STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 06/05/2018

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F 000	INITIAL COMMENTS The survey team exited the building on 6/4/18 with physician interviews pending. The interviews were completed on 6/5/18 and the investigation closed.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews the facility failed to identify that a test ordered by the physician had not been completed by the laboratory as ordered that caused a delay in treatment and resulted in prolonged abdominal pain and diarrhea for 1 of 3 residents reviewed for pain (Resident #3). The facility also failed to recognize a change in a resident ' s skin condition for 1 of 4 residents reviewed for wound care. The resident required hospitalization and surgery (Resident #2). The findings included: 1. Resident #3 was admitted to the facility on 5/16/18 and had a diagnosis of necrotizing fasciitis of the left upper extremity and sepsis. The Admission Minimum Data Set (MDS) Assessment dated 5/23/18 revealed Resident #3	F 684	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. On 6/3/2018 the physician was notified of the incorrect lab, the facility obtained an order for a STAT lab for C-Diff, the resident was started on antibiotics to treat C-Diff, and correct isolation precautions were initiated for Resident #3. The nurse responsible for documenting the weekly skin assessment for resident #2 is no longer an active employee of the	6/28/18

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

Electronically Signed | 06/18/2018

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F 684	Continued From page 1 was cognitively intact. The resident ' s Care Plan dated 5/24/18 noted the resident had pain of the left upper extremity but did not include information regarding abdominal pain or diarrhea. A nurse ' s note dated 5/23/18 noted Resident #3 was alert and oriented times 3 (person, place and time), was continent of bowel and bladder at bedside commode and one person assist with activities of daily living and transfers. A nurse ' s note dated 5/26/18 at 6:07 AM noted no loose stools this shift. Temperature 97.8 degrees Fahrenheit. There were no nurses ' notes prior to this entry to indicate the resident was having loose stools. A nurse ' s note dated 5/27/18 at 2:26 PM revealed the following: Resident #3 complained of diarrhea with no visible evidence of diarrhea at the time, was Instructed to leave stool in bedside commode to be observed by staff and fluids were encouraged. The note revealed the following vital signs: Temperature 100.3 degrees Fahrenheit, Pulse 94, Respirations 20 and Blood Pressure 132/69. The PA (Physician ' s Assistant) was notified of resident ' s condition. A nurse ' s note dated 5/27/18 at 3:39 PM revealed PA #1 called and gave orders for a CBC (complete blood count), BMP (basic metabolic panel) and stool for C-Diff (Clostridium Difficile) and this was reported to the on-coming nurse. Clostridium Difficile or C-Diff is a bacteria that can cause abdominal cramping and diarrhea. Review of the physician ' s orders revealed an order dated 5/27/18 for laboratory tests of a CBC, BMP and stool for C-Diff.	F 684	facility. A head to toe skin assessment was completed on resident #2 by our treatment nurse on 6/4/2018 to identify any areas on the skin receiving treatment, to verify the appropriateness of the treatment, to identify any area needing treatment orders, and ensure identified areas are being monitored per facility policy. Root cause: Clinical systems not being followed by the facility regarding checking the labs to ensure the lab completed was the lab ordred by the provider in the daily clinical meeting. Nurse #3 singularly acted and violated the standard of care regarding documentation of skin assessments 2. Any resident with ordered labs has the potential to be affected. A 30 day look back of 100% of charts was completed by the Director of Nursing (DON) and Regional Clinical Director (RCD) to ensure ordered labs were completed as ordered and results were received for the correct labs ordered. Skin assessments were completed on all residents by staff nurses to identify any areas on the skin receiving treatment and to verify the appropriateness of the treatment, to identify any area needing treatment orders, and ensure any resident identified with active skin issues were being monitored per facility policy. 3. The Administrative Nursing Team was in-serviced by the RCD on 6/5/2018	

