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	345439	A. BUILDING _____ B. WING _____	01/17/2019

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS)assessment to reflect behaviors displayed by Resident #12. This was evident in 1 of 2 residents reviewed for dementia care. Findings included Resident #12 had cumulative diagnoses which included anemia, idiopathic thrombocytopenia purpura, and hypothyroidism. Review of the Monitoring Weekly Report form for behaviors revealed: On 11/4/18 during the day shift the resident experienced 1 episode of anxiety/restless. On 11/5/18 during the evening shift the resident experienced 1 episode of anxiety/restless. On 11/6/18 during the day shift there were 2 episodes of continuous screaming. On 11/6/18 during the night shift there was 1 episode of continuous screaming. Review of the quarterly MDS dated 11/10/18 revealed the resident was coded to have no behaviors. Interview on 01/17/19 on 2:54 PM with MDS coordinator #2 who stated she conducted this assessment and used the nurses notes to determine if the resident experienced behavior issues and does not use the monitoring	F 641	1. Corrective action for the resident affected by the alleged deficient practice: Resident #12 MDS assessment dated for 11/10/2018 was modified to capture behaviors documented on behavior sheets on 2/5/2019. MDS Coordinator was educated by the DON on accurately coding the MDS assessment to reflect behaviors documented on the resident behavior monitoring sheets that are within the 7 day look back. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents with documented behavior have the potential to be affected. On 2/5/2019 a 100% audit was conducted on all transmitted MDS assessments, section E, to ensure assessments reflected accurately any behaviors that were documented on the behavior monitoring sheets in the 7 day look back. This audit was completed by the Social Worker. 3. Measures/Systemic changes put in place to assure alleged deficient practice does not re occur: The DON implemented new process identifying staff responsible for the completion of section E on the MDS	2/13/19

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

Electronically Signed | 02/08/2019

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F 641	Continued From page 1 behavioral sheet. Interview on 01/17/19 at 3:04 PM with the Administrator revealed he expected the MDS to be coded according to the Resident Assessment Instrument (RAI) manual and use the behavior monitoring sheet to determine coding on the MDS.	F 641	assessment. The Social Worker is responsible for the completion but in their absences the MDS Coordinator has been assigned. On 2/5/2019 the DON meet with the Social Worker and MDS Coordinators to educate on this new process and on accurately coding the MDS assessment to reflect behaviors documented in the medical record in the 7 day look back. This education placed emphasis on capturing the behaviors documented on the behavior monitoring sheets. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: To ensure ongoing compliance the Social Worker will audit all MDS assessments 3 times a week x 4weeks, then 1 time a week x 3 months, and then the DON will spot audit monthly as needed to ensure 100% compliance is maintained. Audit results will be reported monthly to QAPI Committee for further review and recommendations.	
F 686 SS=D	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	F 686		2/13/19

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F 686	Continued From page 2 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to perform pressure ulcer care as ordered on 1 of 1 resident (Resident #56) reviewed for pressure ulcers. Findings include: Resident #56 was admitted to the facility on 11/3/14 with diagnoses that included acute respiratory failure with hypoxia, atrial fibrillation, diabetes, and anxiety. A review of Resident #56's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and dated 1/4/19. Resident #56 was coded as cognitively impaired. Skin conditions included 2 stage II pressure ulcers and 1 stage III pressure ulcers with 2 stage II pressure ulcers present on admission. A review of Resident #56's most current care plan dated 12/13/18 revealed the resident was care planned for the pressure ulcer to the sacrum with interventions that included for the staff to turn and reposition frequently, keep clean and dry, pressure reducing cushion to wheelchair, low air loss mattress, and protein supplement to promote wound healing. A review of Resident #56's medical record revealed a progress note dated 1/10/19 written by	F 686	1. Corrective action for the resident affected by the alleged deficient practice: Immediately on 1/16/19 Resident #56 coccyx wound was reassessed and determined to be unchanged from previous assessment. Unit Manger #13 was reeducated by the DON on proper wound care and completing treatments per the physician□s order. Resident #56 treatment to the coccyx was redone per the physician□s order to include cleanse coccyx wound with normal saline, pat dry, apply nickel size Santyl to areas of slough, apply Silver Alginate to wound bed and then covered with a dry dressing. The treatment order was clarified and rewritten as a single order. The physician and Resident/Responsible party notification was completed. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents with wounds have the potential to be affected. All Residents□ with wounds were audited to ensure proper treatments were applied on 1/16/2019 by the Unit Mangers. All treatment orders were audited by the DON on 1/16/2019 to ensure treatment orders were accurate, clear, and concise.	

