orders. The treatment was to continue with Medi-honey, Calcium Alginate and a foam dressing daily and as needed.

Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum with Anaspet spray and Calcium Alginate 01/23/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/23/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments 01/23/18.

Review of a physician order dated 01/23/18 read Resident #1 was ordered a wound culture of his sacrum.

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During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated that, regarding all the missing documentation for treatments on the TAR, she must have forgotten to initial the TAR but Resident #1 received his treatments on 01/16/18, 01/19/18 and 01/23/18.

Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed on his sacrum with Anaspet spray and Calcium Alginate on 01/24/18. Review of the daily schedule assignment sheet indicated the floor nurses were responsible for their own treatments on 01/24/18. Nurse #2 was assigned to complete Resident #1's treatment on 01/24/18.

During a telephone interview on 02/15/18 at 2:40 PM,Nurse #2 stated she provided Resident #1's pressure ulcer treatment on 01/24/18 but forgot to inital off on the TAR.

Review of a physician order dated 01/25/18 read Resident #1 was prescribed an antibiotic (Levaquin) daily for ten days for pneumonia.

Review of Physician #1's progress notes dated 01/26/18 read Resident #1 had a 4.0 length with 4.0 cm width sacral pressure ulcer. The note read the pressure ulcer needed debriding and intense wound care. The plan read to consult the wound consultant for wound care. Additional orders included a Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP) and pre-albumin (marker of nutritional status and was used to help detect and diagnose protein-calorie malnutrition).

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Review of Resident #1's January 2018 TAR indicated documented initials that his treatments were completed to his sacrum with Anasept spray and Calcium Alginate on 01/25/18, 01/26/18, 01/27/18 and 01/28/18.

Review of the final wound culture dated 01/28/18 read Staphylococcus Aureus was present in Resident #1's sacrum. It was noted the results of the wound culture were faxed to Physician #1 on 01/28/18.

Review of nursing note dated 01/28/18 read Physician #1 was aware of the wound culture result and there were no new orders except Physician #1 stated would treat with Levaquin already ordered on 01/25/18 for pneumonia.

Review of a nursing note dated 01/29/18 read that on 01/28/18 at 9:30 PM, Resident #1's responsible party (RP) requested Resident #1 be sent to the hospital for intravenous (IV) antibiotics. Physician #1 was contacted and Resident #1 was transferred to the hospital as requested.

Review of the hospital admission summary dated 01/29/18 read Resident #1 was admitted with severe sepsis secondary to a urinary tract infection and an infected pressure ulcer. Bed-side debridement was completed on 01/29/18 of a stage 4 sacral pressure ulcer. It measured 10 cm length, 12 cm width and depth was down to the muscle. He was started on wound management and IV antibiotics. Resident #1 was discharged from the hospital on 02/09/18 to another facility.

An interview was conducted on 02/13/18 at 11:10

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AM, with the Treatment Nurse. She stated she began working at the facility sometime in October 2017 but started as a floor nurse on night shift. She stated she began doing treatments a few month ago. The Treatment Nurse stated during that time, she received no training except for two days with the previous treatment nurse. She stated there was a lack of communications from the floor staff to her so she instituted a wound communication notebook and placed one at each nursing station. When a new area was identified, she would know about it if the nurses documented it in her wound communication notebook. She stated she checked the wound communication notebooks daily. The Treatment Nurse stated the facility did not have any standing orders for pressure ulcer treatments and the physician should be contacted for new orders when a new area or worsening area was noted. The Treatment Nurse stated she normally arrived to work at 7:00 AM and worked eight hours. She stated she did not always attend morning stand-up meeting with the management team and floor staff supervisors. She stated some morning she was busy with the wound nurse consultant or working on a cart.

During a telephone interview on 02/13/18 at 3:10 PM, the Wound Nurse Consultant stated she only recently started coming to the facility and it was her practice not to be overly aggressive. She stated she chose to act conservatively when treating pressure ulcers. She stated Resident #1's missing treatments could have caused his pressure ulcers to have worsened rather than the lack of debridement. She confirmed she had not spoken with Physician #1 regarding Resident #1's pressure ulcers. The Wound Nurse Consultant stated the Treatment Nurse should have written

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the orders she gave on 01/15/18. She confirmed the Treatment Nurse made wound rounds with her weekly.

An interview was conducted with the Unit Manager (UM) #1 on 02/15/18 at 11:35 AM. UM #1 stated Resident #1 was on her unit. She stated concerns regarding the Treatment Nurse performing her duties became evident sometime in January 2018. UM #1 stated the interim Administrator was notified and aware of the concerns and worsening of Resident #1's pressure ulcers. She stated the new Administrator started on 02/12/18 but she was also aware of concerns related to the Treatment Nurse. UM #1 stated the Treatment Nurse was never pulled from treatments but rather she was left in her position until the new Administrator suspended her on 02/14/18. UM #1 stated the Treatment Nurse did not attend the morning stand up meeting where residents were discussed daily. She stated the floor nurses were instructed by the Treatment Nurse to complete a wound communication form which was a shower sheet and put it in her notebook for her to address.

During an Interview on 02/15/18 at 12:05 PM the Director of Nursing (DON) stated there were no facility standing orders for the treatment of new or worsening pressure ulcers. She stated it was her expectation that whoever found a pressure ulcer would communicate it to the floor nurse who would then communicate it to the Treatment Nurse. The Treatment Nurse was then to notify the resident's physician to obtain orders for treatment. The DON stated she did not know where the Treatment Nurse was getting the orders she implemented for Resident #1. She stated she did not complete wound rounds with

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the Treatment Nurse but rather thought wound rounds were completed by the Wound Nurse Consultant. She stated "Patient at Risk" (PAR) were discussed daily in morning stand up meetings but the Treatment Nurse did not attend. The DON stated the interim Administrator was notified of the concerns about the Treatment Nurse not completing her treatments but the interim Administrator did not offer any directive.

Physician #1 was interviewed via Telephone on 02/13/18 at 3:50 PM. Physician #1 stated he was in office 01/09/18 through 01/12/18 and noted that the facility let him know that Resident #1 was admitted but he was unsure if there was a request for treatment orders. Physician #1 stated the request for treatment orders could have gotten lost but he would have expected the facility to contact him again if they had not received a reply for treatment to Resident #1's pressure ulcer. Physician #1 stated he was responsible for his residents in the facility. He stated he was under the impression that Wound Nurse Consultant was also involved in the treatment of Resident #1's pressure ulcer. Physician #1 stated it appeared the facility was not adequately treating Resident #1's pressure ulcers and did not notify him of worsening of the pressure ulcers. He stated it was his expectation that the facility would have re-attempted to contact him for treatment orders, notified him of worsening of the pressure ulcers and provided any treatments as ordered. Physician #1 stated the worsening of Resident #1's pressure ulcers was likely avoidable.

The Medical Director was interviewed via Telephone on 2/13/18 at 5:15 PM. The Medical Director stated he was unaware until recently of

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the new Wound Care Management providers that apparently replaced the previous providers two weeks ago. He stated he was under impression the Wound Nurse Consultant was following all residents with pressure ulcers. He stated there was a Physician Assistant (PA) at the facility Monday through Friday but Resident #1 was admitted under the services of Physician #1 and would not have been involved in giving treatment orders for Resident #1. He stated it was his expectation that all newly developed or worsening pressure ulcers be assessed, treatment orders obtained timely, and treatments be completed as ordered. The Medical Director stated there seemed to be a lack of reaction and communication on the part of the facility.