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F 684	Continued From page 2 A nurse ' s note dated 5/27/18 at 11:01 PM revealed the following: The resident ' s temperature was down from 100.5 degrees Fahrenheit to 99.8 degrees Fahrenheit. It was noted fluids were encouraged, the resident had a good appetite. The note revealed the resident had two episodes of diarrhea and a stool sample was collected for C-Diff. Vital signs were documented as follows: Blood Pressure 114/60, Pulse 76, Respirations 18. A provider note dated 5/28/18 at 10:09 AM by Physician Assistant (PA) #3 revealed the following: "Resident complained of diarrhea all weekend and felt nothing was being done and described mild abdominal cramping. Resident was on antibiotics while in the hospital but none since being here. Febrile overnight but temperature 97.8 degrees Fahrenheit this AM. A stool for C-Diff (Clostridium Difficile) collected this AM. Will order Imodium (medication for diarrhea) as needed and discontinue scheduled bowel medications. Labs (laboratory studies) also ordered to check white blood cell count and hydration." A nurse ' s note dated 5/30/18 at 2:52 AM noted the resident complained of pain to the abdomen about 1:00 AM and pain medications were given with good effect. A nurse ' s note dated 5/30/18 at 3:02 AM noted the stool for C-Diff still pending at this time. A lab report dated 5/30/18 revealed a stool sample was received in the lab on 5/28/18 and a stool culture had been done. There was no information in the report regarding the results for	F 684	regarding the clinical process of reviewing labs in the morning clinical meeting to ensure the correct lab is drawn and correct results are received. The licensed nurses were in-serviced by the Staff Development Coordinator (SDC) regarding utilizing the Lab Requisition Log to ensure lab results are checked against the provider lab orders the ensure the correct lab results are received. The licensed nurses were in-serviced regarding the importance of completing a thorough weekly skin assessment, signing off the assessment on the Medication Administration Record (MAR) as well as documenting the skin assessment in the progress note under weekly skin assessment, and responding to issues reported by the nursing assistants by completing an assessment. These items will be added to the general orientation process for all licensed nurses. All identified staff will receive in-service training before 6/28/2018 or will not be allowed to work until completed. 4. The Lab Requisition Log will be audited in the daily clinical meeting by checking it against the provider orders to determine if the correct lab was drawn. When results are received, the results will be checked against the provider order the ensure the results are for the ordered lab. The audit will be completed daily for four weeks, then weekly until 100% compliance is met for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring	

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F 684	Continued From page 3 C-Diff. A provider note dated 5/31/18 by PA #1 revealed the resident ' s diarrhea was improved and the work-up negative. A nurse ' s note dated 6/2/18 at 7:19 AM revealed Imodium 2mg (milligrams) was given for diarrhea. A nurse ' s note dated 6/2/18 at 9:22 AM noted the resident was given Zofran for nausea and was effective. On 6/2/18 at 9:58 AM, Resident #3 stated in an interview he had been experiencing abdominal pain and diarrhea for 2 weeks and had a fever this morning. The resident was observed lying in bed grunting with a pained expression on his face. The Resident further stated a stool sample had been taken and blood work done and was told everything was Okay. The Resident stated he had received pain medication that morning as well as a medication for the diarrhea. On 6/2/18 at 2:00 PM an interview was conducted with the Medical Director who stated a stool culture would not test for C-Diff. On 6/2/18 at 2:05 PM during an interview the Director of Nursing (DON) became aware that a stool culture had been done and not a stool for C-Diff. A nurse ' s note dated 6/3/18 at 7:00 AM revealed Resident #3 was on contact precautions for possible C-Diff while waiting results. On 6/3/18 at 8:56 AM the DON stated in an interview she had ordered a STAT C-diff	F 684	schedule will be modified based on findings. 4. Quality assurance committe will audit ten charts per week by the DON to ensure the weekly skin assessments are completed and documented in the medical record. Four nursing assistants per shift per week will be interviewed by a member of the Administrative Nursing Team to determine if there were any changes in condition reported to the nurse. The chart will be audited of any reported change in condition to ensure appropriate follow up by the nurse had occurred. The Director of Nursing will follow up with nursing staff as needed. The interviews and audits will continue until 100% compliance is maintained for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings. The Administrator will ensure the outlined POC is carried out as outlined.	

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yesterday and hoped to have the results today. STAT is a medical term used to let staff know the test was to be done urgently or immediately.

On 6/3/18 at 10:50 AM the DON stated in an interview the test came back positive for C-Diff and she had notified the physician and an order given for Flagyl 1 tablet three times a day. Flagyl is an antibiotic used to treat C-Diff.

On 6/3/18 at 12:23 PM NA #1 who worked regularly with Resident #3 stated in an interview the Resident had been having diarrhea for about one week.

On 6/3/18 at 12:00 PM an interview was conducted with Unit Manager #1 who stated she knew Resident #3 had diarrhea and that a stool for C-Diff had been sent to the lab and the results were pending. The Unit Manager further stated when she got the results of the stool culture and saw no growth she reported this to the PA #1. The Unit Manager stated she noticed the results looked different but it did not dawn on her the results did not say anything about C-Diff. The Unit Manager stated the nurse on night shift does a chart check to ensure they did not miss any orders.

