STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 03/06/2019

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WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

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E 000	Initial Comments An unannounced Recertification survey was conducted on 01/07/19 through 01/10/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #2RY711.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 1/7/19 for a recertification and complaint investigation survey and exited on 1/10/19. Per CMS and management review of the 2567, Immediate Jeopardy was identified at: CFR 483.12 at tag F 600 at a scope and severity K CFR 483.25 at tag F 686 at a scope and severity K Tags F 600 and F686 constituted Substandard Quality of Care The survey team entered the facility on 3/6/19 and conducted an extended survey. On 3/6/19 the survey team identified Immediate Jeopardy at: CFR 483.35 at tag F 725 at a scope and severity K CFR 483.70 at tag F 835 at a scope and severity K Immediate Jeopardy for F600, F686, F725, and F835 began on 11/6/18 and were removed on 3/6/19.	F 000		

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

Electronically Signed | 03/25/2019

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F 000	Continued From page 1 The exit date was changed to 3/6/19.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		4/3/19

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, Department of Social Services (DSS) interview, and staff interview, the facility failed to treat residents in a dignified manner as evidenced by inappropriate staff to resident verbal statements (Resident #32 and #49) and by not answering a call light related to a request for incontinence care (Resident #49). This failure caused Resident #49 to cry and to feel "humiliated" and "helpless". The facility also failed to cover Resident #47 ' s urinary catheter drainage bag to promote dignity for 3 of 5 sampled residents reviewed for dignity and respect. The findings included: 1. Resident #49 was admitted to the facility on 12/6/18 with diagnoses that included cerebrovascular disease, major depressive disorder, adjustment disorder with depressed mood, and anxiety disorder. A Social Work (SW) note dated 12/6/18 indicated Resident #49 was admitted from an acute hospital after being taken to the Emergency Department by Adult Protective Services (APS) following the death of her spouse who was her primary caregiver at home. A Psychiatric Nurse Practitioner (PNP) Note	F 550	F550- Resident Rights/ Exercise of Rights 1. On 3/12/19 and 3/13/19 Resident #'s 32 and 49 were interviewed by the Social Service Director (SSD) and the Regional Director of Clinical Services to ensure call lights are answered timely and staff are verbally appropriate. No concerns voiced regarding care at this time. Resident #47 no longer resides at the facility. 2. The Social Services Director and or the Regional Director of Clinical Services conducted resident interviews of all interviewable residents to ensure residents' call lights are answered time and staffs are verbally appropriate by 3/19/19. On 3/14/19 the Regional Director of Clinical Services completed quality monitoring (audit) of residents with catheters to ensure privacy covers for catheter bags are provided and in place. No issues identified during audit. 3. The Regional Director of Clinical Service (RDCS), Executive Director (ED), Director of Nursing (DON) and or SSD will provide re-education to facility and contracted staffs, including all shifts, part-time and prn, on the federal regulations and guidelines relating to the	

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F 550	Continued From page 3 dated 12/10/18 indicated Resident #49 was going through the normal grieving process related to the death of her spouse. She was noted with new diagnoses of adjustment disorder and grieving and worsening diagnoses of major depression, insomnia, and anxiety. The admission Minimum Data Set (MDS) assessment dated 12/13/18 indicated Resident #49 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #49 required the extensive assistance of 1 for bed mobility and toileting and 2 or more for transfers. She was frequently incontinent of bladder and always incontinent of bowel. She was administered antianxiety medication and antidepressant medication during the MDS review period. The Care Area Assessment (CAA) related to urinary incontinence for Resident #49 ' s 12/13/18 admission MDS indicated she was alert, oriented, and able to make decisions and communicate needs. Resident #49 indicated she had a history of incontinence and that she could feel a sensation in her bladder, but it was difficult to hold. A SW note dated 12/13/18 indicated Resident #49 was on antidepressant medication and antianxiety medication. She was noted to become tearful when speaking about her spouse who recently passed away. The active care plan for Resident #49 included, in part, the following areas: - Resident #49 had an Activities of Daily Living (ADL) self-care performance deficit related to mobility, Cerebrovascular Accident (CVA) and	F 550	resident's right to a dignified existence, self-determination and exercise of rights and, nursing staff in regard to answering call lights timely, being verbally appropriate to residents and providing privacy covers for catheter bags, by 3/21/19. Staff will not be allowed to return to work until education complete. 4. The ED, DON and/or SSD will conduct quality monitoring (audit) of five residents, and/or their representative interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents are provided care in a dignified manner, their ability to exercise their rights is respected, call lights are answered timely and staffs are verbally appropriate. The DON will conduct quality monitoring (audit) of residents with catheters 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents with catheters privacy is maintained with a privacy cover. This quality monitoring (audit) will include all shifts and some weekends. The SSD and DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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impaired balance. The interventions included, in part, assistance with tasks of washing hands, adjusting clothes, and cleaning self in relation to toilet use.
- Resident #49 had altered bladder elimination related to CVA with right sided hemiplegia and contractures of the right hand and wrist. Resident #49 was noted to report difficulty holding her urine. The interventions included, in part, bed pan, mechanical lift for transfers, and encourage communication of needs for assistance with toileting.
- Resident #49 utilized antianxiety medication and antidepressant medication. She was noted to be grieving the loss of her husband, she had a diagnosis of adjustment disorder, and episodes of tearfulness. The interventions included behavior monitoring and side effect monitoring.

An interview was conducted with Resident #49 on 1/7/19 at 3:00 PM. Resident #49 was alert and oriented with no impaired cognition noted. When asked if she had any concerns with her care she stated that several weeks ago during the second shift (3:00 PM to 11:00 PM) she rang her call bell and requested for staff to adjust her bed pan, so she could urinate. She explained that she preferred to urinate in her bed pan. She reported 2 staff members came into her room and 1 of them said the bed pan was too small for her. Resident #49 stated that this staff member then said to her, "do it in your pants ...haven ' t you ever gone in your pants?" She reported she told the staff she hadn ' t gone in her pants since she was a baby. Resident #49 indicated the staff had taken the bed pan with them out of her room and she had to urinate in her brief. She was unable to recall the names of either staff member and was unable to recall how long it took for incontinent

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care to be provided to her after this incident. She stated she felt "humiliated" and she recalled crying after the incident occurred. She reported that she had lost her husband, she lost her home, and she lost her independence. She indicated that she felt like the staff were speaking to her as if she were a child. Resident #49 stated that she had reported this incident to one of the nurses (unable to recall the name of the nurse) and she believed the Director of Nursing (DON) was also aware. She indicated she had not seen either of the 2 staff members again after she reported this incident to the nurse. Resident #49 expressed concern and fear of reprisal with this incident being investigated as she had not wanted to "make anyone angry".

A complaint/grievance report dated 1/8/19 communicated by Resident #49 to the Human Resources Coordinator (HRC) indicated that the resident was concerned about how long she waited for her call light to be answered. This form had been reviewed by the SW and was assigned to the DON for investigation.

A follow up interview was conducted with Resident #49 on 1/9/19 at 11:30 AM. Resident #49 stated that she changed her mind and wanted the incident she reported during the 1/7/19 interview to be investigated. She stated she located her personal calendar that she kept handwritten notes in. The calendar was observed to have a handwritten note on the date 12/14/18 that read, "2 [staff] came in my room and upset me about the bed pan. Told me to do it in my pants. They took the bed pan with them." During this interview the grievance dated 1/8/19 written by the HRC that discussed the resident ' s concern with how long it took for her call light to

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be answered was reviewed with Resident #49. She stated that in the early morning on 1/8/19 she pressed her call bell because she had to urinate. She indicated it took over 2 hours for her call bell to be answered. She stated she urinated in her brief during that time as she had difficulty holding her urine. She revealed she sat in her brief that was soaked with urine until her call bell was answered by the HRC. Resident #49 indicated this incident made her feel "helpless". She stated the DON then provided her with incontinent care.

A phone interview was conducted with Department of Social Services (DSS) staff by phone on 1/9/19 at 8:09 AM. She stated that Resident #49 reported to her several weeks ago that she had requested staff to adjust her bed pan and they said something to her about the size of the bed pan and told her that if she had not wanted to use the bed pan that she would "pee on herself". She stated that Resident #49 was "tearful and upset" when she provided this information. DSS staff stated that she spoke with Resident #49 again yesterday, 1/8/19, and the resident told her she sat in a urine-soaked brief for over 2 hours after pressing her call light for assistance.

An interview was conducted with the HRC on 1/9/19 at 2:40 PM. The complaint/grievance report dated 1/8/19 related to Resident #49 was reviewed with the HRC. She stated she was walking the halls on 1/8/19 when she saw Resident #49 ' s call light on, so she entered the room and asked the resident if there was something she could help with. Resident #49 informed her she had been waiting awhile and needed "cleaned up". She stated that Resident #49 reported that she turned her call light on at

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4:45 AM. The HRC estimated it to be around 7:10 AM when she entered the room to answer the call light. She stated there was no obvious odor of urine in the room. She indicated that Resident #49 was visibly upset and was crying when she spoke with her. She said that after speaking to Resident #49 she went to the DON and Administrator to report the information.

An interview was conducted with the SW on 1/9/19 at 12:00 PM. She indicated she spoke with Resident #49 on 1/8/19 after the grievance was reported by the HRC. She revealed that Resident #49 was visibly upset and tearful at the time she spoke with her. She stated that she had not asked Resident #49 how the incident made her feel, but instead focused on trying to find out who the staff members were that were assigned to her during the 1/8/19 incident. She stated the investigation was ongoing. The SW denied knowledge of any previous incidents related to incontinent care for Resident #49.

An interview was conducted with the DON on 1/9/19 at 2:30 PM. She reported she had provided incontinent care to Resident #49 on 1/8/19 after the HRC reported she answered the resident ' s call light and the resident said her light had been on for over 2 hours. The DON stated that Resident #49 had urinated in her brief. She reported Resident #49 was visibly upset and was tearful when she provided care. The DON indicated she expected call bells to be answered timely.

This interview with the DON continued. She revealed she had previously heard one of the staff say something about Resident #49 reporting that a staff member told her to use her brief to

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urinate because they were unable to change her at that time. She confirmed that this was prior to the 1/8/19 grievance and was a separate incident. The DON stated she was unable to recall what staff member she heard this from and she was also unable to recall when this occurred. She revealed there was no grievance written related to this incident and no investigation was conducted. The DON reported it was a dignity issue for a resident to be told to urinate in their brief. She indicated she expected residents to be treated with dignity and respect.

Based on review of the nursing schedule and DON confirmation on 1/9/19 at 2:45 PM, Nursing Assistant (NA) #5 was assigned to Resident #49 on 12/14/18 during the second shift and Nurse #2 and NA #1 were assigned to the resident for the third shift on 1/7/19 beginning at 11:00 PM and ending on 1/8/19 at 7:00 AM.

An interview was conducted with NA #5 on 1/9/19 at 2:52 PM. She stated she was not frequently assigned to Resident #49 but acknowledged that she had worked with her in the past. She denied telling Resident #49 to urinate in her brief and additionally denied making any statement related to the size of the resident ' s bed pan.

A phone interview was conducted with Nurse #2 on 1/9/19 at 3:00 PM. He confirmed he was assigned to Resident #49 during the third shift beginning 1/7/19 and ending 1/8/19. He indicated that 2 NAs were working the third shift for the entire building and that NA #1 was assigned to Resident #49. Nurse #2 revealed he recalled Resident #49 ' s call light being on for an extended period of time during the early morning on 1/8/19. He was not surprised that it took over

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2 hours for Resident #49 ' s call light to be answered. He explained that when there were only 2 NAs working it was difficult for them to answer call lights timely which caused a delay in meeting the residents ' needs.

An interview was conducted with NA #1 on 1/9/19 at 3:15 PM. He confirmed he was assigned to Resident #49 during the third shift beginning 1/7/19 and ending 1/8/19. He stated he was working a double that day beginning on the second shift 1/7/19 and working through the third shift ending 1/8/19. He reported that he was 1 of 2 NAs working the third shift that day and they each had about 30 residents. NA #1 indicated he had not recalled Resident #49 ' s call light being on for an extended period of time during the early morning on 1/8/19, but revealed it was not a surprise to him. He explained that he had difficulty meeting residents ' needs timely when there were only 2 NAs working on the third shift. He stated he was unaware a complaint/grievance form had been filed related to Resident #49 ' s concern about how long she waited for her call light to be answered during the early morning hours of 1/8/19.

An interview was conducted with the Administrator on 1/9/19 at 10:20 AM. He indicated he spoke with Resident #49 on 1/8/19 after the grievance was reported by the HRC. He stated that Resident #49 reported to him that she had to wait a long time for her call bell to be answered. He additionally stated that Resident #49 reported a staff member told her that she could just "go" in her brief if she had not wanted to wait. The Administrator indicated the investigation into these reports was just beginning. He stated he had not previously been

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made aware of incidents related to incontinent care or dignity for Resident #49. The Administrator stated it was unacceptable for a resident to be told to urinate in their brief. He additionally stated it was unacceptable for a resident to wait over 2 hours for a call bell to be answered.

2. Resident #32 was admitted to the facility on 1/2/14 and most recently readmitted on 10/11/18 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), respiratory failure, dysphagia, and Diabetes Mellitus Type II.

The quarterly Minimum Data Set (MDS) assessment dated 7/2/18 indicated Resident #32' s cognition was fully intact. He had no behaviors and no rejection of care. Resident #32 was assessed with no swallowing disorders. He was on a mechanically altered and therapeutic diet.

The investigation report dated 8/17/18 for a Facility Reported Incident (FRI) of staff to resident abuse that occurred on 8/12/18 at 10:30 AM involving Resident #32 and Cook #1 was reviewed. The allegation details indicated that Resident #32 overheard Cook #1 state "I ' ll give him a muffin but if the [m ...fer] chokes then its not on us." The summary of the facility ' s investigation indicated that Cook #1 was overheard by staff and residents being "rude". Cook #1 was immediately sent out of the facility and was terminated the same day (8/12/18). The investigation was conducted by the Administrator and the allegation of staff to resident abuse was substantiated by the facility.

A written statement dated 8/12/18 that was

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unsigned was provided by the Administrator. On 1/9/19 at 10:15 AM he stated this written statement was completed by NA #4. The statement indicated Resident #32 had asked for a muffin in the dining room. NA #4 requested the muffin from dietary staff and Cook #1 told her the resident was unable to have the muffin because it wasn ' t on his meal ticket. NA #4 wrote that she spoke with Nurse #1 and Nurse #4 and they stated that Resident #32 was able to have a muffin. NA #4 indicated she and Nurse #1 returned to the kitchen and informed Cook #1 that Resident #32 was able to have a muffin. NA #4 wrote that Cook #1 stated, "If he [m ...fing] choke then it was on [nursing staff]."

A phone interview was conducted with NA #4 on 1/10/19 at 8:17 AM. NA #4 confirmed she had completed the written statement dated 8/12/18. She reported that Resident #32 was in the dining room and he asked her if he could have a muffin. She stated she went into the kitchen and asked Cook #1 for a muffin for Resident #32. NA #4 reported that Cook #1 said she wouldn ' t give Resident #32 a muffin because it wasn ' t on his meal ticket. She stated she went to speak with Nurse #1 and Nurse #4 and asked if Resident #32 was able to have a muffin. Nurse #1 and Nurse #4 reported that if Resident #32 wanted a muffin he could be given a muffin. NA #4 indicated she went back to the kitchen and informed Cook #1 that Nurse #1 and Nurse #4 said Resident #32 could have a muffin. She stated that Cook #1 stated, "if he [m ...fing] chokes it ' s on you." NA #4 explained that Cook #1 meant that it was not the dietary staff ' s fault if Resident #32 choked on the muffin. She stated that she was holding the kitchen door open at the time Cook #1 made this statement and that

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multiple residents were within hearing distance. She reported Resident #32 had overheard the statement. She indicated she spoke with Resident #32 after the incident and he was upset. NA #4 stated she recalled him say something like, ' I don ' t understand why she doesn ' t like me ' and that he ' never did nothing to her ' .

A written statement dated 8/12/18 completed by Nurse #1 indicated NA #4 informed her that Resident #32 wanted a muffin from the kitchen and Cook #1 refused to give him the muffin. She reported that she went to the kitchen and told Cook #1 to give Resident #32 a muffin. Nurse #1 wrote that Cook #1 replied, "if the MF choke its gonna be on [nursing staff]." Nurse #1 indicated she informed Nurse #4 about Cook #1 ' s statement regarding Resident #32. She additionally indicated that Resident #32 had overheard Cook #1 ' s statement.

A phone interview was conducted with Nurse #1 on 1/9/19 at 10:42 AM. She stated that she recalled the 8/12/18 incident related to the muffin that involved Resident #32 and Cook #1. She additionally confirmed she had completed the written statement dated 8/12/18. Nurse #1 reported that she was unable to recall all of the specifics of the incident, but that remembered one of the kitchen staff had used profanity directed at Resident #32. Nurse #1 indicated she spoke with Resident #32 after the incident and he shared with her that the incident had "upset" him.