During an interview on 2/14/18 at 9:50 AM, the Administrator stated the facility had no standing orders for new or worsening pressure ulcers but rather the nurse was to notify the responsible physician each time for specific orders. She stated when an order is received from the attending physician, the Wound Nurse Consultant or the Physician Assistant, it was her expectation that the original order be written with the prescriber's signature then entered into the electronic medical record. The Administrator stated nothing should be entered into the electronic medical record unless there was a written order. She stated she took over as the facility Administrator on 02/12/18 and prior to 02/12/18, there was an interim Administrator. She stated she was still involved and had knowledge of concerns related to the treatment nurse not performing her duties. The Administrator stated it became evident around mid-January 2018 during inclement weather. She stated the Unit Managers (UM) brought it to the attention interim

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Administrator. The Administrator stated she only recently became aware of how the facility staff were completing skin assessment by only documenting whether the skin was intact or not-intact. She stated it was her expectation a full body inspection be completed weekly with a narrative description of each resident's skin status. She stated she also recently became aware that the Treatment Nurse was not attending morning stand-up meetings where patients at risk (PAR) were discussed daily. She stated it was her expectation that the Treatment Nurse would have attended those meetings. The Administrator stated it was her expectation that residents be assessed timely for new or worsening pressure ulcers and treatments be initiated and followed as ordered.

2. Resident #2 was admitted to the facility on 01/01/18 with cumulative diagnoses of Congestive Heart Failure (CHF) a fractured fibula with non-weight-bearing status, Urinary Retention, Peripheral Vascular Disease (PVD) and Dementia without behaviors.

Resident #2's admission Minimum Data Set (MDS) dated 01/08/18 indicated severe cognitive impairment with rejection of care on one to three days. He was coded as requiring extensive assistance with bed mobility, toileting and hygiene. Resident #2 was coded as incontinent of bladder and bowel and as admitted with one arterial ulcer. The Care Area Assessment (CAA) dated 01/08/18 read Resident #2 was admitted to the facility with no existing pressure ulcers but one arterial ulcer was noted and he was non-ambulatory. He was at risk for the development of additional skin impairments. The CAA indicated a care plan would be developed.

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Review of Resident's #2's admission orders dated 01/01/18 read he was ordered a skin assessment weekly every Monday.

Review of Resident #2's admission nursing note dated 01/01/18 at 2:40 PM did not include any documentation regarding his skin condition.

Review of Resident #2's Interim Care Plan dated 01/01/18 read repositioning every two hours for pressure ulcer relief.

Review of Resident #2's Admission Skin Assessment dated 01/02/18 read pink area to his sacrum. There was no evidence of new orders.

Review of Resident #2's new admission skin assessment documented on a shower sheet dated 01/03/18 read a pink area to his sacrum. This assessment was completed by the Treatment Nurse. There was no evidence of any new orders.

Review of Resident #2's care plan dated 01/05/18 read he had the potential for skin breakdown related to his recent history of refusing to lie down in bed from his wheelchair to assess for incontinence. Interventions included the following: encourage resident to turn and reposition on routine rounds, provide assistance with repositioning as needed, observe skin daily and report any redness or impairment to nurse, full weekly skin assessment by the nurse, keep skin clean, dry and apply barrier cream if ordered and encourage resident to shift weight frequently while up in chair.

Review of Resident #2's skin assessment

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documented on a shower sheet and dated 01/09/18 read pink area to sacrum. This assessment was completed by the Treatment Nurse. There was no evidence of any new orders.

Review of an occupational therapy assistant (OTA) note dated 01/10/18 at 2:12 PM read nursing aware of skin breakdown to Resident #2's buttocks.

During an interview on 02/15/18 at 12:20 PM, NA #2 stated she recalled the day when she and the OTA were in Resident #2's room together. She stated she recalled applying barrier cream because his buttocks were only red at the time. She stated Resident #2 was on a pressure reducing mattress and had a cushion in his wheelchair.

During a telephone interview on 02/15/18 at 12:10 PM, the OTA stated she was in the room with Resident #2 and the NA #2 on 01/10/18 working on his upper body range of motion when she noticed NA #2 putting an ointment on Resident #2's buttocks. She stated she charted that nursing was aware of his skin impairment in her note dated 01/10/18.

Review of Resident #2's January 2018 physician's orders revealed a new order for an indwelling urinary catheter due to urinary retention on 01/10/18.

Review of a nursing note dated 01/13/18 at 3:24 PM read the Nursing Assistant reported open area to Resident #2's right and left buttocks. New orders to cleanse the right and left buttock with wound cleanser, apply Calmoseptine ointment and foam dressing every other day and as

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needed. The note read the wound communication notebook was updated. This note was completed by Nurse #1.

During a telephone interview on 02/12/18 at 4:50 PM, Nurse #1 stated the aide reported to her an area on Resident #2's sacrum on 01/13/18 so she completed the wound communication form and put a copy in the wound communication notebook and left a copy for the Director of Nursing (DON). She stated she contacted the PA and received orders for treatment.

Review of a shower sheet dated 01/13/18 completed by Nurse #1 read Resident #2 had open areas to his left and right buttock and sacrum. The shower sheet indicated the Medical Director, the Responsible Party (RP), the Treatment Nurse and the Director of Nursing (DON) were all notified on 01/13/18 at 2:30 PM.

Review of Resident #2's January 2018 Treatment Administration Record (TAR) indicated he received his treatment as written by Nurse #1's nursing note on 01/13/18 with the next treatment due until 01/15/18.

Review of Resident #2's January 2018 TAR indicated he received his treatment on 01/15/18 as written by Nurse #1's nursing note on 01/13/18.

Review of the Wound Nurse Consultant note dated 01/15/18 read Resident #2's arterial ulcer was assessed. There was no mention of an assessment to Resident #2's right or left buttocks open areas.

Review of a nursing note dated 01/16/18 at 9:30

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AM as an addendum for 01/14/18 was conducted. The note read on assessment, Resident #2 was noted with a stage 3 pressure ulcer to his right buttock measuring 7.0 cm length, 3.5 cm width and 0.2 cm depth. It was described as having 80% slough (soft, moist avascular dead tissue) and 20% granulation tissue (pink tissue containing capillaries formed around the wound edges). There was a stage 3 pressure ulcer to his left buttock measuring 5.0 cm length, 4.7 cm width and 0.1 cm depth with 70% granulation tissue. The note read currently pending treatment orders and Resident #2 had a history of refusing peri-care and assessment for incontinence. The note was written by the MDS nurse.During an interview on 02/15/18 at 10:50 AM, the MDS Nurse stated she was working at the facility on Sunday 01/14/18 and assessed Resident #2's pressure ulcers. She stated Nurse #1 had already contacted the PA and received orders on 01/13/18 so she left the Treatment Nurse a wound communication form with her assessment dated 01/14/18. The facility was unable to offer evidence of a wound communication form dated 01/14/18 at the time of exit on 02/15/18.

Review of Resident #2's care plan dated 01/16/18 read he had stage 3 pressure ulcers to his right and left buttocks. Interventions included the following: measure wound weekly, report decline in wound to physician, administer treatments as ordered, use pillows, air mattress for positioning, Dietician to evaluate as needed, monitor lab-work and encourage resident compliance.