On 6/4/18 at 8:25 AM Resident #3 stated in an interview his intestines hurt and they started his medication last night. The resident was observed sitting on the bed side commode and was grunting with pain.

On 6/4/18 at 1:50 PM an interview was conducted with PA #1. The PA stated she did not order the stool for C-Diff (ordered by PA #3) and the stool culture results popped up on the computer and

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she saw it was negative and did not know a stool for C-Diff had been ordered. The PA stated it would take at least 3 days from the time the Flagyl was started for the resident to see an improvement in the abdominal pain and diarrhea.

On 6/4/18 at 10:55 AM an interview was conducted with the Administrator and the DON. The DON stated when a lab test was ordered, the order was entered into the computer and a log printed for the lab technician of what tests were to be done that day. The DON provided a document from the lab that showed a C-Diff culture was entered into the computer and the specimen collected on 5/28/18 and the Daily Log dated 5/28/18 for the lab tech noted Resident #3 was to have a C-Diff culture done. The Administrator stated for some reason the lab did a stool culture and not a test for C-Diff and PA #1 signed off on the lab and did not recognize a C-Diff was supposed to have been done and not a stool culture.

2. Record review revealed Resident # 2 was admitted to the facility on 8/29/17. The resident had diagnoses of paraparesis secondary to spinal injury, neurogenic bladder, neuropathy, and diabetes.

Review of the resident's minimum data set assessment, dated 3/4/18, revealed the resident was cognitively intact and required extensive assistance with his hygiene and bathing needs.

Review of the resident's care plan, revised on 3/20/18, revealed the staff identified the resident was at risk for skin integrity problems due to his

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muscle weakness, impaired mobility, and episodes of incontinence. A care plan intervention was to perform a weekly skin assessment.

Review of physician progress notes revealed Physician's Assistant (PA) # 1 evaluated Resident # 2 on 4/27/18 at 2:57 PM. The PA noted the following. The resident was assessed to have a yeast infection in his groin area. A barrier cream, which was being utilized, would be discontinued. The staff were to start using Nystatin powder to dry the area out.

Review of nursing notes revealed from 5/1/18 through 5/8/18 there were no nursing notations made regarding the resident's skin condition.

On 5/7/18, Nurse # 3 placed a check mark on the resident's medication administration record noting she had completed a skin check. The check mark was placed on the MAR by directions that a skin check was to be performed and a progress note was to be entered in the resident's record. There was no corresponding progress note on 5/7/18 which contained documentation of the resident's skin assessment.

On 5/8/18, PA # 2 documented at 2:26 PM the following information. She was asked to see Resident # 2 because the resident had redness to his abdomen and was febrile. The resident was assessed to have marked erythema (redness) across the lower half of his abdomen with increased warmth. The middle lower abdomen had a 6 inch by 4 inch area of induration (hardening of the soft skin tissue) and a few sites of pale pustules (small bumps on the skin that contain fluid or pus), which were not opening or draining at the time. The resident was accessed

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to have an abscess/cellulitis. According to the PA's note, the resident needed to start aggressive treatment given the appearance of his skin and fever. An order was given to send the resident to the emergency room.

Review of hospital records revealed Resident # 2 was admitted to the hospital on 5/8/18 where he was identified to have abdominal wall cellulitis (infection of the skin and tissues beneath the skin) and abscess (a collection of pus underneath the skin). A surgical consult was initiated, and the resident underwent an incision and drainage of the abscess.

PA # 1 was interviewed on 6/4/18 at 12:40 PM. The PA reported the following. When she had assessed Resident # 2 on 4/27/18, the resident appeared to have a yeast infection in his groin area and some excoriation on his scrotal area. At the time of her exam, the resident did not have any problems on his abdomen. The resident tended to stay wet frequently due to medical reasons. Therefore, she ordered the Nystatin to help dry the affected areas and clear the resident's skin.

NA # 2 was interviewed on 6/4/18 at 1:40 PM. NA # 2 routinely cared for the resident. NA # 2 reported the following. A few days before Resident #2 was transferred to the hospital on 5/8/18, she had noticed the resident had a very "strange looking bubble bump" which had arisen on his lower abdomen. It was located on the skin near the top of the resident's brief. It was approximately ½ inch wide and tall. It was filled with fluid. If pressure was applied to the area, then fluid could be seen moving from one side to the other. It was as if his skin was transparent in

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that area with the fluid beneath it. Routinely she always reported things like this to the nurse, but the resident was very alert and oriented. She asked the resident about it, and he told her the nurses said it was a bedsore. Since it appeared the nurses were knowledgeable about the area, she never reported it to a nurse.