A phone interview was conducted with Nurse #4 on 1/9/19 at 5:58 PM. She stated that she recalled the 8/12/18 incident related to the muffin that involved Resident #32 and Cook #1. She

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confirmed the information provided by NA #4 and Nurse #1. She added that Resident #32 had not been given a muffin because his meal ticket indicated that he was to have toast based on his diet and his swallowing issues. Nurse #4 stated Resident #32 was alert and oriented and that he understood the risks of eating a muffin related to his swallowing issues. She additionally stated that it was Resident #32 ' s right to receive the muffin as long as he understood the risks. Nurse #4 reported she was not present when NA #4 and Nurse #1 returned to the kitchen to instruct Cook #1 to give Resident #32 a muffin.

A phone interview was conducted with Cook #1 on 1/9/19 at 3:36 PM. Cook #1 stated that she was terminated on 8/12/18 for the incident involving the muffin and Resident #32. She reported that she was in the kitchen with Dietary Aide (DA) #1 and DA #2 when NA #4 came to the kitchen and said that Resident #32 wanted a muffin. Cook #1 stated she told NA #4 that the muffin was not on his meal ticket as he had some choking issues and he was provided with toast instead of the muffin. She reported that she told NA #4 she was not giving Resident #32 a muffin. Cook #1 said that NA #4 then brought one of the nurses over and they told her to give Resident #32 a muffin. She stated she told the nurse and NA #4 that if Resident #32 choked on the muffin and died that it was not on her or the dietary staff, but that it was on the nursing staff. She indicated that NA #4 was holding the kitchen door open when this exchange of words occurred. She stated she was unsure if any residents had overheard the conversation. Cook #1 denied using profanity when speaking about Resident #32.

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A phone interview was conducted with DA #2 on 1/9/19 at 11:03 AM. She stated that she recalled the 8/12/18 incident related to the muffin that involved Resident #32 and Cook #1. She reported that she was in the kitchen with DA #1 and Cook #1 on 8/12/18 at the time of the incident. DA #2 stated that Cook #1 said to NA #4, "if the [m ...fer] chokes, don ' t bring it back here on the kitchen leave it out there". She explained that Cook #1 wanted to make sure dietary staff were not to blame if Resident #32 choked on the muffin.

A phone interview was conducted with DA #1 on 1/9/19 at 2:05 PM. She stated that she recalled the 8/12/18 incident related to the muffin that involved Resident #32 and Cook #1. She reported that she was in the kitchen with DA #2 and Cook #1 on 8/12/18 at the time of the incident. DA #1 reported that Cook #1 told NA #4 that it was not on the kitchen staff if Resident #32 choked on the muffin. She stated that NA #4 was holding the kitchen door open and that residents were in the dining room during this incident. She indicated she was unsure if any residents overheard the conversation.

An interview was conducted with Resident #32 on 1/7/19 at 4:40 PM. He was alert and oriented with no signs of cognitive impairment. He stated he recalled the incident on 8/12/18 that involved Cook #1 and the muffin. He reported that Cook #1 said something rude to him and she was fired by the Administrator. He indicated he was content with this resolution. Resident #32 indicated that this incident no longer bothered him, and he had no additional concerns with staff treating him with dignity and respect.

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An interview was conducted with the Administrator on 1/9/19 at 10:20 AM. He stated he completed the investigation related to an allegation of staff to resident verbal abuse on 8/12/18. He stated this incident occurred over a weekend and he was not present at the actual time it happened. He stated one of the staff phoned him to report the incident. He indicated he had Cook #1 leave the facility grounds immediately upon receipt of the report. He stated he came into the facility that same day to begin his investigation. The Administrator stated he interviewed Resident #32 on 8/12/18 and the resident reported that he heard someone in the kitchen say that they "hope he chokes on the [m ...fing] muffin". Resident #32 told the Administrator he had not seen who made the statement. He indicated the resident said this bothered him and made him angry. The Administrator reported that based on Resident #32 ' s interview and corroborating interviews with nursing staff he substantiated the allegation and terminated Cook #1. He stated that this behavior from staff was unacceptable and that he expected residents to be treated with dignity and respect at all times.

3. Resident #47 was admitted 10/6/08 and readmitted 3/26/18 with cumulative diagnoses of chronic pressure ulcers and Diabetes.

Review of Resident #47 quarterly Minimum Data Set dated 12/7/18 indicated he was cognitively intact and exhibited no behaviors. He was coded for an indwelling urinary catheter.

Review of Resident #47 care plan dated last revised 11/19/18 indicated he had indwelling urinary catheter. Interventions included the

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application of a leg strap to anchor his catheter. The care plan did not include the intervention of a privacy bag for dignity.

In an interview and observation on 1/7/19 at 1:40 PM, Resident #47 was sitting up in his room in a wheelchair. His urinary catheter drainage bag was observed covered in a privacy bag for dignity. Resident #47 stated he was paralyzed and unable to move his lower extremities.

In an observation on 1/9/19 at 4:20 PM, Resident #47 was observed lying in bed with his urinary drainage bag facing toward the hall with his door open. There was no observed privacy bag covering his urinary drainage bag.

In an observation on 1/10/19 at 8:30 AM, Resident #47 was observed lying in bed with his urinary drainage bag facing toward the hall with his door open. There was no observed privacy bag covering his urinary drainage bag.

In an observation on 1/10/19 at 9:00 AM, Resident #47 was observed lying in bed with his urinary drainage bag facing toward the hall with his door open. There was no observed privacy bag covering his urinary drainage bag.

In an interview and observation on 1/10/19 at 9:45 AM, Resident #47 was observed lying in bed with his urinary drainage bag facing toward the hall with his door open. He stated he had a privacy bag for his urinary drainage bag that was attached to his wheelchair. He stated he was not aware that his urinary drainage bag was uncovered at present while lying in bed. He stated he preferred his urinary drainage bag to be

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F 550	Continued From page 17 covered but expressed no psychological ill affect from it being exposed at present. Resident #47 requested that staff come and address it. In an interview on 1/10/19 at 9:45 AM, Nurse #3 was shown the uncovered urinary drainage bag from the hall into Resident #47's room. She stated it should be covered always for dignity. Nurse #3 stated whoever put Resident #47 back to bed must have forgotten to move the privacy bag on his wheelchair to his bed. Nurse #3 stated Nursing Assistant (NA) 9 was assigned Resident #47. In an interview on 1/10/19 at 11:15 AM, the Director of Nursing (DON) stated NA #9 had to leave work due to a family emergency and was unavailable for interview. She stated it was her expectation that Resident #47's urinary collection bag be covered at all times for dignity.	F 550		
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561		4/3/19

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choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident interview, observation, Nurse Practitioner interview, and staff interview, the facility failed to consistently honor a resident's choice of getting out of bed at his preferred time in the morning for a resident who required extensive assistance with transfers (Resident #32) and failed to trim, clean and file resident's nails (Resident #30) for 2 of 2 residents reviewed for choices. Resident #30's nails were long, jagged, dirty and the left thumb nail was painful and cracked down past the nail bed.
The findings included:

1. Resident #30 was admitted 6/7/18 with Chronic Obstructive Pulmonary Disease and Dysphagia.

Resident #30's quarterly Minimum Data Set dated 11/2/18 indicated he was cognitively intact and exhibited no behaviors. He was coded for impaired vision and limited assistance with personal hygiene.

Review of Resident #30's activities of daily living (ADL) care plan dated last revised 11/13/18

F561- Self Determination
1. The Social Services Director interviewed Resident #32 in regard to preferences and to ensure his preferred time to get up out of bed is being honored on
3-13-19. Resident #30 nails were trimmed and cleaned on his shower day on
3-16-19 by the Certified Nursing Assistant.

2. The facility Social Services Director and or Regional Director of Clinical Services completed resident interviews of current interviewable residents to ensure residents' preference related to getting out of bed is being honored and nail care is being provided by 3-19-19. Care Plans and Kardex updated to reflect residents choice. No negative findings were identified during interviews. The SSD/DCS will make observation of residents' preference on getting out of bed and ensure nail care complete and honored as resident prefers.

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F 561	Continued From page 19 indicated he required staff assistance with bathing, eating and locomotion. There was no indicated staff assistance noted with his personal hygiene. Review of Resident #30's undated Nurse Tech Information Kardex indicated he required staff assistance with brushing his teeth, combing his hair, perineum care and shaving. Assistance with nail care was not checked for assistance. In an observation on 1/7/19 at 3:30 PM, Resident #30 was sitting on the side of his bed watching television. His finger nails were observed. They appeared approximately ¾ of an inch long, jagged and dirty. He stated the staff had not offered to assist him with nail care and he did not have a pair of nail clippers in his possession. Resident #30 stated he preferred his nails to be trimmed and they were too long for his liking. He stated he had not requested staff assistance in trimming his nails. In an observation on 1/8/19 at 11:10 AM, Resident #30 was observed lying in bed. His nails still appeared long, dirty and jagged. In an interview on 1/9/19 at 8:05 AM, Nursing Assistant (NA) #9 confirmed she was assigned Resident #30. She stated he did not refuse any assistance with his ADLs, but that he was very independent. In an interview and observation on 1/9/19 at 11:45 AM, Resident #30 was sitting on the side of his bed. His nails appeared long, clean and jagged. He stated his left thumb nail was painful. His left thumb nail was observed cracked down past the nail bed. He stated even if he had clippers, he	F 561	3. The RDCS, ED and or SSD will re-educate facility staff, including all shifts, part-time and prn, on resident preference of time to get out of bed and providing nail care per resident choice by 3/21/2019. Staff will not be allowed to return to work until education complete. 4. SSD and or DON will conduct five resident interviews and resident observations 3 times per week for 4 weeks, then weekly for 3 months, to ensure residents exercise their right to Self Determination and Choice for resident's choice for getting out of bed and nail care completed and provided per residents choice. The SSD and DON will report the results of the quality monitoring (audit) to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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would have difficulty seeing how to cut his nails. Resident #30 stated he could not remember the last time he received nail care.

In an interview on 1/9/19 at 11:55 AM, NA #9 stated she was under the impression that Resident #30 was able to cut his own nails, but she would assist him immediately.

In an observation on 1/19/19 at 12:40 PM, Resident #30 was eating his lunch. His nails were trimmed and filed. He stated the nurse recently trimmed his finger nails and they felt better.

In an interview on 1/10/19 at 9:30 AM, the Nurse Practitioner stated even if Resident #30 had clippers in his possession, his vision would be a concern and it was her expectation that the staff assist Resident #30 routinely with his nail care.

In an interview on 1/10/19 at 2:30 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #30 receive nail care as needed or requested.

2. Resident #32 was admitted to the facility on 1/2/14 and most recently readmitted on 10/11/18 with diagnoses that included cerebrovascular disease, left foot drop, and left-hand contracture.

The quarterly Minimum Data Set (MDS) assessment dated 11/9/18 indicated Resident #32's cognition was fully intact, and he had no

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behaviors or rejection of care. He required the extensive assistance of 1 for bed mobility, transfers, personal hygiene, dressing, and toileting. Resident #32 had functional impairment with range of motion on 1 side of his upper and lower extremities.

An interview was conducted with Resident #32 on 1/7/19 at 4:40 PM. He indicated that he was an early riser and preferred to get out of bed between 4:00 AM and 5:00 AM. He stated he required staff assistance to get out of bed. Resident #32 reported that staff were aware of this preference as he had been a resident at the facility for several years. He revealed that although staff was aware, they had not consistently been getting him out of bed at his preferred time. He stated that on average there were 2 to 3 times per week that he was not assisted out of bed until closer to 7:00 AM. Resident #32 indicated he thought that there were not enough staff on the third shift which caused them to get him up later than he preferred.

An observation and interview were conducted of Resident #32 on 1/10/19 at 6:00 AM. Resident #32 was seated in his wheelchair. He stated that his Nursing Assistant (NA) had gotten him out of bed about an hour ago and he was satisfied with this timing.

An interview was conducted with Nursing Assistant (NA) #1 on 1/9/19 at 3:58 PM. He stated that he was hired to work the third shift, but that he frequently worked other shifts as well. He reported he was very familiar with Resident #32 and was aware he liked to get up between 4:00 AM and 5:00 AM. NA #1 stated that third shift normally had 2 or 3 NAs for around 60-65

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residents total depending on the census that day. He indicated that recently the NA staffing for the third shift had been 2 NAs. He explained that he had difficulty meeting residents' needs timely when there were only 2 NAs working on the third shift. He further explained that tasks were prioritized and that sometimes getting Resident #32 out of bed at his preferred time was not able to be accomplish because more critical tasks were prioritized before him.

An interview was conducted with NA #2 on 1/10/19 at 6:20 AM. She stated that she had worked at the facility for over 8 months and normally worked the third shift. She reported she was familiar with Resident #32 and was aware he liked to get up between 4:00 AM and 5:00 AM. NA #2 stated that third shift normally had 2 or 3 NAs for around 60-65 residents total depending on the census that day. She indicated that recently the NA staffing for the third shift had been 2 NAs. She explained that she had difficulty meeting residents' needs timely when there were only 2 NAs working on the third shift. She further explained that she had to prioritize her tasks to make sure the more important tasks were completed first. NA #2 revealed that this prioritization caused other non-critical tasks such as getting Resident #32 up at his preferred time to be pushed back and completed later in the morning.

An interview was conducted with NA #3 on 1/10/19 at 6:25 AM. She stated that she began working in the facility 2 months ago and normally worked on the third shift. She reported she was familiar with Resident #32 and was aware he liked to get up very early in the morning. NA #3 stated that third shift normally had 2 or 3 NAs for

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around 60-65 residents total depending on the census that day. She indicated that recently the NA staffing for the third shift had been 2 NAs. She revealed she had difficulty meeting residents' needs timely when there were only 2 NAs working on the third shift. She stated that tasks had to be prioritized to make sure the most important tasks were completely first. NA #3 revealed that this prioritization caused other non-critical tasks such as getting Resident #32 up at his preferred time to be pushed back and completed later in the morning.

During an interview with the Administrator on 1/8/19 at 10:30 AM he stated he began working as the Administrator at this facility in June of 2018. He revealed that the facility had difficulty obtaining and maintaining enough NAs to staff all three shifts since he began as the Administrator. When asked what his definition of sufficient staffing was he stated that sufficient staffing was enough staff both in terms of quality and quantity to meet the needs of the residents.

During an interview with the Director of Nursing (DON) on 1/9/19 at 3:31 PM she stated she began working as the DON at the facility in June of 2018. She confirmed the Administrator's interview related to the facility having difficulty obtaining and maintaining enough NAs to staff all three shifts. She stated that third shift was normally staffed with 2 or 3 NAs. She revealed that one day recently she had to come in to work as an NA on the 3rd shift because 1 of the 2 NAs who were on the schedule called off and she was unable to find anyone else to fill in.

A follow up interview with the Administrator and Director of Nursing on 1/10/19 at 2:31 PM they

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F 561	Continued From page 24 both indicated their expectation was for the choices of residents to be honored. They additionally indicated their expectation was to provide sufficient staffing to meet the residents' needs.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have	F 565		

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F 565	Continued From page 25 family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve the repeat concern reported during Resident Council meetings for 4 of 4 consecutive months regarding call lights not being answered timely. The findings included: Review of the monthly Resident Council meeting minutes dated 9/19/18 indicated the residents expressed the concern of call lights not being answered timely. The Activities Director was present at the meeting. Review of the monthly Resident Council meeting minutes dated 10/17/18 indicated a follow up of the previous month ' s (9/19/18) concern of call lights not being answered timely. This follow up stated that all staff were aware they needed to answer, and address call light needs when a light was on. These minutes indicated that the issue of call light response time continued. The Activities Director was present at the meeting. Review of the monthly Resident Council meeting minutes dated 11/22/18 indicated a follow up of the previous month ' s (10/17/18) concern of call lights not being answered timely. This follow up stated that call light issues continued, but residents had reported it was improving. These minutes indicated that the issue of call light response time was not resolved and that the issue still needed improvement. The Activities	F 565	F565- Resident/Family Group and Response 1. On 1/31/2019 the Regional Vice President of Operations (RVPO) re-educated the Executive Director (ED) and Activities Director (AD) on timely response and filing of Grievances and/or Concerns received during Resident Council and, ensure follow-up is reported to Resident Council at the next scheduled meeting. 2. The ED and SSD conducted a Resident Council meeting to discuss prompt response to call lights, to ensure residents are free to participate in Group Meeting and receive a prompt response on their grievance on 1/16/2019. Call lights were discussed at the meeting and the Resident Council was informed of the center□s steps taken to resolve the issue. A follow-up Resident Council meeting is scheduled for 02/11/19. Follow up based on findings. 3. The ED and RDCS will re-educate the department managers on federal regulations and guidelines for Resident/Family Grievance process and timely response and resolution of grievances voiced in Resident Group meetings, specifically to promptly responding to call lights by 2/20/2019.	