Review of Resident #2's Wound Assessment Report dated 01/16/18 read a new wound to his right buttock was identified on 01/14/18. It was described as a stage 3 measuring 7.0 cm length

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3.5 cm width and 0.2 cm depth with 60% granulation tissue and 40% slough. There was moderate serous (body fluids resembling serum) drainage with no odor. A second new wound was noted to his left buttock was identified on 01/14/18. It was described as a stage 3 measuring 5.0 cm length, 4.7 cm width and 1.0 cm depth with 70% granulation tissue and 30% slough. There was moderate serous drainage with no odor. The report was completed by the Treatment Nurse and indicated the Medical Director was notified on 01/16/18 with new orders to cleanse right buttock with wound cleanser, apply Calmoseptine and cover with a foam dressing daily and as needed. A new order was given to cleanse the left buttock wound with wound cleanser, apply Silver Alginate to the wound bed and Calmoseptine to the peri-wound and cover with a foam dressing daily and as needed.

Review of Resident #2's January 2018 written physician orders did not include any treatment orders for the resident's pressure ulcers on 01/16/18. The electronic medical record indicated on 01/16/18 at 12:02 PM the Treatment Nurse entered the following new treatment which auto-populated the TAR: Cleanse right and left buttock with wound cleanser, pat dry and apply Calmoseptine and a foam dressing daily and as needed. The Silver Alginate to the left buttock documented as a new order on the Wound Assessment Report dated 01/16/18 was not added to the electronic medical record and did not appear on the TAR.

Review of Resident #2's January 2018 TAR indicated no documented initials that his treatment of Calmoseptine with a foam dressing

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was completed to his right buttocks or any documented initials of his treatment of Calmospetine, Silver Alginate with foam dressing to his left buttocks as written by the Treatment Nurse on the Wound Assessment Report dated on 01/16/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/16/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments 01/16/18.

During an interview on 02/12/18 at 3:30 PM, the Treatment Nurse stated she did not receive the wound communication form dated 01/13/18 until 01/16/18. She stated she was aware there was a place on his sacrum on 01/13/18 and asked the Wound Nurse Consultant to look at it on 01/15/18 but Resident #2 refused to get back into the bed. The Treatment Nurse offered no explanation as to why she did not assess it on 01/13/18 and why she was not given a wound communication form until 01/16/18. The Treatment Nurse stated she completed his treatment on 01/16/18 but did not initial it on the TAR.

During an interview on 02/12/18 at 3:10 PM, Unit Manager (UM) #2 and the MDS Nurse stated Resident #2 was admitted with no pressure ulcers. UM #2 stated he was up daily with therapy and staff tried to lay him down after lunch but sometimes he would refuse. UM #2 and the MDS Nurse recalled on 01/16/18 giving the Treatment Nurse the wound measurement obtained by the MDS nurse on 01/14/18. UM #2 told the Treatment Nurse to ensure the wound nurse consultant observed his sacrum. UM #2 stated she did not assess the pressure ulcers.

Review of Resident #2's January 2018 TAR

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indicated he received Calmoseptine and a foam dressing daily to his right and left buttocks on 01/17/18 through 01/25/18. Resident did not receive Silver Alginate to his left buttock as indicated on the Wound Assessment Report dated 01/16/18.

Review of Resident #2's January 2018 orders dated 01/17/18 read Prostat (nutritional supplement used in improving wound healing through nutritional support) and Medpass (fortified nutritional shake that provides supplement calories and protein), Vitamin C and Zinc were prescribed by the Registered Dietician for wound healing.

Review of Resident #2's Wound Nurse Consultant notes dated 01/22/18 read the area to buttocks measured 15.6 cm length, 10 cm width and 0.1 cm depth. It was described as having excessive necrotic (dry, scab of dead tissue) tissue, yellow in color with mild serous drainage and no odor. There were no new orders or recommendations. There was no documented staging of Resident #2's buttocks by the Wound Nurse Consultant.

Review of Resident #2's skin assessment documented on a shower sheet dated 01/22/18 read his right buttock measured 6.0 cm length, 3 cm width and 0.1 cm depth. It was described as 80% granulation and 20% slough. The left buttock measured 5.0 cm length, 4 cm width and 0.1 cm depth with 80% granulation and 20% eschar. There were no changes in the wound consultant nurse orders. This assessment was completed by the Treatment Nurse.

Review of Resident #2's written physician orders

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dated 01/26/18 read new orders to clean his sacrum right and left buttocks with normal saline, pat dry then apply Santyl (debriding ointment) and Calcium Alginate and cover with a foam dressing daily and as needed. This order was signed by the PA.

Review of Resident #2's January 2018 TAR indicated no documented initials that his treatment of Santyl and Calcium Alginate with a foam dressing was completed to his right and left buttocks as ordered on 01/26/18.

Review of the daily schedule assignment sheet indicated the floor nurses were responsible for their own treatments. Nurse #3 was assigned to complete Resident #2's treatment on 01/26/18.

During a telephone interview on 02/15/18 at 2:40 PM, Nurse #3 revealed she provided Resident #2's pressure ulcer treatment on 01/26/18 as ordered but forgot to initial off on the TAR.

Review of Resident #2's January 2018 TAR indicated he received his treatment of Calmoseptine with a foam dressing to his right and left buttock on 01/27/18.

Review of a nursing note dated 01/27/18 at 5:30 PM, read Resident #2 was sent to the hospital for difficulty breathing.

Review of Resident #2's hospital admission dated 01/27/18 read he was admitted with a stage 4 sacral pressure ulcer measuring 6.0 cm length, 6.0 cm width and extended for subcutaneous tissue. Bedside debridement was performed on 01/29/18. The wound cultured positive for Methicillin-Resistant Staphylococcus Aureus

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(MRSA) and he was treated with intravenous antibiotics. Resident #2 expired at the hospital on 02/11/18 from a cardiac arrest.

Review of an anonymous grievance called in on 01/29/18 read Resident #2 did not receive adequate nursing care resulting in a pressure ulcer. The grievance read the Social Worker contacted the resident representative (RP) who denied knowledge of the call. The Social Worker stated the facility was investigating the concerns. Attached to the grievance was in-service agenda dated 01/29/18 titled Wound Care Management given by the Staff Development Coordinator (SDC). Also attached was the staff who attended the in-service. There was no documented signature of the Treatment Nurse on the in-service roster.

During an interview on 02/14/18 at 10:50 AM, Nursing Assistant (NA) #2 stated Resident #2 would refuse baths and once he was up, he did not want to lay back down because he was afraid of the mechanical lift. She stated he had a urinary catheter so he was not wet but he was incontinent of stool.

During an interview on 02/15/18 at 12:00 PM, the DON stated she was not aware Resident #2 had a pressure ulcer until 01/16/18. She stated she and the treatment nurse assessed the area on 01/16/18 and notified the PA of the worsening of his pressure ulcer. The DON stated she did not receive a copy of the wound communication form completed by Nurse #1 dated 01/13/18.

During an interview on 02/13/18 at 11:10 AM, the Treatment Nurse stated she began working at the facility sometime in October 2017 but started as a

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floor nurse on night shift. She stated she began doing treatments a few months ago. The Treatment Nurse stated during that time, she received no training except for two days with the previous treatment nurse. She stated there was a lack of communication from the floor staff to her so she instituted a wound communication notebook and placed one at each nursing station. When a new area was identified, she would know about it if the nurses documented it in her wound communication notebook. She stated she checked the wound communication notebooks daily. The Treatment Nurse stated the facility did not have any standing orders for pressure ulcer treatments and the physician should be contacted for new orders when a new area or worsening area was noted. She stated she did not always attend morning stand-up with the management team and floor staff supervisors. She stated some morning she was busy with the Wound Nurse Consultant or working on a cart when there for a floor nurse call out.

During a telephone interview on 02/13/18 at 3:10 PM, the Wound Nurse Consultant stated she first assessed Resident #2's sacrum on 01/22/18. She stated Resident #2 was non-complaint with offloading and she made no recommendations and no new orders. The Wound Nurse Consultant stated she only recently started coming to the facility and it was her practice not to be overly aggressive. She stated she chose to act conservatively when treating pressure ulcers. She confirmed she had not spoken with the Medical Director or the PA regarding Resident #2's pressure ulcers.