Nurse # 3 was interviewed on 6/4/18 at 5:20 PM. Nurse # 3 was the nurse who had checked on the MAR that a skin assessment was completed on 5/7/18. According to the May, 2018 MAR, Nurse # 3 had also applied the resident's Nystatin during the dayshift of 5/6/18 and 5/7/18. Nurse # 3 reported the following during her interview. She did not recall doing a skin assessment on the resident prior to his hospitalization. The nurse stated she was new to the facility at the time of 5/6/18 and 5/7/18, and was still in orientation while working with another nurse. She recalled that she had very little care responsibilities for the resident during her orientation period, and was not able to describe any problems with Resident # 2's skin.

Unit manager # 1 was interviewed on 6/4/18 at 12:05 PM. The unit manager was not familiar with Resident # 2's skin issues prior to his hospitalization.

Resident # 2 was interviewed on 6/4/18 at 2:30 PM. The resident stated the bump on his abdomen was there a few days before he went out to the hospital, and was in an area that got wet when his brief was heavily soiled with urine. He said at times he felt warmth in the area, and he asked the nurses about it. He could not recall the specific nurses, with whom he had discussed it, but recalled he was told by them that it just

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F 684	Continued From page 9 needed some cream on it. Due to his condition and limitations, he was not able to see the area himself. PA # 2 was interviewed on 6/4/18 at 2 PM. The PA reported the following. The area appeared to be originating from below the skin. She was not aware of the area until 5/8/18 when she was asked to see the resident due to the redness and fever. Typically with an abscess, a resident would have pain. Resident # 2 had some sensory deficits due to his spinal injuries, which had possibly impaired his ability to feel the pain associated with it. At the time of her assessment, she recognized he was in immediate need to be evaluated at the hospital. Depending on the type of bacteria involved, an abscess can form and progress at different time intervals. Some develop and progress within a matter of hours while others develop and progress in days. According to the PA, either she or another PA is in the facility daily. They would have evaluated the fluid filled bump noted by the NA earlier if it had been drawn to their attention. The Administrator was interviewed on 6/4/18 at 6:30 PM. It was the administrator's expectation that nurses were to perform weekly skin assessments and document their findings in the progress note. The administrator could find no evidence this had been done on 5/7/18 when the nurse checked that it had been done on the MAR.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		6/28/18

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F 689	Continued From page 10 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews the facility failed to use 2 persons to transfer a resident for 1 of 2 residents observed to be transferred with a mechanical lift (Resident #2). Resident #2 was admitted to the facility on 8/29/17 and had a diagnosis of cord compression and paraplegia. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 3/4/18 revealed the resident was cognitively intact and required total assistance from staff for transfers. The MDS noted the resident had a functional limitation in range of motion of one upper extremity and both lower extremities and used a wheelchair for mobility. Review of the resident ' s Care Plan dated 3/18/18 noted the resident was at risk for falls related impaired immobility. One of the interventions read: "To be transferred using a (name of mechanical lift)." Another intervention noted the resident was to be transferred with a mechanical lift. Resident #2 was re-admitted to the facility on 5/14/18 after a hospital stay. Review of the Nursing Assistant Care Guide for Resident #2 with an admission date of 5/14/18	F 689	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. NA #5 was in-serviced by the Director of Nursing regarding the policy of utilizing 2 employees when utilizing a mechanical lift for transfers. Root cause: Lack of understanding of NA #5 of the intent of the policy of another person being present to spot/assist during the transfer. The presence of the surveyor did not count because they were not assisting with the transfer. 2. All residents transfer status was reviewed by the therapy department regarding the appropriate mechanical lift to be used for transfers. The Kardexes were reviewed and updated by the DON to ensure residents identified to utilize a mechanical lift for transfers were acurate and appropriate as deemed by the therapy department.	