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F 565	Continued From page 26 Director was present at the meeting. Review of the monthly Resident Council meeting minutes dated 12/19/18 indicated a follow up of the previous month ' s (11/22/18) concern of call lights not being answered timely. This follow up stated that call light issues continued to improve but had not been resolved. The Activities Director was present at the meeting. A Resident Council meeting was conducted on 1/8/19 2:00 PM with 6 alert and oriented residents who were active participants in the facility's Resident Council. The residents reported that the only concern discussed repeatedly in the Resident Council meetings was the issue with the length of time it took for their call bells to be answered. The residents indicated this issue had improved but had not been resolved. When asked what the facility ' s response was to them regarding this repeat concern the group indicated they were informed the facility staff had been told that everyone was to answer the call lights regardless if their staff title. An interview was conducted with the Activities Director on 1/8/19 at 2:25 PM following the Resident Council meeting. She confirmed she was aware that the residents had repeated concerns related to call bells not being answered timely. She verified the information provided in the minutes that this issue had improved but had not been resolved. An interview was conducted with the Administrator on 1/8/19 at 10:30 AM. He stated he began working as the Administrator at this facility in June of 2018. He reported he was aware that call bell response time was a	F 565	Staff will not be allowed to return to work until education complete. 4. ED, RDCS and DCS will conduct random resident interviews 3 times per week for 4 weeks, then weekly for 3 months, to ensure resident□s grievances including call light response are followed up and timely. ED and DCS will attend Resident Group meetings (when invited) to ensure timely follow-up and response to grievances. Resident council meetings will be held every other week for 8 weeks then continue with monthly. The DCS will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 2/20/2019.	

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F 565	Continued From page 27 continued issue at the facility and indicated that staff education was provided to remind all staff regardless of discipline that they were to answer call lights and assist the resident if able or find an appropriate staff member to complete the task if it was out of their scope of practice. The Administrator indicated it was ongoing process to improve on this concern. During an interview with the Director of Nursing and the Administrator on 1/10/19 at 2:31 PM they both reported they expected concerns discussed in the Resident Council to be reviewed, investigated, and addressed after each meeting in which they were discussed. They additionally indicated they expected call bells to be answered timely to meet the needs of the residents.	F 565		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		4/3/19

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on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

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F 585	Continued From page 29 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident and family interview, and Department of Social Services (DSS) staff interview, the facility failed to provide a written summary for grievances	F 585	F585- Grievances 1. Resident #36 no longer resides at the facility. The Regional Director of Clinical Services interviewed Resident #49 on	

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reported (Resident #36) and failed to write and investigate a grievance that was reported verbally to staff (Resident #49) for 2 of 2 residents reviewed for grievances.

Findings included:

1. Resident #36 was admitted on 10/1/18 with the diagnoses of neuropathy, diabetes, pressure ulcer of the right heel unstageable, and need for assistance with activities of daily living.

A review of the residents care plan dated 10/1/18 revealed goals and interventions for pressure ulcer prevention and status.

A review of the admission Minimum Data Set (MDS) dated 10/8/18 revealed the resident had an intact cognition. The resident required extensive assistance of 2 persons for transfer, bathing and incontinence care. The resident required supervision for meals.

A review of the significant change MDS dated 1/1/19 was in progress for worsening disease process, meals were now assistance of one staff, and a swallowing decline.

A review of the resident ' s grievance report dated 10/21/18 revealed Resident #36 ' s family filed a grievance that the resident had not had a bath in 3 weeks since admission other than the bath the family provided. The family informed the nurse at the station about the lack of bath. The grievance report Investigation revealed: the resident had refused a shower, but staff documentation and notification were not completed and had been an issue. The staff was in-serviced. The resolution included a care plan meeting with the family. The

3/12/19 to ensure any concerns with care are resolved and determine if any other grievances exist or require follow-up. Resident # 49 expressed their grievances were resolved and no additional grievances were voiced.

2. The SSD and or the RDCS completed interviews of interviewable residents, and the responsible party of un-interviewable residents, to ensure residents are provided care in a respectful and dignified manner, and grievances are resolved and follow up provided by 3/21/19. All grievances received were documented with a written summary of resolution. No negative findings were identified in the interviews. Any future residents identified with grievances will follow re-established grievance process.

3. The RDCS and DON will provide the facility staff, including all shifts, part-time and prn, re-education on the federal regulations and guidelines related to the resident's right to ensure grievances are resolved, followed up and a written summary by 3/21/19. Staff will not be allowed to return to work until education complete.

4. RDCS, DON and or SSD will conduct five resident interviews 3 times per week for 4 weeks, then weekly for 3 months, including all shifts and some weekends, to ensure resident's grievances are resolved and followed up. The SSD will report on the results of the quality monitoring (audit)

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F 585	Continued From page 31 facility switched the resident to a shower. A review of the resident ' s grievance report dated 10/22/18 revealed the family filed a grievance that the resident had not had a bath, the foot wound dressing had not been changed, and the resident needed to be offered incontinence care. Investigation: the resident refused a shower three times on 10/22/18. The plan was to meet with the family. Nurses were educated on timely incontinence care. A review of the resident ' s grievance report dated 10/23/18 reported by the family revealed the family came to the facility at 7:45 pm to ensure the resident had received his scheduled "Tuesday" bath. Upon arrival the family found the resident's light was on and he was wet with urine through to the mattress. The nurse responded there were only 2 Nursing Assistants (NA) on the floor, they could not get to everyone in a timely manner, and that they were short staffed. Investigation: the family and administration staff found which NA was confused because there were 5 NAs on shift that night. The NA in question was written up and in-serviced on how to speak with families. Plan was to change the resident ' s "diaper" more frequently. A review of the resident ' s grievance dated 10/25/18 reported by the family revealed that the resident was not thoroughly cleaned after bowel incontinence. Investigation: Re-education was provided to the NA. The results were not documented as being provided. A review of the resident ' s grievance dated 10/25/18 reported by the family revealed the staff postponed the resident ' s shower until next shift.	F 585	and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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The NA referred the resident to another shift if the resident refused on her shift. The plan was when the resident refused to document and call the daughter. The resident ' s shower was moved to a different shift to ensure compliance. The resident was unhappy with late (2nd shift) showers. No written response was provided.

A review of the resident ' s grievance dated 11/23/18 reported by the family revealed the resident returned back to the facility after a family outing and the family was unable to assist the resident out of the car. NA #7 was asked by family to assist the resident and stated he could not help get the resident back inside the facility. The daughter had to call the fire department and medical emergency service to help her get the resident out of the car and back into the facility. Investigation: The nurse who informed the daughter the facility could not help the resident get back into the facility building was educated. The results were provided verbally.

A review of the resident ' s grievance dated 12/17/18 reported by the family revealed that the packaged terminal air conditioner (PTAC) was not working. The PTAC was replaced. There was no written response.

On 1/7/19 at 10:30 am an interview was conducted with Resident #36 who stated his family member had informed the facility of his concerns but had not always received a response or the problem continued. The resident stated that his call light was not always answered timely, he needed incontinence care and his foot dressing was not always changed.

On 1/7/19 at 11:00 am an interview was

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conducted with Resident #36 ' s family member who stated she filed multiple grievances for bathing, wound care, incontinence care, time taken to respond to the call light, and assistance with transfer out of her car. The family member also commented that she informed the staff multiple times that the heat was not working in the resident ' s room before it was fixed. The family member stated that she was not provided a copy of the written grievances but was asked to sign three of them. The family member further explained the facility had not provided her with a written response or written summary for her grievances.

On 1/8/19 at 3:00 pm an interview was conducted with the Director of Nursing (DON) who was responsible for grievance resolution. The DON stated that Resident #36 family ' s grievance was always written and provided to the family for signature on some of the occasions. The family was not provided a written response to their grievances. The DON stated she was not aware that a grievance required the facility to provide a written summary to the person who voiced or filed the grievance but thought that having the family sign the grievance met the requirement.

2. Resident #49 was admitted to the facility on 12/6/18 with diagnoses that included cerebrovascular disease.

The admission Minimum Data Set (MDS) assessment dated 12/13/18 indicated Resident #49 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #49 required the extensive assistance of 1 for bed mobility and toileting and 2 or more for transfers. She was frequently incontinent of bladder and

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always incontinent of bowel.

An interview was conducted with Resident #49 on 1/7/19 at 3:00 PM. Resident #49 was alert and oriented with no impaired cognition noted. When asked if she had any concerns with her care she stated that several weeks ago during the second shift (3:00 PM to 11:00 PM) she rang her call bell and requested for staff to adjust her bed pan, so she could urinate. She explained that she preferred to urinate in her bed pan. She reported 2 staff members came into her room and 1 of them said the bed pan was too small for her. Resident #49 stated that this staff member then said to her, "do it in your pants ...haven ' t you ever gone in your pants?" She reported she told the staff she hadn ' t gone in her pants since she was a baby. Resident #49 indicated the staff had taken the bed pan with them out of her room and she had to urinate in her brief. She was unable to recall the names of either staff member and was unable to recall how long it took for incontinent care to be provided to her after this incident. Resident #49 stated that she had reported this incident to one of the nurses (unable to recall the name of the nurse) and she believed the Director of Nursing (DON) was also aware. She indicated she had not seen either of the 2 staff members again after she reported this incident to the nurse.

A phone interview was conducted with Department of Social Services (DSS) staff by phone on 1/9/19 at 8:09 AM. She stated that Resident #49 reported to her several weeks ago that she had requested staff to adjust her bed pan and they said something to her about the size of the bed pan and told her that if she had not wanted to use the bed pan that she would "pee on herself". She indicated she believed nursing

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staff was informed of the incident by Resident #49.

An interview was conducted with the DON on 1/9/19 at 2:30 PM. The DON revealed she had heard one of the staff say something about Resident #49 reporting that a staff member told her to use her brief to urinate because they were unable to change her at that time. The DON stated this was not appropriate as it was a dignity issue for a resident to be told to urinate in their brief. She indicated she expected residents to be treated with dignity and respect. The DON stated she was unable to recall what staff member she heard this information from and she was also unable to recall when this occurred. She revealed there was no grievance written related to this incident and no investigation was conducted. The DON indicated the facility ' s grievance policy stated that issues voiced to staff, such as this report of Resident #49 not being treated with dignity and respect, were expected to be written up as a grievance for the resident or on behalf of the resident by the staff member who was notified of the information.

During an interview with the Administrator on 1/8/19 at 10:30 AM he stated he started working at the facility as the Administrator in June of 2018. He reported that since that time there had been several administrative staff changes which included the Social Worker (SW) position that was reassigned about a month ago. He stated the SW was responsible for maintaining the grievance log, creating grievances reported to her, assigning the grievances to the appropriate department for investigation, and ensuring follow up on the grievance was completed. He revealed that the facility had identified the former SW had

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F 585	Continued From page 36 failed to perform these responsibilities. A follow up interview was conducted with the Administrator and DON on 1/10/19 at 2:31 PM. They both indicated they expected the grievance policy to be followed. The Administrator stated it was unacceptable for a resident to be told to urinate in their brief as it was a dignity issue and he expected all staff to report any issues such as this, so it could be investigated and resolved.	F 585		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interview, resident interview, family interview, wound care Nurse Practitioner interview, Nurse Practitioner interview, and Department of Social Services interview, the facility neglected to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation,	F 600	F600 Free of Abuse/Neglect 1. On 1/8/2019 resident #36 had wound care provided by a licensed nurse. Resident #36 had a pressure reducing mattress and pad on bed and wheelchair 10/1/18. Resident #36's heels were floated and he was provided an off loading boot for therapy 10/11/18. Wound care	4/3/19

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and communication with the outside podiatrist who was also treating, resulting in worsening, increase in size and infection of the pressure ulcer (Resident #36); neglected to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation resulting in a worsening pressure ulcer (Resident #1); and neglected to provide daily pressure ulcer wound care as ordered and weekly wound measurement/assessment and documentation (Resident #44) for 3 of 4 residents reviewed; the facility neglected to provide catheter care (Resident #44) for 1 of 1 resident reviewed; and the facility also neglected to answer a call light related to a request for incontinence care (Resident #49) for 1 of 1 resident reviewed.

Immediate Jeopardy began on 11/6/18 when staff neglected to provide pressure ulcer care with resulting infection for Resident #36. Immediate Jeopardy was removed on 3/6/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal.

The facility will remain out of compliance at a lower scope and severity level to ensure monitoring of systems are put in place and to complete employee in-service training.

The facility was also cited at a scope and severity of H (a deficiency that constitutes a pattern of actual harm that is not Immediate Jeopardy) for Example #2 (Resident # 1).
The facility was cited at a scope and severity of G (an isolated deficiency of actual harm that is not Immediate Jeopardy) for Example #3 (Resident #49).

was provided to Resident #36's heel daily starting 1/10/19 as ordered by the physician and his wound was assessed weekly for signs of improvement by the licensed nurse starting 1/23/19. Resident #36 was followed by his physician starting on admission to facility on 10/1/2018, and his care plan was updated on 1/29/19 by the MDS nurse. Resident #36's wound resolved on 2/8/2019 and he was discharged 2/20/2019. Daily wound care was provided starting 1/10/19 following physician's orders. Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).On 01/22/19 a root cause analysis was completed by the Regional Vice President of Operations, Regional Director of Clinical Services, the Director of Nursing and the Divisional Executive Director (acting administrator) and determined that the Executive Director failed to provide consistent staffing to ensure treatments were completed as ordered. Resident #1 was provided daily wound care beginning 1/12/19 by licensed nurse. Resident #1 and #44 wounds was measured and assessed weekly by licensed nurse beginning 1-23-19. Resident #44 was provided daily wound care beginning 1-10-19 by licensed nurse. Resident #44 had urinary catheter care provided by the licensed nurse on 2-13-19. On 3/12/19 Resident #49 was interviewed by the Regional Director of Clinical Services to

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The facility was also cited at a scope and severity of E (a deficiency that constitutes a pattern of no actual harm with a potential for minimal harm that is not Immediate Jeopardy) for Example #4 (Resident #44). Findings included:

1. Resident #36 was admitted to the facility on 10/1/18 with the diagnoses of Parkinson's, neuropathy, diabetes, and unstageable pressure ulcer of the right heel.

A review of the resident ' s care plan dated 10/1/18 revealed goals and interventions for pressure ulcer prevention and status.

A review of the physician order dated 10/1/18 revealed a treatment order for the right side of the heel that read "cleanse with normal saline, pat dry, apply antibiotic ointment, and cover with dry sterile dressing each day."

A review of the resident ' s physician progress note for admission dated 10/1/18 revealed, a present on admission, unstageable pressure ulcer to the right lateral heel with a small area with yellow/brown drainage, but no erythema or odor.

A review of the admission Minimum Data Set (MDS) dated 10/8/18 revealed the resident had an intact cognition. The resident required extensive assistance of 2 persons for transfer, bathing and incontinence care. The resident had one unstageable pressure ulcer on the side of the right heel.

A review of the resident ' s October 2018 treatment administration record (TAR) for dressing change of the right heel pressure ulcer

ensure call lights are answered timely and staff are verbally appropriate. No concerns voiced at this time.

2. On 2/15/2019 the Director of Nursing completed a quality review of all current resident treatment sheets, compared them to the treatment orders and observed treatments to ensure that residents were provided wound care as ordered. There are 3 current residents with pressure sores. Current residents with wounds are followed by wound physician associated with the medical director's practice or a Vascular Surgeon. Residents with wound care had their care plans reviewed on 2/27/19-2/28/19 to ensure that the facility addressed the pressure sores comprehensively to prevent worsening and promote healing of the pressure sores. Residents with pressure ulcers had their care plans reviewed on 2/28/19 by the Divisional MDS nurse. Resident's wounds are observed and measured weekly by the treatment nurse, beginning 1/23/19. The facility's treatment nurse coordinates outside services as needed and/or as ordered in collaboration with the physician. Current residents with wounds are followed by the wound physician associated with the Medical Directors practice, or a Vascular Surgeon. The physician notes are sent to the facility via secure server email for the Director of Nursing's review and then they are filed in the medical record. Alert and oriented residents were interviewed 3/4/2019 if they have ever felt neglected. No

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revealed there was no documentation for wound care on 10/6-8, 10/13-14, 10/17-18, 10/20-21, and 10/27-28.

A review of the resident ' s November 2018 TAR for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care on 11/15-16, 11/23-25, and 11/20.

A review of the resident ' s wound culture lab results dated 11/2/18 revealed an infection of methicillin resistant staphylococcus aureus (MRSA) of the side of right heel.

A review of the resident ' s physician progress note dated 11/6/18 revealed an unstageable pressure ulcer of the right heel which was present on admission had a positive MRSA culture. There was an order for Doxycycline 100 mg (antibiotic) ordered 11/2/18 for 7 days.

A review of the resident ' s physician progress note dated 11/8/18 revealed the resident had a pressure ulcer to his right later heel which was present on admission. The resident was his own responsible party.

A review of the physician ' s progress note dated 11/27/18 revealed the resident was treated for MRSA to the right heel. The resident finished his antibiotic (11/8/18) medication and contact precautions were no longer needed (healed).