During a telephone interview on 02/13/18 at 5:56 PM, the PA confirmed she was available and

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present at the facility Monday through Friday and available after hours by phone. She stated she was not involved in wound care and any pressure ulcers were addressed by the Treatment Nurse and the Wound Nurse Consultant. She stated she was aware Resident #2 developed a sacral ulcer but was unsure of the onset date. The PA recalled someone calling her for orders and she gave the nurse orders but was unsure of the date.

The Medical Director was interviewed via telephone interview on 02/13/18 at 5:15 PM. He stated he was unaware until recently of the new Wound Care Management providers who started several weeks ago. He stated he was under impression the Wound Nurse Consultant was following all residents with pressure ulcers. He stated he was not aware Resident #2 developed a pressure ulcer to his sacrum. He stated Resident #2 was being followed by the contracted PA who was in the facility Monday through Friday and it was his expectation the PA would have been contacted with concerns regarding Resident #2's pressure ulcer. The Medical Director stated it was his expectation that all newly developed or worsening pressure ulcers be assessed, treatment orders obtained timely and treatments be completed as ordered. The Medical Director stated there seemed to be a lack of reaction and communication on the part of the facility.

During an Interview on 2/14/18 at 9:50 AM, the Administrator stated the facility had no standing orders for new or worsening pressure ulcers but rather the nurse was to notify the responsible physician each time for specific orders. She stated when an order is received from the attending physician, the Wound Nurse Consultant or the Physician Assistant, it was her expectation

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that an original order be written with the prescriber's signature then entered into the electronic medical record. The Administrator stated nothing should be entered into the electronic medical record unless there was a written order. She stated she took over as the facility Administrator on 02/12/18 and prior to 02/12/18, there was an interim Administrator. She stated she was still involved and had knowledge of concerns related to the Treatment Nurse not performing her duties. The Administrator stated it became evident around mid-January 2018 during inclement weather. She stated the Unit Managers (UM) brought it to the attention interim Administrator. She stated it was her expectation a full body inspection be completed weekly with a narrative description of each resident's skin status. She stated she also recently became aware that the Treatment Nurse was not attending morning stand-up meetings where patients at risk (PAR) were discussed daily. She stated it was her expectation that the Treatment Nurse would have attended those meetings. The Administrator stated it was her expectation that residents be assessed timely for new or worsening pressure ulcers and treatments be initiated and followed as ordered.

The Administrator was notified of immediate jeopardy on 02/15/18 at 9:10 AM. The Administrator provided the following Credible Allegation:

Resident#1 and Resident#2 no longer reside in the facility.
There was a lack of communication between care providers; nursing staff were not consulting the doctor before they initiated treatment. There was confusion if there was a standing order or

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protocol or not. Also, there was a treatment not being provided as ordered due to the failure of the treatment nurse to complete treatments as ordered by the physician.

The Treatment Nurse was removed from completing treatments 2/14/18 and retraining initiated. Floor staff will complete treatments beginning 2/14/18 until the Treatment Nurse's retraining is completed.

A 100% of all current residents residing the facility received a head to toe skin audit that was initiated on 2/13/18 and was completed on 2/14/18 by the Unit Managers x 2, Staff Development Coordinator, and Director of Nursing to identify any unreported skin concerns. Three new concerns were identified, the attending provider was notified and treatment initiated as ordered and documented on the Treatment Administration Record, entered the Wound Communication Book, and the Responsible Representative was notified.

A 100% audit of Treatment Administration Records were reviewed with physician's orders for the past 30 days by the Unit Managers x 2 and the Staff Development Coordinator on 2/15/18 to verify all treatments on the TAR have corresponding physician's order and the order was transcribed as ordered.

The Wound Consultant recommendations for treatment changes will be reviewed with the provider upon receipt of the recommendations to obtain approval by the attending provider by the Treatment Nurse or Unit Manager. All orders will be transcribed per the attending provider's approval by the Treatment Nurse or Unit

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Manager.

The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of all nursing assistants on reporting skin changes noted during care by completing a full body shower sheet and submitting the sheet to the Charge Nurse. The Charge Nurse will observe the resident's skin, notify the physician for treatment orders, transcribe the order to the Treatment Administration Record, initiate the treatment, and notify the Responsible Representative. The Charge Nurse will enter the resident and the skin issue in the Wound Communication Book for the Treatment Nurse to review and follow. The completed shower sheet will be given to the Unit Manager to verify all phases of the process have been completed.

The Staff Development Coordinator initiated an in-service on 2/14/18 to 100% of all licensed staff to complete admission/re-admission head to toe skin assessments and weekly head to toe skin assessments with documentation of the assessment in the electronic medical record. The in-service included what to do when a new skin issue is identified and notification to the MD, Resident Representative, Treatment Nurse, and Unit Managers. All newly hired nursing staff will receive the appropriate education during orientation. No staff will work until the in-service is completed.

Utilizing a Treatment Record Administration QI Audit Tool, the Staff Development Coordinator will review 100% of all treatment records to assure the treatments have been completed and signed off by the staff. Monitoring will occur Monday through Friday x 2 weeks then twice weekly x 2

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weeks, then weekly x 4 weeks, then monthly x 1 month. Utilizing a Wound Assessment Manager (WAM) QI Audit Tool, the Staff Development Coordinator will complete a record review to verify all wounds are documented in the WAM to assure all parts of an assessment for 100% of wounds have been completed weekly. Monitoring will occur weekly x 8 weeks, then monthly x 1. Using an Admissions Wound QI Tool, the Unit Managers will review all new admission/re-admission records to assure a skin assessment was completed on admission and any identified skin issues were addressed with a treatment order, progress note, notification to the MD and Resident Representative was made, and notification was completed in the Wound Communication book. The Director of Nursing will review the QI Audit Tools weekly x 8, then monthly x 1 for trends and concerns.

The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process

The Medical Director, Physicians and Physician Assistants were all re-educated on 2/14/18 by the Staff Development Coordinator regarding the physician order process. All physicians understand that if we are unable to locate the attending physician or the physician assistant, the Medical Director is responsible for giving the facility staff orders for the resident. This includes wound care orders. Otherwise, all physicians and their extenders are responsible for giving orders for their residents.

This Administrator will be responsible for

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F 686	Continued From page 49 implementing the acceptable plan of correction on 2/15/18, date of removal 2/15/18. The credible allegation was verified on 02/15/18 at 5:00 PM as evidence by staff interviews on regarding skin assessments, identification of new pressure ulcers, worsening of pressures and actions to take immediately when a newly in-house acquired pressure ulcer identified or worsened. Review of on-going in-service records revealed licensed and unlicensed staff present at the facility received training and staff who did not have the in-servicing would be in-serviced prior to working on the floor.	F 686		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 6 of the past 30 days reviewed (1/15/18, 1/22/18, 1/25/18, 1/31/18, 2/12/18 and 2/13/18).	F 727	The Facility was unable to correct past staffing postings. The facility failed to ensure a minimum of 8 consecutive hours of RN coverage per	2/26/18