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F 686	Continued From page 3 the physician assistant. The physician assistant reported the resident had a partial thickness stage 2 pressure ulcer to the coccyx. She reported it was smaller in size and measured 3.0 cm (centimeters) length by 2.5 cm width by 0.4cm depth. The physician assistant reported she would treat the wound with Santyl plus Alginate for enzymatic drainage and drainage control. A review of Resident #56's medical record revealed a physician's order written on 1/14/19 that read 'Santyl 250 unit/g ointment every am shift (6am-2pm). Cleanse coccyx pressure wound with normal saline, apply nickel size Santyl to areas of slough daily and as needed. Diagnosis: pressure ulcer of sacral region. Stage 3." The review of Resident #56's medical record also revealed a second wound care physician's order dated 1/14/19 that read for the staff to 'Cleanse coccyx wound with normal saline, pat dry, apply Silver Alginate to wound bed. Cover with dry dressing. Change every day and as needed for soilage or dislodgement.' An observation was made on 1/16/19 at 9:35am of Unit Manager #13 performing wound care on Resident #56's coccyx pressure ulcer. Unit Manager #13 performed wound care using aseptic technique. She washed her hands prior to donning gloves and after removing her gloves. Observed Unit Manager #13 remove the old dressing from the pressure ulcer with moderate amount of serosangious drainage noted on the old dressing. The wound bed was observed to have 75% of slough noted. Wound edges were well defined. The periwound was pink in color. Observed Unit Manager #13 cleanse the wound with normal saline. She then applied Silver Alginate to the wound bed. She applied skin	F 686	3. Measures/Systemic changes put in place to assure alleged deficient practice does not re occur: Licensed Nursing Staff will be in serviced by the Staff Development Coordinator on the policy and procedure of wound care to include verification of treatment order prior to procedure and the policy and procedure on proper transcription of a treatment order. All active licensed nurses will have completed the education by the date of compliance. Orientation of new nurses will include policy and procedure of wound care and proper transcription of wound care orders. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: To ensure ongoing compliance all treatment orders will reviewed 5 times a week by the interdisciplinary team to monitor orders for accuracy. DON will audit wound care 2 times a week X 4 weeks. Audits then will continue 1 time a week X 4 weeks, and then DON will spot audit 6 treatments quarterly as needed to ensure 100% compliance is maintained. Audit results will be reported monthly in QAPI for further review and recommendations.	

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F 686	Continued From page 4 protectant to the periwound and covered the wound with dry gauze and secured with tape. Unit Manager #13 explained each step to Resident #56. Resident #56 tolerated the dressing change well. Observed that Resident #56 was positioned to the right side with pillows wedged under her back and buttocks and was on a low air loss mattress. An interview was conducted on 1/16/19 at 10:55am with Unit Manager #13. Unit Manager #13 reported she forgot to apply Santyl to the wound bed prior to applying the Silver Alginate as ordered when she performed the wound care on Resident #56. An interview was conducted with the DON (Director of Nursing) on 1/16/19 at 10:58am. She reported the unit managers perform wound care to the residents as the facility did not have a treatment nurse at this time. She reported it was her expectation that wound care orders were followed when the staff was performing wound care on the residents.	F 686		
F 732 SS=C	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.	F 732		2/13/19

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F 732	Continued From page 5 (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. (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 review and staff interview the facility failed to retain a minimum of 18 months of daily posted data. This was evident in 4 months of posted staffing data reviewed. (December 2017, July 2018, August 2018 and September 2018). Findings included: Record review of retained Daily Posted Staffing forms revealed no posted staffing for the following days: a. 12/12/17, 12/19/17, 12/21-24/17 and 12/29-31/17.	F 732	1. Corrective action for the resident affected by the alleged deficient practice: Posted Nurse Staffing Information for previous months were not readily available for residents and families upon request. The required information was posted during the survey process and the staffing information was then stored in a binder in the DON office. The Staff Development Coordinator will be educated by the DON on the process and responsibility to retain a minimum of 18	

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F 732	Continued From page 6 b. 7/1-7/2/18, 7/7-7/8/18, 7/13-7/15/18, 7/22/18, 7/26/18 and 7/28/18 c. 8/11-25/18 d. 9/1/18, 9/2/18, 9/8-9/9/18 and 9/29-9/30/18 Interview on 01/17/19 at 5:45 PM with the Staff Development Coordinator (SDC)(responsible for retaining the staff posting) was conducted. The SDC stated the unit managers post the staffing each day and place the previous staff posting in the Director of Nurses (DON) communication box. Then DON places the form into a pile and the SDC would sort and file. Continued interview with the SDC revealed she started her position in July 2018 and unaware of the need to retain 18 months of posted staffing. Interview with the DON on 01/17/19 at 5:54 PM revealed she expected staff to retain a minimum of 18 months of posted staffing.	F 732	months of posted staffing on 02/07/2019. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Posted Nurse Staffing Information for previous months were not readily available for residents and families upon request. The required information was posted during the survey process and the staffing information was then stored in a binder in the DON office. The Staff Development Coordinator was educated by the DON on the process and responsibility to retain a minimum of 18 months of posted staffing. 3. Measures/Systemic changes put in place to assure alleged deficient practice does not re occur: To ensure ongoing compliance the Administrator has developed a new procedure for posting and retaining posted staffing. The Unit Mangers are responsible for posting daily staffing during the weekdays and the weekend Manger is responsible for posting on weekends. The previous day posting will be placed in the DON communication box. The Staff Development Coordinator will be responsible to store in binder in the DON office. The Management Team will be in serviced on this new procedure on 02/07/2019.	

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F 732	Continued From page 7	F 732	4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: To ensure ongoing compliance the DON will audit facility staffing sheets for accuracy, completeness, and ensure daily staffing postings are accessible upon request of residents or families. These audits will be conducted 3 times a week x 4weeks, then 1 time a week x 3 months, and then the DON will spot audit monthly as needed to ensure 100% compliance is maintained. Audit results will be reported monthly to QAPI Committee for further review and recommendations.	