A review of the resident ' s December 2018 TAR for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care on 12/1-2, 12/5, 12/7, 12/15-17, 12/21-23, 12/25, and 12/28-31.

negative responses were noted.

3. Director of Nursing, Divisional Executive Director, and Regional Director of Clinical Services provided education to all staff on abuse and neglect with emphasis that not providing care to the resident is neglect on 2/3/19, 2/5/19, 2/11/19, and 2/19/19 and re-educated on 3/3/19 and 3/4/19. New hires will be provided training on neglect to include not providing care to the resident is neglect. Newly hired licensed nursing staff will be provided training and education on neglect including not providing care to the resident as well as not providing wound care and treatment as being neglect. The facility employees a full time treatment nurse. If the treatment nurse is unavailable, it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. The licensed nurses have the capacity to complete their assignments, including treatments within the parameters of their work schedule. If the licensed nurse cannot complete the treatment within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing. The Director of Nursing will grant overtime to the licensed nurse to complete the task, delegate the responsibility to another nurse or assist with the task. The DON or MDS nurse will complete the assessment and measurements if the treatment nurse is unavailable. Corporate Human Resources and Regional staff worked with the Interim Executive Director to

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F 600	Continued From page 40 Physician progress note dated 12/27/18 revealed a resident decline secondary to Parkinson ' s disease. The resident was followed by wound care (Foot and Ankle Center outside the facility) for the side of the right heel pressure ulcer. On 1/7/19 at 10:45 am an interview was conducted with the resident who stated his right heel wound dressing was not always changed every day. On 1/7/19 at 2:00 pm an interview was conducted with the resident ' s family member who stated the right foot wound dressing was not being changed each day as ordered and that she had taken the resident to the podiatrist to follow up. The family member commented that the resident informed her the dressing was not always being changed and the family member looked at the date on the dressing and could see the date had passed by a couple of days. On 1/8/19 at 3:00 pm an observation was done of the resident ' s right heel pressure ulcer wound care provided by the treatment nurse (TN). The dressing of the right heel was dated 1/4/19 and was soaked through with yellow purulent drainage and the wound was macerated (wet, white, and peeling) around the edges. A review of the January 2019 TAR for dressing change of the right heel pressure ulcer revealed the dressing was documented as being done on 1/1, 1/4 and 1/8. On 1/8/19 at 10:25 am an interview was conducted with the TN who stated that she was responsible for all resident treatments but was frequently being re-assigned to work as a nursing	F 600	implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels to ensure adequate staffing is maintained. On 2/7/19 the Regional Vice President of Operations and Regional Director of Clinical Services began monitoring daily staffing of direct care per resident per day using morning meeting and internal labor portal. Facility leadership, including the Executive Director, Director of Nursing and Interdisciplinary team provide direct oversight through rounding, observation and resident/family communication to ensure neglect is not present and the residents receive the care and services they need. Interdisciplinary team to include Social Worker, Activities Director, Medical Records Director, Dietary Manager, Housekeeping Manager, Rehab Director, Business Office Manager, MDS Coordinator and Human Resources Director. Issues identified will be presented to the Executive Director and will follow the Abuse and Neglect process for investigation, resolution and/or reporting. 4. Regional Director of Clinical Services and or Director of Nursing will conduct quality monitoring (audit) for neglect including observation and interview of resident treatments and documentation for 3 residents (rotating residents), 3 times per week for 4 weeks, then weekly for 3 months. The Director of Nursing will	

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F 600	Continued From page 41 assistant due to staff shortage. The TN stated when she was not in the role of treatment nurse the assigned floor nurse was responsible to provide wound care for their residents. The treatment nurse stated that she was responsible to measure all the resident's wounds once a week and when she was assigned as a nursing assistant the wounds were not measured or reassigned. The treatment nurse stated she assisted the wound care Nurse Practitioner once a week during weekly rounds except when she was assigned as a nursing assistant. 1/8/19 at 10:30 am an interview was conducted with the Administrator who stated that there had been several staff resignations as well as terminations. To temporarily resolve the nursing assistant shortage, licensed nurses have been assigned to the nursing assistant role. The staff informed the Administrator that they were exhausted. On 1/8/19 at 1:57 pm an interview was conducted with Nurse #9 who stated that the resident had a pressure ulcer to his right heel that was present on admission and the dressing change was completed by the treatment nurse. Nurse #9 also stated that she was not responsible to change the dressing. Nurse #9 stated that she was assigned to the resident on 1/7-9/19, she had not changed the resident ' s right heel dressing and later learned that the resident had not received his dressing change by the treatment nurse. If there was no documentation in the resident ' s record the wound care was not done. On 1/8/19 at 2:21 pm an interview was conducted with the TN who stated the resident acquired an infection of the right heel pressure ulcer during	F 600	report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting by the Director of Nursing for review of on going wound care monthly. The Executive Director will provide data on staffing to the QAPI committee for review of any staffing challenges. Quality Improvement monitoring schedule will be modified based on findings of monitoring The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 02/22/19, including the Interim Executive Director, Director of Nursing, the SDC, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director and the Environmental Services Director regarding the plan of removal of immediacy. 5. Date of Compliance 4/3/19	

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his stay at the facility. Not changing the resident ' s pressure ulcer dressing placed him at risk for an infection. The treatment nurse stated that the right heel wound had worsened after he completed his antibiotic and the dressing was not changed daily by becoming larger with increased drainage and the drainage that was scant serous was now moderate creamy yellow. The TN further commented that the family took the resident to a podiatrist for the right heel wound because they were aware the dressing was not being changed by the date on the dressing and by what the resident stated. On the weeks the resident saw the podiatrist the wound care Nurse Practitioner could not treat the resident. The resident ' s wound was not followed by the facility because there was no weekly measurement done at the facility nor did the facility obtain the podiatry notes, the resident ' s dressing was not changed, and when the wound had gotten larger with increased drainage the facility ' s medical nurse practitioner or wound care nurse practitioner had not assessed the wound.

On 1/8/19 at 3:10 pm an interview was conducted with the treatment nurse (TN) who stated the resident ' s right heel pressure ulcer dressing had the date she placed on the gauze from last week, dated 1/4/19. The TN stated she referred back to the treatment administration record (TAR) and was the last nurse to document/change the resident's right heel dressing on 1/4/18. The TN commented that if the TAR was not signed/documented the dressing was not changed. The TN nurse stated that other than the nurse practitioner notes there were not facility documented wound measurements.

On 1/8/19 at 3:30 pm an interview was conducted

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with the Director of Nursing (DON) who stated that she expected staff to complete all treatments as ordered.

On 1/10/19 at 9:00 am an interview was conducted with the wound care Nurse Practitioner who stated she rounded on the residents for wound assessment each week with the facility's treatment nurse. Due to staff shortage, the TN was not available to assist each week to measure the wounds and Resident #36 was being seen periodically by the podiatrist. The wound care Nurse Practitioner stated she observed Resident #36 ' s right heel pressure ulcer during nursing wound care today and assessed that the wound was larger and had increased drainage than last month (she had not measured the wound) but was not infected. She was aware that the resident had acquired a MRSA infection of the right heel wound last month but was not aware that the dressing was not changed as ordered until now. The failure to change the dressing placed the resident at high-risk to acquire a wound infection and would have contributed to his prior MRSA infection. MRSA was in the environment and a wound that was not cared for by dressing change was high-risk cause for MRSA to infect an open wound with accumulating wound drainage in the dressing.

The wound care Nurse Practitioner went on to state that she asked the DON for the resident ' s podiatry notes and they were not provided to her nor available in the resident ' s medical record. She also stated that she was aware of the nursing staff shortage, made aware that wound care and measurements were not completed, and had brought her concerns to the DON in the past couple of months. The wound care Nurse

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Practitioner stated that she could not evaluate, treat and measure the resident ' s wound on a regular basis because he was being seen outside the facility by a podiatrist (duplication of services).

On 1/10/19 at 9:30 am an interview was conducted with the facility medical Nurse Practitioner who stated that the resident ' s right heel pressure ulcer wound was macerated around the edges and changed the wound care order due to the failure to change the dressing and wound status change and decline. The facility Nurse Practitioner stated she had not usually followed the right heel pressure ulcer wound because he was seen by an outside podiatrist and it was considered a duplication of services.

On 1/10/19 at 2:00 pm an interview was conducted with the DON who stated there were no podiatry notes in the facility record for the resident. The DON stated she would attempt to obtain a copy from the podiatry office.

On 1/10/19 at 10:10 am an interview was conducted with the TN who stated she was informed by the DON that she would be assigned as NA for 1/7, 1/8, and 1/9 and would not be responsible for facility treatments. The facility treatments would be assigned to the nurse on each hall responsible for their residents that required a treatment which included all wounds.

On 1/10/19 at 10:12 am an interview was conducted with the DON with Nurse #7 and TN present. DON stated that she was aware that treatments were not completed for Resident #36 on 1/7, 1/8, and 1/9 and expected the TN nurse to complete the treatments on all the facility

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residents in the afternoon after her NA day shift duties.

On 1/9/18 3:10 pm the DON and the TN to accompany the surveyor to observe resident ' s right heel dressing change. The DON stated she was made aware that the dressing was dated 1/4/19 and that the dressing had not been changed for 4 days. The TN nurse stated that she was not aware that she was responsible to complete treatments including wound care after her NA day shift on the three days. Nurse #7 stated that she was not responsible for treatments and had not completed the resident ' s wound care on 1/7, 1/8, and 1/9. The DON stated she agreed there was a breakdown in communication as to who was responsible to complete the resident's treatments. The DON also stated that the resident was seen by an outside podiatrist and would obtain the records.

The Administrator and Director of Nursing were notified of Immediate Jeopardy on 3/4/19 at 1:00 pm.

On 3/5/19 the facility provided the following credible allegation of Immediate Jeopardy removal:

The center Executive Director alleges abatement of immediate jeopardy on 03/05/19.

1. The corrective action for the alleged deficient practice was accomplished by:
On 1/8/2019 resident #36 had wound care provided by a licensed nurse. Resident #36 had a pressure reducing mattress and pad on bed and wheelchair 10/1/18. Resident #36 ' s heels were floated and he was provided an off loading boot

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for therapy 10/11/18. Wound care was provided to Resident #36 ' s heel daily starting 1/10/19 as ordered by the physician, and his wound was assessed weekly for signs of improvement by the licensed nurse starting 1/23/19. Resident #36 was followed by his physician starting on admission to facility on 10/1/2018, and his care plan was updated on 1/29/19 by the MDS nurse. Resident #36 ' s wound resolved on 2/8/2019 and he was discharged 2/20/2019. Daily wound care was provided starting 1/10/19 following physician ' s orders.

Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).

On 01/22/19 a root cause analysis was completed by the Regional Vice President of Operations, Regional Director of Clinical Services, the Director of Nursing and the Divisional Executive Director (acting administrator) and determined that the Executive Director failed to provide consistent staffing to ensure treatments were completed as ordered.

2. Residents with the potential to be affected by alleged deficient practice:
On 2/15/2019 the Director of Nursing completed a quality review of all current resident treatment sheets, compared them to the treatment orders and observed treatments to ensure that residents were provided wound care as ordered. There are 3 current residents with pressure sores. Current residents with wounds are followed by wound physician associated with the medical director ' s practice or a Vascular Surgeon. Residents with

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wound care had their care plans reviewed on 2/27/19-2/28/19 to ensure that the facility addressed the pressure sores comprehensively to prevent worsening and promote healing of the pressure sores. Residents with pressure ulcers had their care plans reviewed on 2/28/19 by the Divisional MDS nurse. Resident ' s wounds are observed and measured weekly by the treatment nurse, beginning 1/23/19. The facility ' s treatment nurse coordinates outside services as needed and/or as ordered in collaboration with the physician.
Current residents with wounds are followed by the wound physician associated with the Medical Directors practice, or a Vascular Surgeon. The physician notes are sent to the facility via secure server email for the Director of Nursing ' s review and then they are filed in the medical record.
Alert and oriented residents were interviewed 3/4/2019 if they have ever felt neglected. No negative responses were noted.

3. Systemic Changes:
Director of Nursing, Divisional Executive Director, and Regional Director of Clinical Services provided education to all staff on abuse and neglect with emphasis that not providing care to the resident is neglect on 2/3/19, 2/5/19, 2/ 11/19, 2/19/19 and re-educated on 3/3/19 and 3/4/19.
New hires will be provided training on neglect to include not providing care to the resident is neglect. Newly hired licensed nursing staff will be provided training and education on neglect including not providing care to the resident as well as not providing wound care and treatment as being neglect.

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The facility employees a full time treatment nurse. If the treatment nurse is unavailable, it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. The licensed nurses have the capacity to complete their assignments, including treatments within the parameters of their work schedule. If the licensed nurse cannot complete the treatment within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing. The Director of Nursing will grant overtime to the licensed nurse to complete the task, delegate the responsibility to another nurse or assist with the task. The DON or MDS nurse will complete the assessment and measurements if the treatment nurse is unavailable. Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).

The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels to ensure adequate staffing is maintained. On 2/7/19 the Regional Vice President of Operations and Regional Director of Clinical Services began monitoring daily staffing of direct care per resident per day using morning meeting and internal labor portal.

Facility leadership, including the Executive Director, Director of Nursing and Interdisciplinary team provide direct oversight through rounding, observation and resident/family communication to ensure neglect is not present and the residents receive the care and services they need. Interdisciplinary team to include Social Worker,

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Activities Director, Medical Records Director, Dietary Manager, Housekeeping Manager, Rehab Director, Business Office Manager, MDS Coordinator and Human Resources Director. Issues identified will be presented to the Executive Director and will follow the Abuse and Neglect process for investigation, resolution and/or reporting.

Regional Director of Clinical Services and or Director of Nursing will conduct quality monitoring (audit) for neglect including observation and interview of resident treatments and documentation for 3 residents (rotating residents), 3 times per week for 4 weeks, then weekly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting by the Director of Nursing for review of on going wound care monthly. The Executive Director will provide data on staffing to the QAPI committee for review of any staffing challenges. Quality Improvement monitoring schedule will be modified based on findings of monitoring.

The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 02/22/19, including the Interim Executive Director, Director of Nursing, the SDC, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity

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Director and the Environmental Services Director regarding the plan of removal of immediacy.

The Medical Director was made aware of the of immediacy plan via telephone with the Executive Director and the Director of Nursing on 3/1/19.

The credible allegation of Immediate Jeopardy removal was validated on 3/6/19 at 12:30 PM which included:

Human resources record review indicated there were 17 new employees documented as starting employment as nursing assistant and licensed nurse between 1/12/19 and 2/27/19.

A review of Resident #36 ' s discharge from the facility to home dated 2/20/19 revealed he was discharged to home with family, was scheduled to follow up with his physician, home care services were started, and medical supply was contacted. The first home visit scheduled was for 2/25/19. A review of Resident #36 ' s treatment administration record for January and February 2019 revealed documentation that he received his daily wound care since the last survey.

A review of the facility audit documentation dated 2/15/19 and 3 current residents were confirmed that their wounds followed by the wound physician associated with the medical director ' s practice or a Vascular Surgeon and wound care as ordered as evidenced by notes in their medical record. Wound care documentation was reviewed, and weekly observations and measurements were identified beginning 1/23/19. Education in-service, sign-in sheets for wound care and abuse/neglect/exploitation were reviewed. Signatures totaled the current

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employment count.

Documentation of resident interviews dated 3/4/2019 was reviewed and resident responses indicated that they had ever felt neglected. No negative responses were noted.

Resident #36 was discharged to home and not available for observation and interview.
On 3/6/19 at 11:55 am an interview was conducted with the Director of Clinical Services/Director of Nursing (DON) who stated the facility was now fully staffed since mid-February 2019 and the new Administrator provided across the board raises for all staff. All facility staff were required to participate in education for abuse, neglect, and exploitation. Staff morale has improved and there are fewer reported grievances. Staffing was the root cause of the failures to provide care (neglect), call light answer, low morale, and failure to meet resident preferences. Resident council is now held every 2 weeks to address concerns. The increased staff has been sustained. Surplus applicants not hired contact information has been retained.

On 3/6/19 at 4:30 pm interviews of 5 random staff members were conducted which revealed that all staff were required to participate in abuse/neglect/exploitation in-service. The staff commented that "several newly employed nursing assistants had started over the past 2 months and the facility was fully staffed." The rate of grievances filed by residents and/or their family had dropped by half. The last resident council meeting in February 2019 identified that call lights and incontinence care were addressed timely to the satisfaction of the residents. An interview was conducted with the Treatment Nurse (TN)

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who stated that she was no longer required to float to the nursing assistant position and was available every day for treatments. On the weekends the nurse assigned to the resident completed the treatments. In the TN ' s absence the nurse assigned completed the treatments and a schedule book for who is responsible was kept at the nurses ' station and managed by the Scheduling Coordinator and Director of Nursing.