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F 727	Continued From page 50 The findings included: A review of the facility's Daily Schedules for the past 30 days was conducted on 2/15/18. The Daily Schedules indicated a Registered Nurse (RN) was not scheduled for at least 8 consecutive hours a day on the following dates: 1/15/18, 1/22/18, 1/25/18, 1/31/18, 2/12/18 and 2/13/18. An interview was conducted on 2/15/18 at 12:55 PM with the facility ' s Administrator. During the interview, inquiry was made in regards to the RN hours indicated on the staffing schedule. The Administrator reported she was aware RN coverage was a problem at the facility and confirmed there were some days where no RN coverage was provided. When asked what her expectation was, the Administrator stated she would expect to be in compliance with the regulations and to have at least 8 consecutive hours of RN coverage each day.	F 727	day. The Administrator initiated an in-service on 2/19/18 to the Staffing Coordinator to alert the Director of Nursing in advance of any days when the RN coverage requirement is not met. The Administrator initiated an in-service on 2/19/18 to the Director of Nursing to review the working schedule in advance to assure the RN coverage requirement is met. The Administrator contacted the Executive Assistant of the Corporate Office on 2/15/18 to post an advertisement with a specific job seekers internet site for RN positions. Corrective action completed on 2/26/18 included adjusting schedules of current RNs in the facility to assure 8 consecutive hours of RN coverage per day, seven days per week. Utilizing a Staff Posting Accuracy/Verification of RN Hours QI Audit Tool, the Human Resources Director will validate the daily posting is accurate and includes 8 consecutive hours of RN coverage per day on each weekday x 2 weeks. The Manager on Duty will audit the postings on each weekend x 2 weekends. Then, the Human Resources Director will audit the staff posting 2 times weekly x 2 weeks, and the Manager on Duty will audit the weekend posting x 1 weekend. Then monitoring will continue once weekly x 8 weeks and 1 weekend x 2 months. The Administrator will review	

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F 727	Continued From page 51	F 727	and initial the Audit tool weekly x 12 weeks for trends and concerns. The Administrator will present the findings of the audits to the Quality Assurance Performance Improvement Committee monthly x 3 months for trends and the need for continued monitoring and recommendations for any modification of the process. The Administrator is responsible for implementing the plan of correction.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		2/26/18

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F 732	Continued From page 52 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. 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. §483.35(g)(4) Facility data retention requirements. 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: Based on record reviews and staff interviews, the facility failed to post accurate nurse staffing information for 14 of the past 30 days (1/14/18, 1/15/18, 1/16/18, 1/21/18, 1/22/18, 1/25/18, 1/26/18, 1/27/18, 1/28/18, 1/31/18, 2/1/18, 2/6/18, 2/12/18, and 2/13/18). The findings included: A review of the facility's daily posts for nurse staffing information from the past 30 days was conducted on 2/15/18. The nurse staff postings included an inaccurate total number of hours worked by Registered Nurses (RNs) on 14 of the last 30 days, which included the following: --On 1/14/18, 1 RN worked 12 hours on the 7:00 AM to 7:00 PM shift and 1 RN worked 12 hours on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/15/18, no RNs worked on either the 7:00 AM to 7:00 PM shift or on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs	F 732	The Daily facility staff posting for 2/17/18 was corrected by the receptionist and posted in the Main Lobby of the facility. The facility utilized an excel spreadsheet to calculate staffing hours based on the number of staff members working per shift. The formula used in the excel spreadsheet for the posting of staffing hours used by the facility was inaccurate. The Receptionist failed to assure the posting was accurate prior to posting. Corrective action was completed on 2/26/18 by implementing a new staff posting sheet that does not use formulas for calculating hours. 100% of Receptionists received an in-service beginning 2/19/18 by the Administrator to assure the daily staff posting was accurately updated and posted each day at the beginning of the work day. All newly hired receptionists will be educated	

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F 732	Continued From page 53 on this date was reported to be 12 hours. --On 1/16/18, 1 RN worked 8 hours during the 7:00 AM to 7:00 PM shift and no RNs worked on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/21/18, 2 RNs worked 12 hours each on the 7:00 AM to 7:00 PM shift and no RNs worked on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/22/18, no RNs worked on either the 7:00 AM to 7:00 PM shift or on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/25/18, no RNs worked on either the 7:00 AM to 7:00 PM shift or on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/26/18, 1 RN worked 12 hours on the 7:00 AM to 7:00 PM shift and 1 RN worked 8 hours during the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/27/18, 1 RN worked 12 hours on the 7:00 AM to 7:00 PM shift, 1 RN worked 8 hours during the 7:00 PM to 7:00 AM shift and 1 RN worked 12 hours on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/28/18, 1 RN worked 12 hours on the 7:00 AM to 7:00 PM shift and 1 RN worked 12 hours on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours. --On 1/31/18, no RNs worked on either the 7:00 AM to 7:00 PM shift or on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours.	F 732	to assure the daily staff posting is completed at the beginning of their shift. Utilizing a Staff Posting Accuracy/Verification of RN Hours QI Audit Tool, the Human Resources Director will validate the daily posting is accurate weekdays x 2 weeks. The Manager on Duty will audit the postings on each weekend x 2 weekends. Then, the Human Resources Director will audit the staff posting 2 times weekly times 2 weeks, and the Manager on Duty will audit the weekend posting x 1 weekend. Then monitoring will continue once weekly x 8 weeks and 1 weekend x 2 months. The Administrator will review and initial the Audit tool weekly x 12 weeks for trends and concerns. The Administrator will present the findings of the audits to the Quality Assurance Performance Improvement Committee monthly x 3 months for trends and the need for continued monitoring and recommendations for any modification of the process. The Administrator is responsible for implementing the plan of correction.	

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F 732	Continued From page 54	F 732		

--On 2/1/18, 1 RN worked 12 hours on the 7:00 AM to 7:00 PM shift and 1 RN worked 12 hours on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours.
--On 2/6/18, 1 RN worked 12 hours on the 7:00 AM to 7:00 PM shift and 1 RN worked 12 hours on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours.
--On 2/12/18, no RNs worked on either the 7:00 AM to 7:00 PM shift or on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours.
--On 2/13/18, no RNs worked on either the 7:00 AM to 7:00 PM shift or on the 7:00 PM to 7:00 AM shift. The total number of hours worked by RNs on this date was reported to be 12 hours.

An interview was conducted on 2/15/18 at 12:55 PM with the facility ' s Administrator. During the interview, the Administrator reported this was her first week working at the facility. Upon review of the nurse staff postings, the Administrator acknowledged there were errors in the total number of working hours reported for Registered Nurses. When asked what her expectation was, the Administrator stated she would expect the daily nurse staff postings to be accurate.

An interview was conducted on 2/15/18 at 4:14 PM with the facility ' s receptionist. During the interview, the receptionist confirmed her duties included completing and posting the nurse staffing information. The receptionist reported she received the nursing schedule from the facility ' s scheduler each day. Using the information provided, she would input the nurse staffing hours onto a spreadsheet, print, and post

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F 732	Continued From page 55 the daily nurse staff posting. The receptionist reported that when the template for the spreadsheet was reviewed earlier this afternoon, it was discovered it had been pre-populated with the number "12," resulting in 12 total hours of RN coverage being reported each day on the posting. She stated no one had noticed the error on the spreadsheet until now.	F 732		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff and Pharmacist interviews and record review, the facility failed to administer an antibiotic as ordered for the treatment of a Urinary Tract Infection (UTI). This resulted in 3 missed does and a significant omission in orders for 1 (Resident #2) of 3 residents reviewed for UTI's. The findings included: Resident #2 was admitted 01/01/18 with cumulative diagnoses of Congestive Heart Failure (CHF) a fractured fibula with non-weight-bearing status, Urinary Retention, Peripheral Vascular Disease (PVD) and Dementia without behaviors. Resident #2's admission MDS dated 01/08/18 indicated severe cognitive impairment. He was coded as requiring extensive assistance with toileting and hygiene. Resident #2 was coded as incontinent of bladder and bowel. The CAA dated 01/08/18 read Resident #2 was at	F 760	Resident #2 no longer resides in the facility. Nurse #4 failed to administer the first dose of antibiotic as it was not yet delivered by the pharmacy and the last dose of the medication in the first dose Pyxis had been used that shift. The nurse did not call the physician to make him aware so that orders could have been given nor did the nurse call the pharmacy to fill the order with the back-up pharmacy. Nurse #5 omitted two doses of antibiotic stating that she was informed during shift report to hold these doses pending culture results. Nurse #5 did not investigate to determine if cultures were back, nor did she contact the physician for orders. The Staff Development Coordinator initiated an in-service on 2/15/18 to 100% of nursing staff to notify the pharmacy	2/26/18