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F 689	Continued From page 11 under Transferring read: "resident is to be transferred using (name of mechanical lift)." Another entry read: "TRANSFER: Requires Mechanical Aid for transfers." On 6/2/18 at 10:48 AM during an interview with the resident, NA (Nursing Assistant) #5 entered the room and told the resident she needed to put him back to bed for the nurse to do a treatment. The NA was observed to ask the resident if he could stand. The Resident stated he was transferred with a sit to stand mechanical lift. The NA left the room and returned with the sit to stand lift. The NA was observed to apply the lift to the resident and transferred the resident to the bed. There were no other staff in the room to assist with the transfer. The nurse was observed to provide wound care for the resident and left the room. The NA remained in the room during the treatment and when completed used the sit to stand lift to transfer the resident back to his wheelchair. On 6/2/18 at 11:30 AM Resident #2 stated in an interview there were usually 2 staff members to transfer him with the sit to stand lift. On 6/4/18 at 8:12 AM NA #5 stated in an interview she had just started working here and during orientation she was trained to use the sit to stand lift with 2 persons. The NA further stated she thought the nurse would be in the room to help her but she did not come so she transferred the resident by herself. On 6/4/18 at 9:03 AM an interview was conducted with the Physical Therapist (PT) who evaluated Resident #2 for transfers. The PT stated the resident was initially screened to be transferred	F 689	3. Any staff responsible for transferring residents were in-serviced by the Staff Development Coordinator and the Therapy Director regarding the facility policy of utilizing 2 staff members for all transfers involving a mechanical lift. All staff received the in-service training by 6/28/2018 or will not be allowed to work until training completed. The policy will be included in the orientation process with a return demonstration competency for any staff responsible for resident transfers. 4. Ten transfers utilizing mechanical lifts will be observed by a member of the Administrative Nursing Team on various shifts per week for four weeks, then ten transfers on various shifts utilizing mechanical lifts will continue until 100% compliance is maintained for two consecutive months to ensure the mechanical lifts are being properly used and the correct number of staff members are present during the transfer. The Director of Nursing will follow up with nursing staff as needed. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings. The Administrator will ensure the outlined POC is carried out as outlined.	

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F 689	Continued From page 12 with the (name of total mechanical lift) and with therapy had progressed to the sit to stand lift. The PT further stated it was the facility ' s policy to transfers residents with a mechanical lift with 2 person assist including the sit to stand lift. On 6/4/18 at 9:23 AM an interview was conducted with the Staff Development Coordinator who stated the NAs were trained to always use 2 persons when using a mechanical lift including the sit to stand lift. On 6/4/18 at 10:37 AM the Administrator stated in an interview she expected the staff to use 2 persons when transferring residents with a mechanical lift including the sit to stand lift.	F 689		
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		6/28/18

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F 842	Continued From page 13	F 842		

§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

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F 842	Continued From page 14 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 interview and record review the facility failed to accurately document wound treatments and accurately enter physician orders into the electronic treatment administration record for 1 of 4 (Resident #1) residents' treatment administration records reviewed for accuracy. Findings included: Resident #1 was admitted to the facility on 5/9/18 with diagnoses of chronic obstructive pulmonary disease and hypertension and was discharged on 5/23/18. Documentation on an initial non pressure skin assessment dated 5/9/18 revealed Resident #1 had left lower leg lateral trauma present on admission. The documentation in the care plan initiated on 5/11/18 for Resident #1 had a focus area that stated the resident had a left lower leg wound. One of the interventions on the care plan was to provide medications and treatments per the physician orders. Review of the physician orders revealed Resident #1 was admitted with an order for a left lower leg wound treatment to be performed daily on the day shift. The documentation on the treatment order dated 5/10/18 indicated the left lower leg wound was to have Adaptic applied directly to the wound,	F 842	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is preparedand / or executed solely because it is required by both Federal and State laws. 1. The Treatment Administration Record (TAR) for Resident #1 was updated to correctly reflect the ordered treatments for this resident. Nurses #7 and #8 were in-serviced by the Staff Development Coordinator regarding accurately documenting treatments on the TAR. Root cause: Clinical systems not being followed by the facility regarding checking to ensure physician orders are correctly transcribed during the nightly chart checks. 2. Any resident with ordered treatments has the potential to be affected. A chart to TAR review will be completed by the Director of Nursing (DON) or designee to ensure ordered treatments are correctly reflected on the TAR and the treatments are being documented when completed by 6/28/2018.	