On 3/6/19 at 5:30 pm an interview was conducted with the Corporate Vice President of Operations who stated he conferenced with the Divisional Human Resources Director and implemented staffing plans including wage increases and recruitment and retention plans to ensure sufficient staffing. On 2/7/19 sufficient staff had been hired and received orientation prior to accepting an assignment. Daily staffing meetings have occurred to ensure sufficient staffing patterns.

2. Resident #1 was admitted to the facility 10/3/18 with cumulative diagnoses of Cirrhosis and a history of a Deep Vein Thrombosis.

Review of Resident #1's admission Minimum Data Set (MDS) dated 10/10/18 revealed that the Cognitive Pattern assessment (Section C) and the Mood (Section D) assessment was not completed. She was coded total staff assistance with bed mobility, toileting and personal hygiene. Resident #1 was coded as non-ambulatory and incontinent of bladder and bowel. She was coded

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for one stage 2 pressure ulcer and one Suspected Deep Tissue Injury (SDTI) both present on admission. Interventions included a pressure reducing mattress to her bed and pressure ulcer care. Resident #1 was coded for a prognosis of less than 6 months and for Hospice Services.

Review of Resident #1's Care Area Assessment dated 10/10/18 for pressure ulcers read she was a Hospice resident and she was admitted with a SDTI and she was dependent of the staff for her activities of daily living.

Review of Resident #1's skin/wound care plan dated initiated 10/17/18 read she had a SDTI to her left heel on 10/17/18. The goal was for Resident #1's wound was to show signs of healing. Interventions included the facility was to provide treatments as ordered

Review of a Hospice nursing note dated 10/8/18 read Resident #1 had a blister to her left heel measuring approximately 10 centimeter (cm). New orders were written to apply Skin Prep to the blister daily and float her heels.

Review of an as needed (PRN) Hospice note read Resident #1 was seen on 10/12/18 because her left heel blister had ruptured. There were new orders dated 10/12/18 which read her left heel was to be cleansed with Normal Saline (NS), the area patted dry and the application of Mepitel (two-sided wound contact layer dressing), cover with area with padding and wrap with a gauze

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dressing. The dressing was ordered to be changed every Monday and Thursday by the Hospice nurse.

Review of a Hospice note dated 10/22/18 read Resident #1's left heel Mepitel dressing was hanging off her heel but not on the wound. New orders were written to clean her left heel wound with NS, pat dry then apply a Vaseline gauze, cover with a non-adherent dressing, pad the heel and secure with a gauze wrap. The dressing change was to be done every Monday and Thursday and the Hospice Nurse would be completing Resident #1's wound care.

Review of a Hospice note dated 10/31/18 read there was new orders for paint Resident #1's left heel wound with Betadine, cover the wound with a nonadherent dressing and wrap with a gauze dressing daily. The note indicated the new wound care orders were discussed with the Treatment Nurse at the facility.

Review of the facility November 2018 Treatment Administration Record (TAR) revealed no documented evidence of Resident #1's daily treatment to her left heel on 11/2/18, 11/3/18,11/4/18, 11/10/18, 11/13/18, 11/16/18, 11/21/18, 11/22/18 11/24/18 and 11/26/18.

Review of the facility December 2018 TAR revealed no documented evidence of Resident #1's daily treatment to her left heel on 12/2/18, 12/7/18, 12/11/18 12/19/18, 12/25/18, 12/28/18 and 12/29/18.

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Review of Resident #1's skin/wound care plan dated revised 1/3/19 read her area to the left heel was described as unstageable. The goal was for Resident #1's wound was to show signs of healing. Interventions included the facility was to provide treatments as ordered

Review of the facility January 2019 TAR revealed no documented evidence of Resident #1's daily treatment to her left heel on 1/1/19, 1/2/19, 1/4/19 and 1/8/19.

During an interview on 1/8/19 at 10:14 AM, the Treatment Nurse stated that she had been the Treatment Nurse at the facility since October 2017. She revealed that prior to sometime around July of August 2018, the facility began having difficulty obtaining and maintaining Nursing Assistants (NA). She further explained at that time due to the lack of NAs on staff, she was normally assigned as an NA and the floor nurses were supposed to complete the treatments.

Review of a Nurse Practitioner (NP) note dated 1/10/19 read Resident #1 was seen for wound follow up to her left heel. The NP assessed Resident #1's left heel pressure ulcer was described as unstageable with 90% eschar with 10% granulation, no odor with a small amount of serous drainage. New orders were given for Thera-honey (dressing impregnated with medical grade honey) daily to any granulated areas and continue to apply betadine daily to the dark eschar.

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During another interview on 1/10/19 at 8:40 AM, the Treatment Nurse revealed she had concerns that treatments were not being provided as ordered to Resident #1 by the floor nurses for over a month.

During an interview with the Director of Nursing (DON) on 1/10/19 at 2:31 PM, she indicated she expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician. She acknowledged that Resident #1's care plan interventions and physician's orders related to pressure ulcer treatment had not been consistently followed.

During an interview with the Administrator on 1/10/19 at 2:31 PM, he indicated he expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician.

Review of the facility Weekly Wound Report revealed Resident #1 did not appear on the report for pressure ulcers until the week of 1/23/19.

Review of Resident #1's skin/wound care plan dated revised 1/30/19 read her left heel wound was described as a stage 3 pressure ulcer. The goal was for Resident #1's wound was to show signs of healing. Interventions included the facility was to provide treatments as ordered.

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During a wound care observation on 3/6/19 at 10:00 AM, the Treatment Nurse provided Resident #1' pressure ulcer treatment to her left heel. There were no observed concerns with her technique or infection control. Resident #1's left heel appeared pale pink in color with white wound edges. There was no odor and evidence of bloody drainage after cleaning the wound with NS. The area was padded dry and Santyl was applied to the wound bed which measured approximately 3 cm by 2 cm by 0.5 cm. The area was covered with a nonadherent dressing and wrapped with gauze. Resident #1's voiced no pain. She was lying on a properly functioning air mattress and her heels were floated above the mattress surface.

During an interview on 3/6/19 at 1:38 PM, the DON validated she worked with Resident #1 on 11/3/18 and 12/7/18 where there was no documented evidence of pressure ulcer care to Resident #1's left heel. She stated she was unable to recall if she did treatments on 11/3/18 and 12/7/18 but if she didn't document, she likely didn't do. The DON stated if she did not complete Resident #1's treatments on 11/3/18 and 12/7/18 it would have been because she didn't have time to do it due to limited staff. When asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered, the DON stated she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.

During an interview on 3/6/19 at 1:48 PM, Nurse #9 verified she worked with Resident #1 on 11/4/18, 11/10/18 and 12/2/18. Nurse #9 stated she was unable to recall if she completed Resident #1's treatment to her left heel on the

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days in question but stated during November 2018 and December 2018, the facility was short staffed, and communication was bad. Nurse #9 stated she was pulled from the medication cart and served as an aide on multiple occasions. She stated the Treatment Nurse was also pulledfrom completing treatments and put on a medication cart and when that happened, each nurse was responsible for completing their own treatments.

During an interview on 3/6/19 at 1:52 PM, Nurse #8 verified she worked with Resident #1 on 12/28/18, 1/1/19, 1/2/19 and 1/8/19. Nurse #8 stated she was unable to recall if she completed Resident #1's treatment to her left heel on the days in question but stated during November 2018, December 2018 and January 2019, she was often pulled from the medication cart to work as an aide due to short staffing. She stated the Treatment Nurse was usually pulled from completing treatments and she was put on a medication cart or worked as an aide too. Nurse #8 stated when the Treatment Nurse was pulled from completing treatments, the nurses were responsible for completing their own treatments.

During an interview on 3/6/19 at 2:00 PM, the Treatment Nurse stated due to staffing she was pulled from completing treatment and either worked on a medication cart or as an aide up until recently. She stated when she was pulled from completing treatments, the nurses were responsible for completing their own treatments.

During an interview on 3/6/19 at 2:10 PM the DON and Treatment Nurse verified Resident #1 was not on the Weekly Wound Report for Pressure Ulcers prior to the week of 1/23/19 therefore, there was no evidence of the facility's

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weekly assessment of her left heel pressure ulcer prior to 1/23/19.

During a telephone interview on 3/6/19 at 2:25 PM, the Hospice Nurse stated there were occasions she knew Resident #1's treatments were not getting done due to staffing. She stated she tried to discuss her concerns with the Treatment Nurse and the floor nurses, but they were not working as aides, so she did not know if management was aware of her concerns. The Hospice Nurse stated Resident #1's left heel wound did worsen to the point it had to be debrided by the wound physician.

During a telephone interview on 3/6/19 at 2:45 PM, the Nurse Practitioner (NP) stated she was aware the facility had experienced staffing issues and the nurses were working as aides. The NP also stated she was aware that the treatment Nurse was unable to perform her duties due to having to work as an aide or on a medication cart. The NP stated the lack of staff contributed to worsening of Resident #1's left heel wound but she could not say that staffing was the sole reason for the wound decline.

During a telephone interview on 3/6/19 at 4:20 PM, the Medical Director stated it was expectation that the necessary care and services were provided to prevent the worsening of Resident #1's pressure ulcer. He stated Resident #1 had several terminal comorbidities that contributed to the worsening of her pressure ulcer but not receiving her treatments as ordered would have also contributed to the wound worsening.

3. Resident #49 was admitted to the facility on 12/6/18 with diagnoses that included

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cerebrovascular disease, major depressive disorder, adjustment disorder with depressed mood, and anxiety disorder.

The admission Minimum Data Set (MDS) assessment dated 12/13/18 indicated Resident #49 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #49 required the extensive assistance of 1 for bed mobility and toileting and 2 or more for transfers. She was frequently incontinent of bladder and always incontinent of bowel.

The Care Area Assessment (CAA) related to urinary incontinence for Resident #49 ' s 12/13/18 admission MDS indicated she was alert, oriented, and able to make decisions and communicate needs. Resident #49 indicated she had a history of incontinence and that she could feel a sensation in her bladder, but it was difficult to hold.

The active care plan for Resident #49 included, in part, the following areas:
- Resident #49 had an Activities of Daily Living (ADL) self-care performance deficit related to mobility, Cerebrovascular Accident (CVA) and impaired balance. The interventions included, in part, assistance with tasks of washing hands, adjusting clothes, and cleaning self in relation to toilet use.
- Resident #49 had altered bladder elimination related to CVA and contractures of the right hand and wrist. Resident #49 was noted to report difficulty holding her urine. The interventions included, in part, bed pan, mechanical lift for transfers, and encourage communication of needs for assistance with toileting.

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A complaint/grievance report dated 1/8/19 communicated by Resident #49 to the Human Resources Coordinator (HRC) indicated that the resident was concerned about how long she waited for her call light to be answered. This form had been reviewed by the SW and was assigned to the DON for investigation.

An interview was conducted with Resident #49 on 1/9/19 at 11:30 AM. The grievance dated 1/8/19 written by the HRC that discussed the resident ' s concern with how long it took for her call light to be answered was reviewed with Resident #49. She stated that in the early morning on 1/8/19 she pressed her call bell because she had to urinate. She indicated it took over 2 hours for her call bell to be answered. She stated she urinated in her brief during that time as she had difficulty holding her urine. She revealed she sat in her brief that was soaked with urine until her call bell was answered by the HRC. She stated the DON then provided her with incontinent care.

A phone interview was conducted with Department of Social Services (DSS) staff by phone on 1/9/19 at 8:09 AM. DSS staff stated she spoke with Resident #49 yesterday, 1/8/19, and the resident told her she sat in a urine-soaked brief for over 2 hours after pressing her call light for assistance.

An interview was conducted with the HRC on 1/9/19 at 2:40 PM. The complaint/grievance report dated 1/8/19 related to Resident #49 was reviewed with the HRC. She stated she was walking the halls on 1/8/19 when she saw Resident #49 ' s call light on, so she entered the room and asked the resident if there was something she could help with. Resident #49

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informed her she had been waiting awhile and needed "cleaned up". She stated that Resident #49 reported that she turned her call light on at 4:45 AM. The HRC estimated it to be around 7:10 AM when she entered the room to answer the call light. She stated there was no obvious odor of urine in the room. She indicated that Resident #49 was visibly upset and was crying when she spoke with her. She said that after speaking to Resident #49 she went to the DON and Administrator to report the information.

An interview was conducted with the DON on 1/9/19 at 2:30 PM. She reported she had provided incontinent care to Resident #49 on 1/8/19 after the HRC reported she answered the resident ' s call light and the resident said her light had been on for over 2 hours. The DON stated that Resident #49 had urinated in her brief. She reported Resident #49 was visibly upset and was tearful when she provided care. The DON indicated she expected call bells to be answered timely.

Based on review of the nursing schedule and DON confirmation on 1/9/19 at 2:45 PM, Nurse #2 and NA #1 were assigned to Resident #49 for the third shift on 1/7/19 beginning at 11:00 PM and ending on 1/8/19 at 7:00 AM.

A phone interview was conducted with Nurse #2 on 1/9/19 at 3:00 PM. He confirmed he was assigned to Resident #49 during the third shift beginning 1/7/19 and ending 1/8/19. He indicated that 2 NAs were working the third shift for the entire building and that NA #1 was assigned to Resident #49. Nurse #2 revealed he recalled Resident #49 ' s call light being on for an extended period of time during the early morning

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on 1/8/19. He was not surprised that it took over 2 hours for Resident #49 ' s call light to be answered. He explained that when there were only 2 NAs working it was difficult for them to answer call lights timely which caused a delay in meeting the residents ' needs.

An interview was conducted with NA #1 on 1/9/19 at 3:15 PM. He confirmed he was assigned to Resident #49 during the third shift beginning 1/7/19 and ending 1/8/19. He stated he was working a double that day beginning on the second shift 1/7/19 and working through the third shift ending 1/8/19. He reported that he was 1 of 2 NAs working the third shift that day and they each had about 30 residents. NA #1 indicated he had not recalled Resident #49 ' s call light being on for an extended period of time during the early morning on 1/8/19, but revealed it was not a surprise to him. He explained that he had difficulty meeting residents ' needs timely when there were only 2 NAs working on the third shift. NA #1 reported that he had informed the DON in the past that it was difficult for him to meet the residents ' needs timely when only 2 NAs were working on the third shift. He stated that this had been going on for months and it had not improved.

During an interview with the Administrator on 1/8/19 at 10:30 AM he stated he began working as the Administrator at this facility in June of 2018. He revealed that the facility had difficulty obtaining and maintaining enough NAs to staff all three shifts since he began as the Administrator. When asked what his definition of sufficient staffing was he stated that sufficient staffing was enough staff both in terms of quality and quantity to meet the needs of the residents.

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During an interview with the Director of Nursing (DON) on 1/9/19 at 3:31 PM she stated she began working as the DON at the facility in June of 2018. She confirmed the Administrator ' s interview related to the facility having difficulty obtaining and maintaining enough NAs to staff all three shifts. She stated that third shift was normally staffed with 2 or 3 NAs. She revealed that one day recently she had to come in to work as an NA on the 3rd shift because 1 of the 2 NAs who were on the schedule called off and she was unable to find anyone else to fill in.

An interview was conducted with the Administrator on 1/9/19 at 10:20 AM. He indicated he spoke with Resident #49 on 1/8/19 after the grievance was reported by the HRC. He stated that Resident #49 reported to him that she had to wait a long time for her call bell to be answered. The Administrator indicated the investigation into this grievance was just beginning. He stated it was unacceptable for a resident to wait over 2 hours for a call bell to be answered.

4a. Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included Multiple Sclerosis (MS) and stage 4 pressure ulcer of the sacral region.

The care plan for Resident #44 included the focus area of skin/wound and identified the continued presence of a Stage 4 pressure ulcer to her sacrum that was acquired prior to her admission. This focus area was initiated on 8/21/18. The interventions included, in part, administer treatments as ordered.

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A physician' s order for Resident #44 dated 10/23/18 indicated Dakin ' s Half Strength (antimicrobial cleanser) cleanse sacral wound with normal saline and pack with Dakin ' s solution, gauze, and cover with dressing twice daily.

The quarterly Minimum Data Set (MDS) assessment dated 11/28/18 indicated Resident #44 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #44 required extensive assistance of 1 staff for bed mobility, dressing, toileting, and personal hygiene. No transfers had no occurred during the MDS look back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel. She had one Stage 4 pressure ulcer that was present on admission. Resident #44 had a pressure reducing device for her bed and chair and she received pressure ulcer care.

A Wound Nurse Practitioner (WNP) note dated 12/6/18 indicated Resident #44 was seen for a follow up visit for a chronic stage 4 pressure ulcer to the sacrum which was being treated with Dakin ' s wet to dry dressings. The wound was noted to have stalled regarding healing secondary to anemia and poor protein supplementation per Resident #44 ' s dietary habits and lack of appropriate iron and protein supplementation. The wound showed no signs or symptoms of infection. The WNP noted to make a repeat advisement to Resident #44 to consider a colostomy because of the persistent wound contamination with stool which was also hindering the wound healing.

The medical record indicated Resident #44 was

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hospitalized for an unrelated condition from 12/12/18 through 12/18/18.