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F 760	Continued From page 56 risk for the development of UTI's related to his incontinence. The CAA indicated a care plan would be developed. Review of nursing note dated 01/08/18 at 12:14 AM read Resident #2 was catharized for a urine sample to rule out a UTI due to increased confusion. Review of Resident #2's January 2018 physician orders revealed a new order dated 01/10/18 for an indwelling urinary catheter due to Urinary Retention. Review of Resident #2's care plan dated 01/10/18 read he had an indwelling urinary catheter due to urinary retention. He was to exhibit no signs or symptoms of UTI's through the next review. Interventions included the following: ongoing assessment for symptoms of an UTI, report abnormal findings to the physician and ongoing assessment of the color, clarity and character of his urine. Review of a urine culture final report dated 01/12/18 read Resident #2 had a UTI positive for Enterococcus (e-coli). The report was reviewed by the Physician Assistant (PA) and orders were written for Ampicillin (an antibiotic) to be given by mouth every six hours for seven days. Review of Resident #2's January 2018 Medication Administration Record (MAR) read his first dose of Ampicillin ordered was not administered on 01/13/18 at 6:00 AM. Review of the nursing note read the Ampicillin was not in the pyxis (automated medication dispensing system) and had not yet been delivered by the pharmacy.	F 760	when a medication is not available to arrange filling the order through the back-up pharmacy and to notify the physician when a medication is not available. This in-service included that medications cannot be held or omitted without a physician□s order. Corrective action was completed on 2/26/18 based on completion of in-servicing with 100% of current nursing staff. All newly hired licensed staff will receive the education during orientation. Utilizing an Antibiotic Use QI Audit Tool, the Staff Development Coordinator and Unit Managers x 2 will review the Medication Administration records for the use of antibiotics ordered to assure the medication was given. Any concerns will be directed to the physician at the time of the audit. Monitoring will occur Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1. The Weekend Supervisor will review the Medication Administration records for the use of antibiotics ordered to assure the medication was given x 2 weekends. The Director of Nursing will review and initial the Audit tools weekly x 8, then monthly x 1 for trends and concerns. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance Quality Improvement Committee meeting X 3 months for trends and recommendations for any modification of the process.	

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F 760	Continued From page 57 Review of Resident #2's January 2018 MAR indicated Ampicillin was ordered but not administered on 01/17/18 at 12:00 AM and at 6:00 AM. Review of the nursing notes written by Nurse # 5 revealed the 12:00 AM and 6:00 AM Ampicillin were held pending the results of his urinalysis. Review of the pharmacy provider undated Quick Reference information read "orders received before 7:00 PM will be delivered the same day. Orders received after 7:00 PM, will be deliver the next business day. New orders, emergency medications or STAT (immediate) orders needed after 7:00 PM, should be obtained from the First Dose Machine (pyxis) if available or called into the back-up pharmacy." Telephone interview on 02/14/18 at 2:50 PM, Nurse # 4 stated she was not aware that Ampicillin was not in the pyxis inventory and she should have contacted the pharmacy the evening of 01/12/18 when she received the order to ensure Resident #2 started timely treatment for his UTI. Telephone interview on 02/14/18 at 3:00 PM, Nurse #5 stated it was reported to her during shift change on 01/16/18 that the results were still pending on Resident #2's urinalysis so she did not administer his 12:00 AM and 6:00 AM Ampicillin doses on 01/17/18. She stated she did not look at the medical record and did not contact the physician about holding his antibiotic for two doses. Telephone interview on 02/15/18 at 3:00 PM, the Pharmacy Technician stated the order was faxed to pharmacy after 8:00 PM and was not ordered	F 760	The Administrator is responsible for implementing the plan of correction.	

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F 760	Continued From page 58 STAT. She stated it was delivered 01/13/18 with the evening medication delivery. She stated the facility did not contact the pharmacy for back-up pharmacy delivery. Telephone interview on 02/15 at 3:10 PM, the Consultant Pharmacist stated since the two missed doses on 01/17/18 occurred in the middle of Resident #2's scheduled administration days, this was considered a significant omission in his antibiotic treatment orders. Interview on 2/14/18 at 9:50 AM, the Administrator stated it was her expectation that Resident #2 would have received his antibiotic as ordered.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		2/26/18

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F 842	Continued From page 59 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 842	Continued From page 60 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff, physician, physician assistant, Wound Nurse Consultant interviews and record review, the facility failed to maintain complete and accurate medical records as evidenced by documentation of treatment orders without approval of Physician #1 for Resident #1. The facility also failed to provide documented evidence Resident #1's treatments were administered as ordered and failed to provide documented evidence that Resident #1 received pressure ulcer treatments 01/16/18, 01/18/18, 01/19/18, 01/23/18 and 01/24/18. The facility also failed to get a physician approval before providing treatment for the pressure ulcer for Resident #2, and failed to provide documented evidence that Resident #2's treatments were provided as ordered by the physician. This was evident for 2 (Resident #1 and Resident #2) of 4 residents reviewed for pressure ulcers. The findings included: 1. Resident #1 was admitted to the facility on 01/09/18 with cumulative diagnoses of Parkinson's disease, Peripheral Vascular Disease, Dysphagia and Benign Hypertrophic Prostrate with an indwelling urinary catheter. Review of Resident #1's Wound Assessment Report dated 01/09/18 read Resident #1 was admitted with unstageable pressure ulcers to his	F 842	Resident #1 and Resident #2 no longer reside in the facility. The Treatment Nurse failed to correctly date wound assessments entered into the Wound Assessment Report. The Treatment Nurse, Nurse #1, and Nurse #2 failed to electronically sign the Treatment Administration Record after completing each treatment on Resident #1. The Treatment Nurse and Nurses #3 failed to electronically sign the Treatment Administration Record after completing each treatment on Resident #2. The Treatment Nurse failed to assure original written treatment orders with prescriber signature prior to entering orders into the electronic health record. The Treatment Nurse was removed from completing treatments 2/14/18 and retraining initiated. Floor staff will complete treatments beginning 2/14/18 until the Treatment Nurse□s retraining is completed. The Charge Nurse will be responsible for providing wound treatments in the event the Treatment Nurse is absent from work or assigned other duties. The Administrator re-educated the	