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F 842	Continued From page 15 covered with 4 X 4 gauze, wrapped in Kerlix and then wrapped in an Ace bandage. The documentation on the electronic treatment administration record (TAR) indicated the treatment for the left lower leg was not completed on 5/11/18, 5/14/18, or 5/15/18. The facility treatment nurse (Nurse #7) was interviewed on 6/3/18 at 10:32 AM. Nurse #7 revealed the hall nurse performed the treatments for the left lower leg for Resident #1 on 5/11/18, 5/14/18, and 5/15/18. Nurse #7 stated that it was her responsibility to make sure the treatments were completed in the facility. She said she noted the treatments were not documented as performed on 5/11/18, 5/14/18, and 5/15/18 so on each one of those days she went to the hall nurse and asked if the treatments were completed. She stated she was told by the hall nurse that the treatments were completed but the hall nurse kept forgetting to document after the treatment was completed. Nurse #7 stated that on 5/11/18, 5/14/18, and 5/15/18 she confirmed the treatment for Resident #1 was completed on those days by checking the date on the bandage on the left lower extremity. Resident #1 had a physician's order dated 5/15/18 that changed the treatment for the left lower leg to every three days. The order stated, "Left lower leg [lateral] - [Discontinue] previous wound orders. Cleanse with [Normal Saline]. Apply Xerform to wound bed [every] 3 days [and as needed with] soiling. Cover [with] dry dressing. May wrap leg [with] Kerlix." Review of documentation on the TAR for Resident #1 revealed the physician's order for the	F 842	3. The licensed nurses were in-serviced by the Staff Development Coordinator (SDC) regarding physician orders being correctly transcribed and accurately documenting treatments as they are being completed. All licensed nurses will receive the in-service training by 6/28/2018 or will not be allowed to work until completed. This education will be added to the orientation process. 4. Five residents with ordered treatments will be audited per week to ensure the ordered treatment is completed and documented as ordered then ten residents per month until 100% compliance is maintained for two consecutive months. The chart will be audited in the daily clinical meeting of any new or changed treatment orders to ensure the medical record accurately reflects the ordered treatments. The audits will continue until 100% compliance is maintained for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings. The Administrator will ensure the outlined POC is carried out as outlined.	

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left lower leg written on 5/15/18 was entered on the TAR on 5/17/18. The order on the TAR dated as initiated on 5/17/18 for the left lower leg indicated that the ordered treatment was to be performed one time a day twice a week on Wednesday and Sunday and as needed when soiled. This order on the TAR was scheduled as "PRN" or as needed. The documentation on the TAR indicated this order was discontinued on 5/22/18. There was no documentation on the TAR to indicate this order was performed at any time.

Review of documentation on the TAR for Resident #1 revealed the physician's order for the left lower leg written on 5/15/18 was entered on the TAR on 5/20/18. The order on the TAR dated as initiated on 5/20/18 for the left lower leg indicated that the ordered treatment was to be performed one time a day twice a week on Wednesday and Sunday and as needed when soiled. The documentation on the TAR indicated this order was discontinued on 5/22/18. There was no documentation on the TAR to indicate this order was performed at any time.

Review of the documentation on the TAR for Resident #1 revealed the physician's order for the left lower leg written on 5/15/18 was reentered on the TAR on 5/22/18 for completion of the ordered treatment one time a day every 3 days. This order on the TAR was scheduled as "PRN" or as needed. The documentation on the TAR indicated this order was discontinued on 5/30/18. There was no documentation on the TAR to indicate this order was performed at any time.

Review of the documentation on the TAR for Resident #1 revealed the physician's order for the left lower leg written on 5/15/18 was reentered on

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the TAR on 5/22/18 for completion of the ordered treatment one time a day every 3 days. The documentation on the TAR indicated this order was discontinued on 5/30/18.

The documentation on the TAR for Resident #1 indicated the initially 5/10/18 ordered treatment for the left lower leg was performed on 5/16/18 and then the revised 5/15/18 treatment order was performed on 5/22/18, five days later.

The treatment nurse (Nurse #7) was interviewed on 6/3/18 at 10:32 AM. She stated that the treatment for the left lower leg of Resident #1 was revised on 5/15/18 and the next scheduled treatment after 5/16/18 would have been on the weekend of 5/19-20/18. Nurse #7 revealed that it was the responsibility of the weekend supervisor to make sure the treatments were performed on the weekend.

The weekend supervisor (Nurse #8) was interviewed on 6/3/18 at 10:45 AM. Nurse # 8 stated she performed the ordered treatment for the left lower leg for Resident #1 on 5/19/18. Nurse #8 indicated she was verbally told to do so by Nurse #7. Nurse #8 indicated she completed her work very quickly and must have forgotten to document the treatment on the TAR. After looking at a paper copy of the TAR of Resident #1, Nurse #8 did not know where she would have documented the 5/19/18 ordered treatment for Resident #1 she performed.