A WNP note dated 12/26/18 indicated Resident #44 continued to have persistent fecal contamination of her wound which was a hindrance to healing. The resident continued to be nonadherent with diet recommendations. She was also noted to be nonadherent to turning and repositioning. The WNPs assessment of the Stage 4 sacral ulcer indicated no signs of improvement nor signs of infection. A recommendation was again made for a colostomy.

A review of Resident #44 ' s hard copy Treatment Administration Record (TAR) for December 2018 related to her Stage 4 sacral ulcer revealed the treatment was not initialed as administered by a nurse per the Physician ' s orders on the following days and shifts: 12/19/18 (2nd shift), 12/21/18 (1st shift), 12/22/28 (2nd shift), 12/28/18 (1st and 2nd shift), 12/29/18 (1st and 2nd shift), and 12/30/18 (1st and 2nd shift), and 12/31/18 (1st shift).

A WNP note dated 1/3/19 indicated Resident #44 continued to have fecal contamination in the wound, nonadherence with diet recommendations, and nonadherence with turning and repositioning. The WNPs assessment of the wound continued to show no healing nor infection. A treatment order change was made for the sacral ulcer from Dakin ' s twice daily to Anasept (antimicrobial gel) wet to dry dressings once daily and as needed if the facility was able to acquire the gel from the pharmacy.

A physician ' s order for Resident #44 dated

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1/3/19 indicated a discontinuation of the current sacral ulcer treatment (Dakin ' s Half Strength cleanse sacral wound with normal saline and pack with Dakin ' s solution, gauze, and cover with dressing twice daily) and initiation of Anasept wet to dry dressing daily and as needed if the facility was able to acquire the gel from the pharmacy.

A review of Resident #44 ' s hard copy TAR for January 2019 from 1/1/19 through 1/8/19 related to her Stage 4 sacral ulcer showed that the 1/3/19 order for Anasept gel once daily and as needed was added to the TAR on 1/3/19 with a notation that read, "when Anasept comes in". The previous order for the Dakin ' s twice daily was to be continued until the Anasept came in. The Treatment Nurse ' s documentation on the TAR indicated that Anasept was received and applied for the first time on 1/9/19. Further review of Resident #44 ' s January 2019 TAR from 1/1/19 through 1/8/19 revealed the treatment was not initialed as administered by a nurse as ordered by the Physician on the following dates and shifts: 1/1/19 (1st and 2nd shift), 1/2/19 (1st and 2nd shift), 1/3/19 (2nd shift), 1/4/19 (2nd shift), 1/5/19 (1st and 2nd shift), 1/6/19 1st and 2nd shift), 1/7/19 (2nd shift), and 1/8/19 (1st and 2nd shift).

An interview was conducted with Resident #44 on 1/7/19 at 12:00 PM. She reported she had a pressure ulcer on her sacrum that developed prior to her admission. She stated that her treatment orders included the changing of her dressing twice daily, once during the first shift (7:00 AM to 3:00 PM) and once during the second shift (3:00 PM to 11:00 PM). She stated that her dressing was not always changed as ordered. She indicated that she believed it was

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normally Nurse #5 who had not changed her dressing as ordered. Resident #44 stated that she was unsure if Nurse #5 just forgot to change the dressing or if she ran out of time during her shift and didn ' t get to it.

An interview was conducted with the Treatment Nurse on 1/8/19 at 10:14 AM. She stated that she had been the Treatment Nurse at the facility since October 2017. She revealed that since June or July of 2018 she was only working in the role of Treatment Nurse once weekly when the WNP came to the facility. She explained the facility had been having difficulty obtaining and maintaining Nursing Assistants (NA). She further explained that due to the lack of NAs on staff, she was normally assigned as an NA and the floor nurses were supposed to complete the treatments.

An observation of wound care that was provided by the Treatment Nurse for Resident #44 ' s sacral pressure ulcer was conducted on 1/9/19 at 11:14 AM. The Treatment Nurse provided the wound care as ordered.

A second interview was conducted with the Treatment Nurse on 1/10/19 at 8:40 AM. The Treatment Nurse revealed she had concerns that treatments were not being provided as ordered to Resident #44 by the floor nurses for over a month. She stated that there were multiple occasions that she had worked on a Friday, changed Resident #44 ' s sacral ulcer dressing, and returned to work the following Monday to find the same dressing on the sacral ulcer that she put in place on Friday. She explained that she dated each of her dressings and this was how she knew it was the same dressing. She further

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revealed that she provided treatment to Resident #44 ' s sacral ulcer on 1/7/19 with Dakin ' s during the first shift and that when she provided the treatment to her sacral ulcer today (1/9/19) the same dressing from 1/7/19 was in place.

This interview, conducted on 1/10/19 at 8:40 AM, with the Treatment Nurse continued. She stated that Resident #44 ' s sacral ulcer was easily contaminated by stool and that inconsistent dressing changes could have a negative impact on the wound healing. She stated that Resident #44 ' s sacral ulcer ' s healing had stalled and remained stable. She indicated the WNP made a change to Resident #44 ' s sacral ulcer treatment on 1/3/19 to discontinue Dakin ' s twice daily and start Anasept wet to dry dressings once daily and as needed. She indicated the Anasept took several days to obtain pharmacy approval for and they just received the medication on 1/9/19. She reported that the Dakin ' s twice daily was supposed to be continued until the Anasept was received, but this had not occurred. The Treatment Nurse stated that she informed the Director of Nursing (DON) of this issue with treatments not consistently being provided as ordered. She was unable to recall when she first informed the DON of this concern.

A phone interview was conducted with Nurse #5 on 1/10/19 at 10:17 AM. Nurse #5 was assigned to Resident #44 on 9 instances (12/22/19 2nd shift, 12/28/19 2nd shift, 12/29/18 2nd shift, 12/30/18 2nd shift, 1/2/19 2nd shift, 1/4/19 2nd shift, 1/5/19 2nd shift, 1/6/19 2nd shift, 1/8/19 2nd shift) when her sacral ulcer treatment was not documented as provided as ordered. She stated that she was responsible for providing treatments to her assigned residents. She was asked if she

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provided wound care treatment to Resident #44 ' s sacral ulcer when she was assigned to her. She stated that she normally worked with Resident #44 on the second shift (3:00 PM to 11:00 PM) and her wound care for the sacral ulcer was provided on the first shift. She revealed that she changed the resident ' s dressing if needed in the evening or if incontinent care was required. Nurse #5 revealed she was unaware Resident #44 ' s previous treatment order for Dakin ' s was supposed to be provided twice daily. She additionally stated that she was unaware that the treatment order for Dakin ' s was supposed to continue until the Anasept gel from the 1/3/19 treatment order was received at the facility.

An interview was conducted with Nurse #3 on 1/10/19 at 11:39 AM. Nurse #3 was assigned to Resident #44 on 4 instances (12/29/18 1st shift, 12/31/18 1st shift, 1/2/19 1st shift, and 1/8/19 1st shift) when her sacral ulcer treatment was not documented as provided as ordered. She stated that she was responsible for providing wound care treatment to Resident #44 when she was assigned to her. She explained that the facility had a Treatment Nurse on staff, but that for the past several months the Treatment Nurse had been assigned as an NA on the floor and had not been providing treatments unless the WNP was in the facility. Resident #44 ' s TARs were reviewed with Nurse #3. She stated that if she had completed Resident #44 ' s treatment she would have marked it on the TAR as completed. She revealed that sometimes there were things that got missed. She explained that some days she worked as a Nurse and sometimes she was assigned as an NA.

A phone interview was attempted with Nurse #11

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on 1/10/19 at 10:18 AM. She was unable to be reached for an interview.

An interview was conducted with the WNP on 1/10/19 at 9:15 AM. She stated that she came to the facility once per week for wound assessments. She indicated that Resident #44 had a large Stage 4 sacral ulcer that was present on her admission to the facility. She reported that the sacral ulcer was easily contaminated by stool due to its location and the resident ' s bowel incontinence. The WNP indicated that Resident #44 ' s wound had been stable, with no signs of improvement and no signs of infection. She verified her notes that reported on Resident #44 ' s nonadherence to diet recommendations and turning/repositioning recommendations. She discussed Resident #44 ' s previous sacral ulcer treatment order for Dakin ' s twice daily (initiated 10/23/18). She reported that Dakin ' s had a 12-hour half-life, meaning that if the Dakin ' s was not reapplied every 12 hours its effect was gone. Stated that she expected for treatments to be provided as ordered. She added that due to the location of Resident #44 ' s sacral ulcer, it was pertinent that treatments were provided as ordered and the dressing was regularly changed to reduce the risk of infection.

An interview was conducted with the DON on 1/10/19 at 2:31 PM. She indicated she expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician. She acknowledged that Resident #44 ' s care plan interventions and physician ' s orders related to pressure ulcer treatment had not been consistently followed. The DON was asked who was responsible for monitoring the TARs to

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ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.
An interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He indicated he expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician.

4b. Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included neurogenic bladder, chronic urinary retention, and personal history of Urinary Tract Infections (UTIs).

The care plan for Resident #44, initiated on 8/31/18, included the focus area of the risk for altered bladder elimination related neurogenic bladder, suprapubic catheter, chronic urinary retention, and recurrent UTIs. The interventions included, in part, suprapubic catheter care as ordered by the physician.

A physician ' s order dated 8/30/18 indicated cleanse Resident #44 ' s suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily.

The quarterly Minimum Data Set (MDS) assessment dated 11/28/18 indicated Resident #44 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #44 required extensive assistance of 1 staff for bed mobility, dressing, toileting, and personal hygiene. No transfers had occurred during the MDS look

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WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

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back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel.

The physician ' s order dated 8/30/18 to cleanse Resident #44 ' s suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily remained an active order.

A physician ' s order dated 12/27/18 repeated the same order that was initiated on 8/30/18 to cleanse Resident #44 ' s suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily.

A review of Resident #44 ' s hard copy Treatment Administration Record (TAR) and Medication Administration Record (MAR) for December 2018 was conducted and revealed the physician ' s order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on the following dates: 12/19/18, 12/20/18, 12/21/18, 12/27/18, 12/28/18, 12/30/18, and 12/31/18.

A review of Resident #44 ' s hard copy TAR and MAR for January 2019 from 1/1/19 through 1/8/19 was conducted and revealed the physician ' s order related to cleansing of the suprapubic catheter once daily (first shift) was not documented as provided as ordered on 1/1/19 through 1/8/19.

An interview was conducted with Resident #44 on 1/7/19 at 12:00 PM. She reported she had a suprapubic catheter. She stated that her treatment orders, including irrigation and cleansing, were not always provided as ordered.

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Resident #44 stated that she was unsure if the nurses just forgot to provide the treatments or if they ran out of time during the shifts and didn ' t get to it. She indicated that she often had a lot of sedimentation which required regular irrigation to be completed.

An interview was conducted with Nurse #3 on 1/10/19 at 11:39 AM. Nurse #3 was assigned to Resident #44 on 8 instances (12/19/18, 12/27/18, 12/31/18, 1/2/19, 1/3/19, 1/4/19, 1/7/19, and 1/8/19) when cleansing of the catheter site was not documented as provided as ordered. She stated that she was responsible for providing catheter care as ordered to Resident #44 when she was assigned to her. Resident #44 ' s TARs and MARs were reviewed with Nurse #3. She stated that if she had completed Resident #44 ' s treatment she would have marked it complete on the TAR or the MAR (as applicable). She revealed that sometimes there were things that got missed. She explained that some days she worked as a Nurse and sometimes she was assigned as an NA due to the facility ' s difficulty obtaining and maintaining enough NAs to staff all three shifts. Nurse #3 also shared that the reason the order for the catheter irrigation was on both the December 2018 TAR for the 1st shift and the MAR for the 2nd shift was because it had been identified that the irrigation was not always provided as ordered for Resident #44 so they put it down for both shifts to ensure it was completed by 1 of the 2 shifts.

An interview was conducted with the Nurse Practitioner (NP) on 1/10/19 at 12:05 PM. She stated that Resident #44 had a very complicated medical history. She reported she had suprapubic catheter and a long history of chronic

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UTIs. She indicated Resident #44 was chronically positive for UTIs and that she had a tendency to become septic rapidly. She stated that she expected her orders to be followed related to catheter care and revealed she was unaware that the orders were inconsistently implemented. The NP expressed that she believed no negative consequences occurred for Resident #44 related to the inconsistent provision of her catheter care orders.

An interview was conducted with the DON on 1/10/19 at 2:31 PM. She stated she expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician. She acknowledged that Resident #44 ' s care plan interventions and physician ' s orders related to urinary catheter care had not been consistently followed. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.

An interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He indicated he expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician.

4c. Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included neurogenic bladder, chronic urinary retention, and personal history of Urinary Tract Infections (UTIs).

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The care plan for Resident #44, initiated on 8/31/18, included the focus area of the risk for altered bladder elimination related neurogenic bladder, suprapubic catheter, chronic urinary retention, and recurrent UTIs. The interventions included, in part, suprapubic catheter care as ordered by the physician.

A Nurse Practitioner (NP) note dated 12/4/18 indicated Resident #44 had her catheter irrigated on this date and the nurse reported the presence of a large amount of sediment that was flushed clear. The NP indicated a plan to flush the suprapubic catheter twice weekly and as needed for increased sedimentation.

A physician ' s order dated 12/4/18 for Resident #44 indicated irrigation to suprapubic catheter twice weekly (Tuesday and Friday) and as needed for increased sedimentation.

A review of Resident #44 ' s hard copy Treatment Administration Record (TAR) and Medication Administration Record (MAR) for December 2018 was conducted and revealed the physician ' s order for irrigation of the catheter was placed on the TAR for the 1st shift staff on Tuesdays and Fridays and also was placed on MAR for the 2nd shift on Tuesdays and Fridays. This order for irrigation of the catheter was not documented as completed on the MAR or TAR on 12/21/18 or 12/28/18.

A phone interview was conducted with Nurse #5 on 1/10/19 at 10:17 AM. Nurse #5 was assigned to Resident #44 on 12/21/18 and 12/28/18 when irrigation of the catheter was not documentation provided as ordered. She was asked if she

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F 600	Continued From page 77 provided catheter care for Resident #44 when she was assigned to her. She initially stated that she had not provided catheter care to Resident #44 as it was normally provided by the first shift. She then stated that she may have provided catheter care if the first shift staff had not gotten to it. Nurse #5 was unable to recall if she had irrigated Resident #44 ' s catheter. She revealed that there were times that things got really "hectic" and she couldn ' t get to everything. An interview was conducted with the DON on 1/10/19 at 2:31 PM. She stated she expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician. She acknowledged that Resident #44 ' s care plan interventions and physician ' s orders related to urinary catheter care had not been consistently followed. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs. An interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He indicated he expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician.	F 600		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 636		4/3/19

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reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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F 636	Continued From page 79 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a comprehensive assessment which included a review of the resident's Cognitive Pattern (Section C) and Mood (Section D) on the Minimum Data Set (MDS) for 2 (Resident #1 and Resident #4) of 20 sampled residents reviewed for completed MDS assessments. The findings included: 1. Resident #1 was admitted 10/3/18 with cumulative diagnoses of Cirrhosis and Depression. Review of Resident #1's admission MDS dated 10/10/18 revealed that the Cognitive Pattern assessment (Section C) and the Mood (Section D) assessment was not completed. In an interview on 1/10/19 at 11:40 AM, the MDS Coordinator stated she was aware of the incomplete admission MDS assessment dated	F 636	F636- Comprehensive Assessments & Timing 1. The Minimum Data Set (MDS) Coordinator completed, and transmitted a quarterly assessment for Resident # 1 (1/8/19) and, Resident # 4 (on 1/10/19) to reflect the each resident's current condition. 2. The DON and or Regional MDS Coordinator completed quality audit (audits) of current residents' MDS, Section C and D to determine completion by 3/1/2019. There were no additional negative findings in the audit. 3. The Regional MDS Coordinator re-educated the MDS Coordinator and Interdisciplinary Team on the proper timing and completion of the MDS to include section C and D on 3-14-19.	