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F 842	Continued From page 61 right buttock, sacrum, and left buttock. The report was completed by the Treatment Nurse and indicated Physician #1 was notified on 01/09/18 with treatment orders pending. During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated she was not made aware of any pressure ulcers found on Resident #1 until 01/12/18. When questioned regarding the Wound Assessment Report she completed on 01/09/18 on Resident #1, the Treatment Nurse stated she must have dated the assessment incorrectly and it should have been dated 01/12/18. The Treatment Nurse stated when she found out about Resident #1's pressure ulcers on 01/12/18, she notified Physician Assistant #1 (PA) who gave her the original treatment orders entered in the electronic record dated 01/12/18 but she must have forgotten to write an original physician order. Review of the electronic physician orders dated 01/12/18 at 11:10 AM was conducted. The Treatment Nurse entered the following new treatment orders which auto-populated the TAR: bilateral buttocks and sacrum were to be cleansed with wound cleanser, patted dry and Calmoseptine ointment (analgesic, antiseptic, antipruritic, and skin protectant combination) was to be applied to the peri-wound with Silver Alginate (an antimicrobial, highly absorbent wound dressing with ionic silver) to the wound bed. It was to be covered with a protective foam dressing daily and as needed. There were no written physician orders for this treatment. Review of the electronic physician orders dated 01/16/18 at 1:06 AM, revealed the Treatment Nurse entered the following new treatment which auto-populated the TAR: cleanse Resident #1's	F 842	Treatment Nurse on 2/16/18 on the expectations of documentation. The Treatment Nurse returned to the floor completing treatments on 2/17/18. All newly hired treatment nurses will receive the education during orientation. A 100% audit of Treatment Administration Records were reviewed with physician□s orders for the past 30 days by the Unit Managers x 2 and the Staff Development Coordinator on 2/15/18 to verify all treatments on the TAR have corresponding physician□s order and the order was transcribed as ordered with no issues identified. All treatments transcribed on the TAR had corresponding treatment orders and were correctly transcribed as ordered. The Wound Consultant will begin writing her own treatment orders as of 2/14/18 while in the facility after her assessment of the wound. The Wound Consult Report will be reviewed with the provider. All orders will be transcribed by the Treatment Nurse or Charge Nurse. The Staff Development Coordinator initiated an in-service on 2/14/18 to 100% of all licensed staff on timely and accurate documentation of treatments. Corrective action was completed on 2/26/18 following completion of all in-servicing. Utilizing a Treatment Record Administration QI Audit Tool, the Director of Nursing and Staff Development Coordinator will review 100% of all	

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F 842	Continued From page 62 unstageable wound to his sacrum with Anasept spray (gentle antimicrobial wound cleanser with broad-spectrum bactericidal properties) for odor control. Pat the area dry and apply Calmoseptine to the peri-wound then apply Calcium Alginate to the wound bed only. Cover with a foam dressing daily and as needed. There were no written physician orders for this treatment. Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum on 1/16/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/16/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned to do all treatments 01/16/18. During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated that, regarding the missing written physician order for treatment change on 1/16/18, the Wound Nurse Consultant gave her those orders on 01/15/18 but the Wound Nurse Consultant was responsible for writing her own treatment orders. The Treatment Nurse stated she only entered the new treatment order into the electronic medical record on 01/16/18 and never saw an original written order. She stated she must have inaccurately entered the orders given by the Wound Nurse Consultant. During a telephone interview on 02/14/18 at 4:10 PM, the Wound Consultant Nurse stated she first assessed Resident #1 on 01/15/18 and gave new orders for Medi-honey and Calcium Alginate to all areas on his sacrum. She stated it was her expectation that the order she gave to the Treatment Nurse on 01/15/18 would have been written and implemented.	F 842	treatment records to assure the treatments have been completed and signed off by the staff. Monitoring will occur Monday through Friday x 2 weeks then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month. The Director of Nursing will review the QI Audit Tool weekly x 8, then monthly x 1 for trends and concerns. The Director of Nursing will report the results of the monitoring to the Quality Assurance Committee monthly x 3 months for trends, concerns, and recommendations for any modification of the process The Administrator is responsible for implementing the plan of correction.	

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F 842	Continued From page 63 Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum. Review of the daily schedule assignment sheet indicated the floor nurses were responsible for their own treatments on 01/18/18. Nurse #1 was assigned to complete Resident #1's treatment on 01/18/18. During a telephone interview on 02/12/18 at 11:30 AM, Nurse #1 stated she completed the treatment on 01/18/18 but must have forgotten to initial the TAR. Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum on 01/19/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/19/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned to all treatments on 01/19/18. Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed to his sacrum on 01/23/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/23/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments 01/23/18. During an interview on 2/14/18 at 12:05 PM, the Treatment Nurse stated that, regarding all the missing documentation for treatments on the TAR, she stated she must have forgotten to initial the TAR but Resident #1 received his treatments on 01/16/18, 01/19/18 and 01/23/18.	F 842		

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Review of Resident #1's January 2018 TAR indicated no documented initials that his treatment was completed on his sacrum on 01/24/18. Review of the daily schedule assignment sheet indicated the floor nurses were responsible for their own treatments on 01/24/18. Nurse #2 was assigned to complete Resident #1's treatment on 01/24/18.

During a telephone interview on 02/15/18 at 2:40 PM, Nurse #2 stated she provided Resident #1's pressure ulcer treatment on 01/24/18 but forgot to initial off on the TAR.

During a telephone interview on 02/13/18 at 3:10 PM, the Wound Nurse Consultant stated the Treatment Nurse should have written the orders she gave on 01/15/18 with Medi-honey and Calcium Alginate.

During an Interview on 02/15/18 at 12:05 PM the Director of Nursing (DON) stated it was her expectation that any new orders, assessments and treatments be documented in the resident medical record. The DON stated she did not know where the Treatment Nurse was getting the orders she implemented for Resident #1.

Physician #1 was interviewed via Telephone on 02/13/18 at 3:50 PM. He stated it was his expectation that the facility accurately document and implement any new orders.

During an interview on 2/14/18 at 9:50 AM, the Administrator stated it was her expectation that when an order is received from the attending physician, the Wound Nurse Consultant or the Physician Assistant, the original order be written with the prescriber's signature then entered into

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F 842	Continued From page 65	F 842		

the electronic medical record. The Administrator stated nothing should be entered into the electronic medical record unless there was a written order. She stated all treatments provided should be documented and completed on Resident #1's TAR. The Administrator stated it was her expectation that resident's physician orders and medical records be accurate and complete.

2. Resident #2 was admitted to the facility on 01/01/18 with cumulative diagnoses of Congestive Heart Failure (CHF) a fractured fibula with non-weight-bearing status, Urinary Retention, Peripheral Vascular Disease (PVD) and Dementia without behaviors.

Review of a nursing note dated 01/13/18 at 3:24 PM read the Nursing Assistant reported open area to Resident #2's right and left buttocks. New orders to cleanse the right and left buttock with wound cleanser, apply Calmoseptine ointment and foam dressing every other day and as needed. The note read the wound communication notebook was updated. This note was completed by Nurse #1.

Review of a nursing note dated 01/16/18 at 9:30 AM as an addendum for 01/14/18 was conducted. The note read on assessment, Resident #2 was noted with a stage 3 pressure ulcer to his right and left buttock. The note read currently pending treatment orders.

Review of Resident #2's Wound Assessment Report dated 01/16/18 read a new stage 3 pressure ulcer to his right and left buttock was identified on 01/14/18. The report was completed by the Treatment Nurse and indicated the Medical

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Director was notified on 01/16/18 with new orders to cleanse right buttock with wound cleanser, apply Calmoseptine and cover with a foam dressing daily and as needed. A new order was given to cleanse the left buttock wound with wound cleanser, apply Silver Alginate to the wound bed and Calmoseptine to the peri-wound and cover with a foam dressing daily and as needed.