The Director of Nursing was interviewed on 6/3/18 at 10:55 AM. She confirmed there were omissions on the TAR for treatments on the left lower leg of Resident #1 and the orders put in the TAR were confusing. She stated on 5/21/18 she

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F 842	Continued From page 18 held a training session for the nurses on accuracy of documentation. She revealed that Nurse #7 and Nurse #8 did not attend the training. The Director of Nursing stated that it was the responsibility of the treatment nurse to accurately put the treatment orders into the computerized TAR after the orders for treatments were received.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		6/28/18

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F 880	Continued From page 19 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff	F 880	Preparation and execution of this plan of	

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F 880	Continued From page 20 interviews and policy review the facility failed to post a contact precautions sign to notify staff and visitors of special precautions required when entering the room of 1 of 2 residents on contact precautions (Resident #7). The facility staff failed to wear a gown and gloves when entering the room of a resident on contact precautions for 1 of 2 residents observed to be on contact precautions (Resident #3) and the facility staff failed to change gloves and sanitize hands during wound care for 1 of 2 residents observed during wound care (Resident #2). The findings included: 1. Review of the facility ' s policy titled Isolation - Categories of Transmission-Based Precautions dated January 2012 under Policy Interpretation and Implementation read: "1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection." Under Contact Precautions read: "Implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment. 2. Examples of infections requiring Contact Precautions include b. Diarrhea associated with Clostridium difficile. 8. Signs-The facility will implement a system to alert staff to the type of precaution resident requires." Resident #7 was admitted to the facility on 6/1/18 and had a diagnosis of ESBL (Extended Spectrum Beta Lactamase) in the urine. According to the Centers for Disease Control	F 880	correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. An isolation sign was posted on the door of resident #7 to accurately reflect the isolation needs of this resident. Nurses #1&2 and NA #4 that entered the room without proper personal protective equipment (PPE) were in-serviced by the Staff Development Coordinator regarding isolation, what PPE is required for each type of isolation. Root Cause: Lack of routine training of the facility staff regarding isolation precautions. 1. Nurse #3 that failed to remove her gloves and sanitize her hands and follow standard infection control practices during the dressing change for Resident #2 is no longer an active employee of the facility. Root Cause: Lack of routine training of the facility staff regarding infection control practices during a clean dressing change. 2. There was no other deficient practice regarding isolation precautions or infection control practices noted at the time of survey. 3. The licensed nurses were in-serviced by the Staff Development Coordinator regarding isolation, what PPE is required for each type of isolation, and the importance of placing appropriate	

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F 880	Continued From page 21 (CDC), ESBL are bacteria that produce an enzyme that has the ability to break down commonly used antibiotics such as penicillin and cephalosporins and render them ineffective for treatment. On 6/2/18 at 9:53 AM a rack of gowns and gloves were hanging on the outside of the door of Resident #7 ' s room. There was no sign posted to notify staff and visitors the resident was on any kind of special precautions. On 6/2/18 at 10:29 AM the Weekend Supervisor stated the resident was admitted yesterday and was on contact precautions for ESBL in the urine. The Supervisor stated the contact precautions kit with gloves and gowns was on the resident ' s door so everyone knows. The Supervisor further stated they did not put up a contact precautions sign because it was a HIPPA (Health Insurance Portability and Accountability Act that was put in place to protect patients ' medical information) violation. On 6/2/18 at 10:42 AM, NA (Nursing Assistant) #4 stated she was in orientation and this was here first day on the floor. The NA was asked what the rack on the door with the box of gloves and gowns meant and she stated the resident was off of precautions because there was no sign on the door. On 6/3/18 at 8:38 AM the Director of Nursing (DON) who was also the facility ' s Infection Control Nurse, stated in an interview that residents put on contact precautions should have a Contact Precautions sign posted on the outside of the room to tell staff and visitors what special precautions were to be taken before entering the	F 880	signage. The facility staff will be in-serviced at least quarterly regarding what PPE is required for each type of isolation, and the importance of placing appropriate signage. The licensed nurses were in-serviced by the Staff Development Coordinator regarding maintaining appropriate infection control practices during a clean dressing change. All staff will receive in-service training before 6/28/2018 or will not be allowed to work. This education will be added to the orientation process of the licensed nurses and will be conducted at least bi-annually. 4. Three isolation room observations per week on each shift will be conducted by the supervisory nursing staff to ensure the facility staff are utilizing proper PPE and hand sanitation with isolation rooms. They will follow up with staff as necessary. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings. Three clean dressing change observations per week will be conducted by the supervisory nursing staff to ensure proper infection control practices are being observed during dressing changes. Five clean dressing changes per month will be observed until 100% compliance is maintained for two consecutive months. They will follow up with staff as necessary. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be	