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F 636	Continued From page 80 10/10/18 for Resident #1. She stated this occurred at the time when the previous Social Worker (SW) resigned. The MDS Coordinator stated it was the responsibility of the SW to complete Section C and D of the MDS. She stated the MDS consultant assisted her with the completion of Resident #1's MDS and she thought the MDS regulations changed in October 2018 and therefore could not be modified once the omission was identified. In an interview on 1/10/19 at 2:30 PM, the Administrator stated it was his expectation that Resident #1's admission MDS dated 10/10/18 would have included a comprehensive assessment in the Section C and Section D of the MDS. 2. Resident #4 was admitted 10/1/18 with cumulative diagnose of Cerebral Vascular Accident and dysphagia. Review of Resident #4's admission MDS dated 10/8/18 revealed that the Cognitive Pattern assessment (Section C) and the Mood (Section D) assessment was not completed. In an interview on 1/10/19 at 11:40 AM, the MDS Coordinator stated she was aware of the incomplete admission MDS assessment dated 10/8/18 for Resident #4. She stated this occurred at the time when the previous Social Worker (SW) resigned. The MDS Coordinator stated it was the responsibility of the SW to complete Section C and D of the MDS. She stated the MDS consultant assisted her with the completion of Resident #4's MDS and she thought the MDS regulations changed in October 2018 and therefore could not be modified once the	F 636	4. DON and or Regional MDS Coordinator will conduct audits of 5 residents of all sections, of 2 Admission MDS 3 times per week for 4 weeks, then weekly for 3 months, to ensure proper timing and completion of MDS. The DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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F 636	Continued From page 81 omission was identified. In an interview on 1/10/19 at 2:30 PM, the Administrator stated it was his expectation that Resident #4's admission MDS dated 10/8/18 would have included a comprehensive assessment in the Section C and Section D of the MDS.	F 636		
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 observations, record review and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessment in the area of activities of daily living for 1 of 2 (Resident #3) residents reviewed for accidents. Findings included: Resident #3 was admitted to the facility on 7/26/15 with diagnoses, in part, of contractures of bilat knees. Review of the quarterly MDS assessment dated 10/2/18 revealed Resident #3 had severely impaired cognition. The resident was non-ambulatory. Section G (functional ability) indicated the resident required total assistance with 1 person for transfers. Review of the care plan for activities of daily living revealed Resident #3 required a lift for transfers.	F 641	F641- Accuracy of Assessments 1. On 1/9/2019 MDS Coordinator modified and transmitted Resident # 3□s MDS to reflect the resident□s current condition. 2. On 2/06/2019 the Divisional MDS Coordinator completed an MDS quality review of residents requiring assistance with transfers to ensure accuracy in the area of Activities of Daily Living (ADL)□s. No additional negative findings were identified. 3. On 1/31/2019 the Divisional MDS provided re-education to the facility MDS Coordinator on the proper completion of MDS in the area of ADL□s to ensure accuracy. 4. DCS and or Regional MDS Coordinator will conduct random quality monitoring (audit) of MDS□ of patient	

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F 641	Continued From page 82 Review of the activities of daily living report for the look back period of 9/26/18 to 10/2/18 revealed Resident #3 required total assistance with 2 people. Observation of Resident #3 being transferred on 1/9/19 at 11:44 AM revealed mechanical lift being used to transfer resident back to bed from her wheelchair. An interview on 1/9/19 at 11:44 AM with NA #1 revealed she was new to the facility but knew Resident #3 required a mechanical lift to transfer from the Kardex and report from other nursing assistants. She revealed she would never attempt to transfer Resident #3 without a lift for her and the resident ' s safety. An interview on 1/9/19 at 10:00 AM with the MDS nurse revealed she knew Resident #3 required a lift for transfer, but coded it wrong on the assessment. An interview on 1/9/19 at 12:03 PM with NA #2 revealed he was familiar with Resident #3 and knew she required a mechanical lift. He stated that information was found on the Kardex. An interview on 1/10/19 at 10:29 AM with the Administrator revealed his expectation was that the MDS be completed accurately and timely.	F 641	ADL□s to ensure accuracy, 3 times per week for 4 weeks, then weekly for 3 months. The DCS will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 2/20/2019. .	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		4/3/19

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care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 84 Based on record review, resident interview, and staff interview, the facility failed to implement the care plan interventions related to pressure ulcer care (Residents #36, #1, and #44), urinary catheter care (Resident #44), and antipsychotic medication (Resident #50) for 5 of 20 sampled residents. The findings included: 1. Resident #36 was admitted to the facility on 10/1/18 with the diagnoses of Parkinson's, neuropathy, diabetes, and unstageable pressure ulcer of the right heel. A review of the resident ' s admission Minimum Data Set (MDS) dated 10/8/18 revealed the resident had an intact cognition. The resident had one unstageable pressure ulcer on the side of the right heel. A review of the resident ' s care plan dated 10/1/18 revealed an intervention to provide pressure ulcer care as ordered. A review of the physician order dated 10/1/18 revealed a treatment order for the right side of the heel that read "cleanse with normal saline, pat dry, apply antibiotic ointment, and cover with dry sterile dressing each day." A review of the resident ' s October 2018 treatment administration record (TAR) for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care on 10/6-8, 10/13-14, 10/17-18, 10/20-21, and 10/27-28. A review of the resident ' s November 2018 TAR	F 656	F656- Develop/Implement Comprehensive Care Plan 1. Resident #36 no longer resides at the facility. The Director of Nursing reviewed the Care Plans for Residents #1, #44 and #50 on 3-22-19 and validated the interventions are in place as outlined in the Care Plan for pressure ulcers, antipsychotic medications and urinary catheter. 2. The Director of Nursing and the MDS Coordinator will complete an audit of all Residents with Pressure Ulcers, urinary catheters and antipsychotic medications to validate a Care Plan is in place that reflects current interventions for Pressure Ulcers, urinary catheters and Dialysis is in place. The Director of Nursing and the MDS Coordinator will observe all Residents with Pressure Ulcers, urinary catheters and antipsychotic to validate Care Planned interventions are in place. This audit will be completed by 3-25-19. The results of this audit indicated all interventions were noted to be in place per plan of care 3. The DON, RDCS or ED will re-educate all Nursing Staff including those working on the weekends and as needed by 3-27-19 related to following the Resident Care Plans for Pressure Ulcers, urinary catheters and antipsychotic medications including completion and implementation of all care planned interventions. The DON will randomly observe 5 Residents and review their Care Plans weekly for 12 weeks to validate care plans are being followed and interventions are	

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F 656	Continued From page 85 for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care on 11/15-16, 11/23-25, and 11/20. A review of the resident ' s December 2018 TAR for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care on 12/1-2, 12/5, 12/7, 12/15-17, 12/21-23, 12/25, and 12/28-31. A review of the January 2019 TAR for dressing change of the right heel pressure ulcer revealed the dressing was documented as being done on 1/1, 1/4 and 1/8. An interview was conducted with the Director of Nursing (DON) on 1/10/19 at 2:31 PM. She indicated she expected care plan interventions to be consistently implemented. She acknowledged that Resident #36's care plan interventions related to following the physician's orders for daily pressure ulcer care had not been consistently implemented. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs. An interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He indicated he expected the necessary care and services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician. 2. Resident #1 was admitted to the facility 10/3/18 with cumulative diagnoses of Cirrhosis and a history of a Deep Vein Thrombosis.	F 656	implemented for Pressure Ulcers, urinary catheters and antipsychotic medications. Opportunities will be corrected daily by the Director of Nursing as identified during these audits. 4. The DON will conduct quality monitoring (audit) and observe 5 Residents and review their Care Plans weekly for 12 weeks to validate care plans are being followed and interventions are implemented for Pressure Ulcers, urinary catheters and antipsychotic medications. Opportunities will be corrected daily by the Director of Nursing as identified during these audits. The DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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Review of Resident #1's admission Minimum Data Set(MDS) dated 10/10/18 revealed that the Cognitive Pattern assessment (Section C) and the Mood (Section D) assessment was not completed. She was coded total staff assistance with bed mobility, toileting and personal hygiene. Resident #1 was coded as non-ambulatory and incontinent of bladder and bowel. She was coded for one stage 2 pressure ulcer and one Suspected Deep Tissue Injury (SDTI) both present on admission. Interventions included a pressure reducing mattress to her bed and pressure ulcer care. Resident #1 was coded for a prognosis of less than 6 months and for Hospice Services.

Review of Resident #1's Care Area Assessment dated 10/10/18 for pressure ulcers read she was a Hospice resident and she was admitted with a SDTI and she was dependent of the staff for her activities of daily living.

Review of Resident #1's skin/wound care plan dated initiated 10/17/18 read she had a SDTI to her left heel on 10/17/18. The goal was for Resident #1's wound was to show signs of healing. Interventions included the facility was to provide treatments as ordered.

Review of a Hospice note dated 10/31/18 read there was new orders for paint Resident #1's left heel wound with Betadine, cover the wound with a nonadherent dressing and wrap with a gauze dressing daily. The note indicated the new wound care orders was discussed with the Treatment Nurse at the facility.

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Review of the facility November 2018 Treatment Administration Record (TAR) revealed no documented evidence of Resident #1's daily treatment to her left heel on 11/2/18, 11/3/18,11/4/18, 11/10/18, 11/13/18, 11/16/18, 11/21/18, 11/22/18 11/24/18 and 11/26/18.

Review of the facility December 2018 TAR revealed no documented evidence of Resident #1's daily treatment to her left heel on 12/2/18, 12/7/18, 12/11/18 12/19/18, 12/25/18, 12/28/18 and 12/29/18.

Review of the facility January 2019 TAR revealed no documented evidence of Resident #1's daily treatment to her left heel on 1/1/19, 1/2/19, 1/4/19 and 1/8/19.

During an interview on 1/8/19 at 10:14 AM, the Treatment Nurse stated that she had been the Treatment Nurse at the facility since October 2017. She revealed that prior to sometime around July of August 2018, the facility began having difficulty obtaining and maintaining Nursing Assistants (NA). She further explained at that time due to the lack of NAs on staff, she was normally assigned as an NA and the floor nurses were supposed to complete the treatments.

During another interview on 1/10/19 at 8:40 AM, the Treatment Nurse revealed she had concerns that treatments were not being provided as ordered to Resident #1 by the floor nurses for

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over a month.

During an interview with the Director of Nursing (DON) on 1/10/19 at 2:31 PM, she indicated she expected care plan interventions to be consistently implemented. She acknowledged that Resident #1's care plan interventions related to following the physician's orders for pressure ulcer treatment had not been consistently followed. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.

During an interview with the Administrator on 1/10/19 at 2:31 PM, he indicated he expected care plan interventions to be consistently implemented.

During an interview on 3/6/19 at 1:38 PM, the Director of Nursing (DON) validated she worked with Resident #1 on 11/3/18 and 12/7/18 where there was no documented evidence of pressure ulcer care to Resident #1's left heel. She stated she was unable to recall if she did treatments on 11/3/18 and 12/7/18 but if she didn't document, she likely didn't do.

During an interview on 3/6/19 at 1:48 PM, Nurse #9 verified she worked with Resident #1 on 11/4/18, 11/10/18 and 12/2/18. Nurse #9 stated she was unable to recall if she completed Resident #1's treatment to her left heel on the days in question.

During an interview on 3/6/19 at 1:52 PM, Nurse

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#8 verified she worked with Resident #1 on 12/28/18, 1/1/19, 1/2/19 and 1/8/19. Nurse #8 stated she was unable to recall if she completed Resident #1's treatment to her left heel on the days in question but stated during November 2018, December 2018 and January 2019, she was often pulled from the medication cart to work as an aide due to short staffing.

3a. Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included Multiple Sclerosis (MS) and stage 4 pressure ulcer of sacral region.

The care plan for Resident #44, initiated on 8/21/18, included the focus area of skin/wound and identified the continued presence of a Stage 4 pressure ulcer to her sacrum that was acquired prior to her admission. The interventions included, in part, administer treatments as ordered.

A physician's order for Resident #44 dated 10/23/18 indicated Dakin's Half Strength (antimicrobial cleanser) cleanse sacral wound with normal saline and pack with Dakin's solution, gauze, and cover with dressing twice daily.

The quarterly Minimum Data Set (MDS) assessment dated 11/28/18 indicated Resident #44's cognition was fully intact. She had no behaviors and no rejection of care. Resident #44 required extensive assistance of 1 staff for bed mobility, dressing, toileting, and personal hygiene.

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No transfers had no occurred during the MDS look back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel. She had one Stage 4 pressure ulcer that was present on admission. Resident #44 had a pressure reducing device for her bed and chair and she received pressure ulcer care.

A review of Resident #44's hard copy Treatment Administration Record (TAR) for December 2018 related to her Stage 4 sacral ulcer indicated the treatment was not administered as ordered on 12/19/18 (2nd shift), 12/21/18 (1st shift), 12/22/28 (2nd shift), 12/28/18 (1st and 2nd shift), 12/29/18 (1st and 2nd shift), and 12/30/18 (1st and 2nd shift), and 12/31/18 (1st shift).

A physician's order for Resident #44 dated 1/3/19 indicated a discontinuation of the current sacral ulcer treatment (Dakin's Half Strength cleanse sacral wound with normal saline and pack with Dakin's solution, gauze, and cover with dressing twice daily) and initiation of Anisept wet to dry dressing daily and as needed if the facility was able to acquire the gel from the pharmacy.

A review of Resident #44's hard copy TAR for January 2019 from 1/1/19 through 1/8/19 related to her Stage 4 sacral ulcer indicated her treatments had not been administered as ordered. This TAR showed that the 1/3/19 order for Anasept gel once daily and as needed was added to the TAR on 1/3/19 with a notation that read, "when Anasept comes in". The previous order for the Dakin's twice daily was to be continued until the Anasept came in. The Treatment Nurse's documentation on the TAR indicated that Anasept was received and applied for the first time on 1/9/19. This TAR review

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revealed the following dates and shifts the pressure ulcer treatment was not provided to Resident #44 as ordered: 1/1/19 (1st and 2nd shift), 1/2/19 (1st and 2nd shift), 1/3/19 (2nd shift), 1/4/19 (2nd shift), 1/5/19 (1st and 2nd shift), 1/6/19 1st and 2nd shift), 1/7/19 (2nd shift), and 1/8/19 (1st and 2nd shift).

An interview was conducted with Resident #44 on 1/7/19 at 12:00 PM. She reported she had a pressure ulcer on her sacrum that developed prior to her admission. She stated that her treatment orders included the changing of her dressing twice daily, once during the first shift (7:00 AM to 3:00 PM) and once during the second shift (3:00 PM to 11:00 PM). She stated that her dressing was not always changed as ordered. She indicated that she believed it was normally Nurse #5 who had not changed her dressing as ordered. Resident #44 stated that she was unsure if Nurse #5 just forgot to change the dressing or if she ran out of time during her shift and didn't get to it.

An interview was conducted with the Treatment Nurse on 1/8/19 at 10:14 AM. She stated that she had been the Treatment Nurse at the facility since October 2017. She revealed that since June or July of 2018 she was only working in the role of Treatment Nurse once weekly when the Wound Nurse Practitioner came to the facility. She explained the facility had been having difficulty obtaining and maintaining Nursing Assistants (NA). She further explained that due to the lack of NAs on staff, she was normally assigned as an NA and the floor nurses were supposed to complete the treatments. The Treatment Nurse confirmed Resident #44's

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interview that the treatment for her sacral pressure ulcer was not consistently provided as ordered. The Treatment Nurse revealed that there were multiple occasions that she had worked on a Friday, changed Resident #44's sacral ulcer dressing, and returned to work the following Monday to find the same dressing on the sacral ulcer that she put in place on Friday. She explained that she dated each of her dressings and this was how she knew it was the same dressing. The Treatment Nurse indicated the Wound Nurse Practitioner (WNP) made a change to Resident #44's sacral ulcer treatment on 1/3/19 to discontinue Dakin's twice daily and start Anasept wet to dry dressings once daily and as needed. She indicated the Anasept took several days to obtain pharmacy approval for and they just received the medication on 1/9/19. She reported that the Dakin's twice daily was supposed to be continued until the Anasept was received, but this had not occurred.

A phone interview was conducted with Nurse #5 on 1/10/19 at 10:17 AM. Nurse #5 was assigned to Resident #44 on 9 instances when her sacral ulcer treatment was not provided as ordered. She was asked if she provided wound care treatment to Resident #44's sacral ulcer when she was assigned to her. Nurse #5 stated that Resident #44's wound care for the sacral ulcer was normally provided on the first shift. She revealed that she changed the resident's dressing if needed in the evening or if incontinent care was required. Nurse #5 revealed she was unaware Resident #44's previous treatment order for Dakin's was supposed to be provided twice daily. She additionally stated that she was unaware that the treatment order for Dakin's was supposed to continue until the Anasept gel from the 1/3/19

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treatment order was received at the facility.

An interview was conducted with Nurse #3 on 1/10/19 at 11:39 AM. Nurse #3 was assigned to Resident #44 on 4 instances when her sacral ulcer treatment was not provided as ordered. She stated that she was responsible for providing wound care treatment to Resident #44 when she was assigned to her. She explained that the facility had a Treatment Nurse on staff, but that for the past several months the Treatment Nurse had been assigned as an NA on the floor and had not been providing treatments unless the WNP was in the facility. Resident #44's TARs were reviewed with Nurse #3. She stated that if she had completed Resident #44's treatment she would have marked it on the TAR as completed. She revealed that sometimes there were things that got missed. She explained that some days she worked as a Nurse and sometimes she was assigned as an NA. She further explained that things got very hectic at times and she was "exhausted".

A phone interview was attempted with Nurse #11 on 1/10/19 at 10:18 AM. She was unable to be reached for interview.

An interview was conducted with the Director of Nursing (DON) on 1/10/19 at 2:31 PM. She indicated she expected care plan interventions to be consistently implemented. She acknowledged that Resident #44's care plan interventions related to following the physician's orders for pressure ulcer treatment had not been consistently followed. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been

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monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.
An interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He indicated he expected care plan interventions to be consistently implemented.