Review of Resident #2's January 2018 written physician orders did not include any treatment orders for the resident's pressure ulcers on 01/16/18. The electronic medical record indicated on 01/16/18 at 12:02 PM the Treatment Nurse entered the following new treatment which auto-populated the TAR: Cleanse right and left buttock with wound cleanser, pat dry and apply Calmoseptine and a foam dressing daily and as needed. The new order for Silver Alginate to the left buttock (documented as a new order on the Wound Assessment Report dated 01/16/18) was not added to the electronic medical record and did not appear on the TAR.

Review of Resident #2's January 2018 TAR indicated no documented initials that his treatment of Calmoseptine with a foam dressing was completed to his right buttocks or any documented initials of his treatment of Calmospetine, Silver Alginate with foam dressing to his left buttocks as written by the Treatment Nurse on the Wound Assessment Report dated on 01/16/18. Review of the archived Time Card Report indicated the Treatment Nurse worked 01/16/18. Review of the daily schedule assignment sheet indicated the Treatment Nurse was assigned all treatments 01/16/18.

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During an interview on 02/12/18 at 3:30 PM, the Treatment Nurse stated she completed his treatment on 01/16/18 but did not initial it on the TAR.

Review of Resident #2's written physician orders dated 01/26/18 read new orders to clean his sacrum right and left buttocks with normal saline, pat dry then apply Santyl (debriding ointment) and Calcium Alginate and cover with a foam dressing daily and as needed. This order was signed by the PA.

Review of Resident #2's January 2018 TAR indicated no documented initials that his treatment of Santyl and Calcium Alginate with a foam dressing was completed to his right and left buttocks as ordered on 01/26/18.

Review of the daily schedule assignment sheet indicated the floor nurses were responsible for their own treatments. Nurse #3 was assigned to complete Resident #2's treatment on 01/26/18.

During a telephone interview on 02/15/18 at 2:40 PM, Nurse #3 revealed she provided Resident #2's pressure ulcer treatment on 01/26/18 but forgot to initial off on the TAR.

During an interview on 02/15/18 at 12:00 PM, the Director of Nursing (DON) stated it was her expectation that any new orders, assessments and treatments be documented in the resident medical record. The DON stated she did not know where the Treatment Nurse was getting the orders she implemented for Resident #1.

During an interview on 02/13/18 at 11:10 AM, the Treatment Nurse stated there was a lack of

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communication from the floor staff to her so she instituted a wound communication notebook and placed one at each nursing station. When a new area was identified, she would know about it if the nurses documented it in her wound communication notebook. She stated she checked the wound communication notebooks daily. The Treatment Nurse stated the facility did not have any standing orders for pressure ulcer treatments and the physician should be contacted for new orders when a new area or worsening area was noted.

During a telephone interview on 02/13/18 at 3:10 PM, the Wound Nurse Consultant stated she first assessed Resident #2's sacrum on 01/22/18. She stated it was her expectation that treatment orders were written and the medical record was accurate and complete.

During a telephone interview on 02/13/18 at 5:56 PM, the PA confirmed she was available and present at the facility Monday through Friday and available after hours by phone. She stated she was aware Resident #2 developed a sacral ulcer but was unsure of the onset date. The PA recalled someone calling her for orders and she gave the nurse orders but was unsure of the date. She stated it was her expectation that Resident #2's medical record be accurate and complete.

The Medical Director was interviewed via Telephone on 2/13/18 at 5:15 PM. The Medical Director stated it was his expectation that all physician orders be obtained and written prior to initialing any new treatment orders. He also stated treatments be completed as ordered and documented in the medical record. The Medical Director stated there seemed to be a lack of

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F 842	Continued From page 69 communication on the part of the facility. During an interview on 2/14/18 at 9:50 AM, the Administrator stated it was her expectation that when an order is received from the attending physician, the Wound Nurse Consultant or the Physician Assistant, the original order be written with the prescriber's signature then entered into the electronic medical record. The Administrator stated nothing should be entered into the electronic medical record unless there was a written order. She stated all treatments provided should be documented and completed on Resident #2's TAR. The Administrator stated it was her expectation that resident's physician orders and medical records be accurate and complete.	F 842		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 865		3/5/18

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F 865	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review, the facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification survey of 08/17/17. This was for one deficiency recited during a complaint investigation of 02/15/18 in Resident Rights at F 580 (F157). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain and effective Quality Assessment and Assurance program. The findings include: This citation is cross referenced to: F580- Based on staff, Physician, Physician Assistant (PA), Wound Nurse Consultant interviews and record review, the facility failed notify the physician of the resident's pressure ulcers on the resident admission and failed to obtain treatment orders, resulting in the resident's delay in treatment from 1/9/18 till 1/12/18. The facility failed to get the physician approval before the initiation of pressure ulcer treatment. The facility failed to notify the physician of the Wound Nurse Consultant treatment orders for Resident #1's pressure ulcers. The facility failed to notify the physician of the worsening of the pressure ulcers and seek an order for treatment. Resident #1's sacral pressure ulcer was described as "quarter size" suspected deep tissue injury (purple or maroon area of discolored intact skin) on 01/09/18. It was described on 01/22/18 as an unstageable sacral pressure ulcer measuring 13.5-centimeter (cm) length, 12.5 cm width and	F 865	The facility failed to monitor assurance of notification to the physician per the Quality Assurance process. Previous monitoring for notification was completed per the 3 month schedule. When there were no issues or concerns identified, monitoring was discontinued. There have been 2 interim Administrators and a new Director of Nursing since the last Quality Assurance for notification had been completed. Monitoring for notification to the physician had not been completed since the end of January 2018. The Administrator and Director of Nursing received an in-service to include past deficiency monitoring for physician notification in the facility Quality Assurance program by the Regional Clinical Manager on 3/5/18 and to assure monitoring continues as part of the facility QA program until certainty of the monitoring has been effective and no longer necessary. 100% of all licensed nurses received an education on physician notification on 2/15/18 by the Staff Development Coordinator. All new licensed staff, Administrator, and Director of Nursing will receive the education during orientation. Utilizing a Change in Skin Condition Audit Tool, the Unit Managers x 2 will review 100% of nurse progress notes and 100% of the Treatment Administration Records daily to identify new wounds/skin changes to assure the physician has been notified.	

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F 865	Continued From page 71 1.5 cm depth having excessive necrotic tissue appearing yellow/black in color and as deteriorated. Resident #1 was hospitalized with an infected stage 4 pressure ulcer requiring sharp debridement and antibiotic therapy. Interview on 2/15/18 at 9:50 AM, the Administrator acknowledged understanding of the reciting of F580 during the complaint survey of 02/15/18. The Administrator stated she felt the repeat citations were related to the lack of communication between Physician #1, the Treatment Nurse and the Wound Nurse Consultant. The Administrator stated it became evident around mid-January 2018 during inclement weather. She stated the Unit Managers (UM) brought it to the attention interim Administrator. She stated she also recently became aware that the Treatment Nurse was not attending morning stand-up meetings where patients at risk (PAR) were discussed daily. She stated it was her expectation that the Treatment Nurse would have attended those meetings and contacted Physician #1 for admission treatment orders, treated Resident #1's pressures as ordered and notified him for worsening of Resident #1's pressure ulcer. The Administrator further stated it was her expectation nurses and/or Treatment Nurse notify the responsible Physician each time for specific treatment orders.	F 865	Monitoring will occur Monday through Friday x 2 weeks, then twice weekly x 2 weeks, then weekly x 4 weeks, then monthly x 4 months. The Director of Nursing will review and initial the Audit Tool weekly x 8 weeks, then monthly x 4 months for trends and concerns. The Director of Nursing will present the results of the monitoring to the Quality Assurance Committee monthly x 6 months for trends, the need to modify any part of the process, and the need to continue monitoring. The Administrator will be responsible for implementing the plan of correction.	