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F 880	Continued From page 22 resident ' s room. 2a. Resident #3 was admitted to the facility on 5/16/18 and had a diagnosis of necrotizing fasciitis of the left arm, sepsis and incision and drainage of the left hand and forearm. On 6/3/18 at 11:50 AM a sign was noted on the door frame of the resident ' s room that read: "Contact Precautions." The sign read: "Wear gloves when entering room and when touching patient ' s intact skin, surfaces, or articles in close proximity. Wear gown when entering room and whenever anticipating clothing will touch patient items or potentially contaminated environmental surfaces." Nurse #1 was observed to enter the room to administer medications to Resident #3. The nurse did not put on a gown or gloves when she entered the room. The nurse was observed to stand in front of the resident ' s over-bed table and the front of the nurse ' s clothing touched the edge of the over-bed table. The nurse was observed to have a small purse hanging on her left arm that touched the edge of the resident ' s over-bed table. On 6/3/18 at 11:53 AM Nurse #1 stated in an interview that she would put on a gown and gloves if she was going to provide direct care for the resident. The Nurse stated the purse was to carry her personal items with her. On 6/3/18 at 10:40 AM the Director of Nursing stated in an interview the stool for C-Diff results just came back positive for C-Diff. C-Diff is a bacteria that can cause abdominal pain and mild to life-threatening forms of diarrhea. On 6/4/18 9:25 AM an interview was conducted	F 880	modified based on findings. The Administrator will ensure the outlined POC is carried out as outlined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345049	A. BUILDING _____ B. WING _____	C 06/05/2018

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F 880	Continued From page 23	F 880		

with the Staff Development Coordinator (SDC). The SDC stated if a resident was on contact precautions for C-Diff the staff was supposed to wear a gown and gloves when entering the room for whatever reason.

On 6/4/18 at 10:55 AM the Director of Nursing stated in an interview the staff should put on a gown and gloves when entering the room of a resident on contact precautions.

2b. On 6/4/18 at 8:20 AM Nurse #2 was observed in the room of Resident #3 to check a finger stick blood sugar and was wearing gloves.

On 6/4/18 at 2:14 PM Nurse #2 stated in an interview she was wearing gloves and had been told in the past she did not have to wear a gown unless providing direct care. The Nurse stated they had an in-service this AM that they needed to wear a gown when they entered the room.

6/4/18 9:25 AM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated if a resident was on contact precautions for C-Diff the staff were supposed to wear a gown and gloves when entering the room for whatever reason.

On 6/4/18 at 10:55 AM the Director of Nursing stated in an interview the staff should put on a gown and gloves when entering the room of a resident on contact precautions.

3. The facility policy titled Clean Dressing Change dated 11/2017 stated the purpose of the policy was "To ensure the licensed nurse completes dressing change in accordance with State and Federal Regulations and National Guidelines."

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F 880	Continued From page 24	F 880		

The procedure included the following: "Don gloves. Removed used dressing and place in resident ' s trashcan. Remove gloves. Hand hygiene. Don gloves. Cleanse wound as ordered. Remove gloves. Hand hygiene. Don gloves. Apply clean dressing as ordered. Remove gloves. Hand hygiene."

Resident #2 was admitted to the facility on 8/29/17 and had a diagnosis of cord compression and paraplegia.
The resident was re-admitted to the facility on 5/14/18 after a hospital stay for treatment of an abscess on the lower abdomen.

On 6/2/18 at 11:15 AM Nurse #3 was observed to provide wound care for Resident #2. The nurse was observed to don gloves and removed the resident ' s abdominal dressing and placed in a trash bag. The dressing was observed to have some discoloration that indicated possible drainage from the wound. The nurse used saline moistened gauze to clean around the wound and placed a clean gauze beneath the wound and poured normal saline into the wound and cleaned inside the wound with another gauze. The Nurse was observed to pick up an opened package with gauze, pulled the gauze out of the package, separated the gauze and reached in her pocket to withdraw a pair of scissors and cut off a piece of the gauze. The Nurse then packed the piece of gauze into the wound bed and covered with a dry gauze and a bordered gauze dressing and taped into place. The nurse never removed her gloves or sanitized her hands during the treatment.

On 6/3/18 at 9:07 AM Nurse #3 stated in an interview she should have removed her gloves and sanitized her hands after removing the soiled

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F 880	Continued From page 25 dressing. The Nurse stated she usually tried to get all her supplies together prior to the dressing change and she was nervous and picked up the wrong gauze and had to cut it and reached into her pocket to get her scissors and she should not have done this. On 6/3/18 at 8:38 AM an interview was conducted with the Director of Nursing (DON) who was also the facility ' s Infection Control Nurse. The DON stated she would expect the nurse to change gloves after removing the old dressing and should not be going into her pocket with gloves on.	F 880		