3b. Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included neurogenic bladder, chronic urinary retention, and personal history of Urinary Tract Infections (UTIs).

A physician's order dated 8/30/18 indicated cleanse Resident #44's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily.

The care plan for Resident #44, initiated on 8/31/18, included the focus area of the risk for altered bladder elimination related neurogenic bladder, suprapubic catheter, chronic urinary retention, and recurrent UTIs. The interventions included, in part, suprapubic catheter care as ordered by the physician.

The quarterly Minimum Data Set (MDS) assessment dated 11/28/18 indicated Resident #44's cognition was fully intact. She had no behaviors and no rejection of care. Resident #44 required extensive assistance of 1 staff for bed mobility, dressing, toileting, and personal hygiene. No transfers had occurred during the MDS look back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel.

A physician's order dated 12/4/18 for Resident

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#44 indicated irrigation to suprapubic catheter twice weekly (Tuesday and Friday) and as needed for increased sedimentation. The physician's order dated 8/30/18 to cleanse Resident #44's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily remained an active order.

The care plan related to Resident #44's suprapubic catheter was updated on 12/4/18 with the intervention of irrigation twice weekly and as need for increased sedimentation.

A physician's order dated 12/27/18 repeated the same order that was initiated on 8/30/18 to cleanse Resident #44's suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily.

A review of Resident #44's hard copy Treatment Administration Record (TAR) and Medication Administration Record (MAR) for December 2018 was conducted and revealed the physician's order related to cleansing of the suprapubic catheter once daily (first shift) was not provided as ordered on 12/19/18, 12/20/18, 12/21/18, 12/27/18, 12/28/18, 12/30/18, and 12/31/18. The order for irrigation of the catheter was placed on the TAR for the 1st shift staff on Tuesdays and Fridays and also was placed on MAR for the 2nd shift on Tuesdays and Fridays. This order for irrigation of the catheter was not provided as ordered on 12/21/18 and 12/28/18.

A review of Resident #44's hard copy TAR and MAR for January 2019 from 1/1/19 through 1/8/19 was conducted and revealed the physician's order related to cleansing of the suprapubic

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catheter once daily (first shift) was not provided as ordered from 1/1/19 through 1/8/19.

An interview was conducted with Resident #44 on 1/7/19 at 12:00 PM. She reported she had a suprapubic catheter.

She stated that her treatment orders, including irrigation and cleansing, were not always provided as ordered.

Resident #44 stated that she was unsure if the nurses just forgot to provide the treatments or if they ran out of time during the shifts and didn't get to it. She indicated that she often had a lot of sedimentation which required regular irrigation to be completed.

A phone interview was conducted with Nurse #5 on 1/10/19 at 10:17 AM. Nurse #5 was assigned to Resident #44 on 2 instances when irrigation of the catheter was not provided as ordered. She was asked if she provided catheter care for Resident #44 when she was assigned to her. She initially stated that she had not provided catheter care to Resident #44 as it was normally provided by the first shift. She then stated that she may have provided catheter care if the first shift staff had not gotten to it. Nurse #5 was unable to recall if she had irrigated Resident #44's catheter. She revealed that there were times that things got really "hectic" and she couldn't get to everything.

An interview was conducted with Nurse #3 on 1/10/19 at 11:39 AM. Nurse #3 was assigned to Resident #44 on 8 instances when cleansing of the catheter site was not provided as ordered. She stated that she was responsible for providing

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catheter care as ordered to Resident #44 when she was assigned to her. Resident #44's TARs and MARs were reviewed with Nurse #3. She stated that if she had completed Resident #44's treatment she would have marked it complete on the TAR or the MAR (as applicable). She revealed that sometimes there were things that got missed. She explained that some days she worked as a Nurse and sometimes she was assigned as an NA due to the facility's difficulty obtaining and maintaining enough NAs to staff all three shifts. She further explained that things got very busy at times and she was "exhausted". Nurse #3 also shared that the reason the order for the catheter irrigation was on both the December 2018 TAR for the 1st shift and the MAR for the 2nd shift was because it had been identified that the irrigation was not always provided as ordered for Resident #44 so they put it down for both shifts to ensure it was completed by 1 of the 2 shifts.

An interview was conducted with the Director of Nursing (DON)on 1/10/19 at 2:31 PM. She indicated she expected care plan interventions to be consistently implemented. She acknowledged that Resident #44's care plan interventions related to following the physician's orders for suprapubic catheter care had not been consistently implemented. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.
An interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He indicated he expected the necessary care and

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services to be provided to residents as indicated in their comprehensive care plan and as ordered by the physician.

4. Resident #50 was admitted to the facility on 12/11/18 with diagnoses that included mood disorder, Alzheimer's, dementia with behavioral disturbance, and psychosis.

A physician's order dated 12/11/18 indicated Seroquel (antipsychotic medication) 100 milligrams (mg) once daily at bedtime.

The Admission Minimum Data Set (MDS) assessment dated 12/18/18 indicated Resident #50's cognition was severely impaired. She had no behaviors and no rejection of care. Resident #50 was administered antipsychotic medication on 7 of 7 days during the MDS review period.

Resident #50's comprehensive care plan, last reviewed 12/27/18, indicated the focus area of antipsychotic medication for diagnoses of mood disorder and psychosis. She was noted to be easily angered. The interventions included, in part, monitor behavioral symptoms and side effects related to the antipsychotic medication.

A review of the December 2018 Medication Administration Record (MAR) for Resident #50 indicated she received Seroquel 100 mg once daily as ordered.

A review was conducted of the December 2018 Behavior/Intervention Monthly Flow Record related to Resident #50's Seroquel. The form had no staff documentation of behaviors or side effect monitoring. It was completely blank except for the documentation of Resident #50's name,

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the month (December 2018), and the medication (Seroquel 100 mg).

A review of the January 2019 MAR from 1/1/19 through 1/8/19 indicated Resident #50 was administered Seroquel as ordered.

There was no Behavior/Intervention Monthly Flow Record for January 2019 for Resident #50 in the medical record.

During an interview with Medical Records staff on 1/9/19 at 11:30 AM he verified there was no January 2019 Behavior/Intervention Monthly Flow Record for Resident #50.

An interview was conducted with Nurse #3 on 1/9/19 at 12:05 PM. She stated that all MARs were completed on hard copy forms. She indicated that behaviors and side effect monitoring related to psychotropic medications were documented on the hard copy Behavior/Intervention Monthly Flow Record that was kept in the same binder with the MARs. Nurse #3 confirmed Resident #50's December 2018 Behavior/Intervention Monthly Flow Record had no documentation related to behavior monitoring or side effect monitoring. Nurse #3 additionally confirmed there was not a January 2019 Behavior/Intervention Monthly Flow Record for Resident #50. She revealed that Medical Records staff just brought out a "stack" of blank Behavior/Intervention Monthly Flow Record forms as it had been identified today (1/9/19) that several residents had not had this form in their chart for January 2019. She was asked who was responsible for ensuring the Behavior/Intervention Monthly Flow Records were in the charts and were completed. She indicated that the third shift

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F 656	Continued From page 100 nurses completed the monthly changeover at the end of each month and they were also responsible for placing the form in the chart. She additionally indicated that all nursing staff who administered medications were ultimately responsible for ensuring the Behavior/Intervention Monthly Flow Record was in the chart and was completed. Nurse #3 revealed she had not realized that this form for January 2019 was not in Resident #50's chart until Medical Records staff requested a copy of the form this morning (1/9/19). She was unable to explain why the December 2018 form for Resident #50 was incomplete. An interview was conducted with the Director of Nursing (DON) on 1/10/19 at 2:31 PM. She stated she expected care plan interventions to be implemented. She additionally stated that she expected behavior monitoring and side effect monitoring to be documented on the Behavior/Intervention Monthly Flow Record.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		

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F 657	Continued From page 101 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to incorporate a Nursing Assistant in the care planning process for 1 of 4 residents reviewed for the care planning process (Resident #50). The findings included: Resident #50 was admitted to the facility on 12/11/18 with diagnoses that included mood disorder, Alzheimer' s, dementia with behavioral disturbance, and psychosis. The Admission Minimum Data Set (MDS) assessment dated 12/18/18 indicated Resident #50 ' s cognition was severely impaired. A review of the care conference record indicated Resident #50 ' s initial care plan meeting was conducted on 12/27/18. This record had a signature section for the staff who attended the meeting. This meeting was attended by the MDS Coordinator, Dietary Manager, Social Worker,	F 657	F657- Care Plan Timing and Revision 1. On 2/1/2019 Resident # 50□s care plan was audited by the MDS Coordinator and updated with input from licensed nurses and CNAs to ensure accuracy. 2. On 2/1/2019 the DCS implemented a schedule to include Certified Nursing Assistants (CNA)s assigned to resident in the care planning of residents. 3. The Divisional MDS Nurse and or DCS will provide re-education to Interdisciplinary Team on the inclusion of CNAs in care plan conferences in planning resident□s care by 2/6/2019. 4. DCS and or Regional MDS Coordinator will conduct random quality monitoring (audit) of resident care conferences to ensure direct care caregivers participation, 3 times per week for 4 weeks, then weekly for 3 months.	

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F 657	Continued From page 102 and Activities Director. There was no Nursing Assistant in attendance at the meeting. An interview was conducted with the MDS Coordinator on 1/8/19 at 3:30 PM. She reported she was responsible for the completion of comprehensive care plans. She stated that the facility utilized care plan conferences to develop and review the care plans for all residents. She indicated that care plan conferences were attended by herself, Dietary Manager, Social Worker, Activities Director, and a Nursing Assistant who was familiar with the resident. She stated that additional staff, such as therapy or hospice, were included in the care plan conference if appropriate. She reported that these care plan conferences were held shortly after admission, quarterly, and as needed. The care plan conference record for Resident #50 that indicated an NA had not attended the 12/27/18 admission care plan meeting was reviewed with the MDS Coordinator. She confirmed there was no NA present at this meeting. She additionally confirmed that an NA had not participated in the development of Resident #50 ' s care plan by any alternative method. The MDS Coordinator revealed it was essential for an NA to be present at the meeting because the NAs were normally the staff that were most familiar with the needs of the resident. She additionally revealed that Resident #50 had a variety of care needs that would have benefited from an NAs input in the development of her care plan such as being a high fall risk, receiving antipsychotic medication, and the need for Activities of Daily Living assistance. This interview with the MDS Coordinator continued. She reported that the facility had been	F 657	The DCS will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 2/20/2019.	

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F 657	Continued From page 103 having difficulty obtaining and maintaining NA staff. She stated that this probably contributed to an NA not attending Resident #50 ' s care plan meeting as one was not available at the time of the meeting. An interview was conducted with the Administrator and Director of Nursing (DON) on 1/10/19 and 2:31 PM. Both indicated they expected the regulations related to care planning to be followed.	F 657		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with resident, family, Department of Social Services, and staff, the facility failed to provide incontinence care, showers, and/or bathing for 3 of 4 dependent residents reviewed for the provision of activity of daily living (ADL) care (Residents #36, #49 and #44). Resident # 49 was upset and teary for staying soaked with urine before the facility staff responded to the call bell to provide incontinence care. Findings included: 1. Resident #49 was admitted to the facility on 12/6/18 with diagnoses that included cerebrovascular disease, major depressive disorder, adjustment disorder with depressed mood, and anxiety disorder.	F 677	F677- ADL Care Provided for Dependent Residents 1. On 1/8/2019 Resident #'s 36, 49 and 44 and received showers, timely incontinence care, showers/bathing and/or daily personal hygiene, including nail care as indicated. 2. On 2/7/19 the DON completed a quality review (audit) of ADL care specific to showers, timely incontinence care, bathing and/or daily personal hygiene, including nail care. No negative findings were identified. 3. The DON will provide re-education to CNAs, on all shifts, part-time and prn, on proper ADL care including showers, timely	4/3/19

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F 677	Continued From page 104 The admission Minimum Data Set (MDS) assessment dated 12/13/18 indicated Resident #49 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #49 required the extensive assistance of 1 for bed mobility and toileting and 2 or more for transfers. She was frequently incontinent of bladder and always incontinent of bowel. The Care Area Assessment (CAA) related to urinary incontinence for Resident #49 ' s 12/13/18 admission MDS indicated she was alert, oriented, and able to make decisions and communicate needs. Resident #49 indicated she had a history of incontinence and that she could feel a sensation in her bladder, but it was difficult to hold. The active care plan for Resident #49 included, in part, the following areas: - Resident #49 had an Activities of Daily Living (ADL) self-care performance deficit related to mobility, Cerebrovascular Accident (CVA) and impaired balance. The interventions included, in part, assistance with tasks of washing hands, adjusting clothes, and cleaning self in relation to toilet use. - Resident #49 had altered bladder elimination related to CVA and contractures of the right hand and wrist. Resident #49 was noted to report difficulty holding her urine. The interventions included, in part, bed pan, mechanical lift for transfers, and encourage communication of needs for assistance with toileting. A complaint/grievance report dated 1/8/19 communicated by Resident #49 to the Human Resources Coordinator (HRC) indicated that the	F 677	incontinence care, bathing and/or daily personal hygiene, including nail care by 2/8/2019. Staff will not be allowed to return to work until education complete. 4. RDCS and or DON will conduct quality monitoring (audit) and observation of 5 residents receiving showers/bathing, nail care and incontinent care, 3 times per week for 4 weeks, then weekly for 3 months. The DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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resident was concerned about how long she waited for her call light to be answered. This form had been reviewed by the SW and was assigned to the DON for investigation.

An interview was conducted with Resident #49 on 1/9/19 at 11:30 AM. The grievance dated 1/8/19 written by the HRC that discussed the resident ' s concern with how long it took for her call light to be answered was reviewed with Resident #49. She stated that in the early morning on 1/8/19 she pressed her call bell because she had to urinate. She indicated it took over 2 hours for her call bell to be answered. She stated she urinated in her brief during that time as she had difficulty holding her urine. She revealed she sat in her brief that was soaked with urine until her call bell was answered by the HRC. She stated the DON then provided her with incontinent care.

A phone interview was conducted with Department of Social Services (DSS) staff by phone on 1/9/19 at 8:09 AM. DSS staff stated she spoke with Resident #49 yesterday, 1/8/19, and the resident told her she sat in a urine-soaked brief for over 2 hours after pressing her call light for assistance.

An interview was conducted with the HRC on 1/9/19 at 2:40 PM. The complaint/grievance report dated 1/8/19 related to Resident #49 was reviewed with the HRC. She stated she was walking the halls on 1/8/19 when she saw Resident #49 ' s call light on, so she entered the room and asked the resident if there was something she could help with. Resident #49 informed her she had been waiting awhile and needed "cleaned up". She stated that Resident #49 reported that she turned her call light on at

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4:45 AM. The HRC estimated it to be around 7:10 AM when she entered the room to answer the call light. She stated there was no obvious odor of urine in the room. She indicated that Resident #49 was visibly upset and was crying when she spoke with her. She said that after speaking to Resident #49 she went to the DON and Administrator to report the information.

An interview was conducted with the DON on 1/9/19 at 2:30 PM. She reported she had provided incontinent care to Resident #49 on 1/8/19 after the HRC reported she answered the resident ' s call light and the resident said her light had been on for over 2 hours. The DON stated that Resident #49 had urinated in her brief. She reported Resident #49 was visibly upset and was tearful when she provided care. The DON indicated she expected call bells to be answered timely.

Based on review of the nursing schedule and DON confirmation on 1/9/19 at 2:45 PM, Nurse #2 and NA #1 were assigned to Resident #49 for the third shift on 1/7/19 beginning at 11:00 PM and ending on 1/8/19 at 7:00 AM.

A phone interview was conducted with Nurse #2 on 1/9/19 at 3:00 PM. He confirmed he was assigned to Resident #49 during the third shift beginning 1/7/19 and ending 1/8/19. He indicated that 2 NAs were working the third shift for the entire building and that NA #1 was assigned to Resident #49. Nurse #2 revealed he recalled Resident #49 ' s call light being on for an extended period of time during the early morning on 1/8/19. He was not surprised that it took over 2 hours for Resident #49 ' s call light to be answered. He explained that when there were

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only 2 NAs working it was difficult for them to answer call lights timely which caused a delay in meeting the residents ' needs.

An interview was conducted with NA #1 on 1/9/19 at 3:15 PM. He confirmed he was assigned to Resident #49 during the third shift beginning 1/7/19 and ending 1/8/19. He stated he was working a double that day beginning on the second shift 1/7/19 and working through the third shift ending 1/8/19. He reported that he was 1 of 2 NAs working the third shift that day and they each had about 30 residents. NA #1 indicated he had not recalled Resident #49 ' s call light being on for an extended period of time during the early morning on 1/8/19, but revealed it was not a surprise to him. He explained that he had difficulty meeting residents ' needs timely when there were only 2 NAs working on the third shift. NA #1 reported that he had informed the DON in the past that it was difficult for him to meet the residents ' needs timely when only 2 NAs were working on the third shift. He stated that this had been going on for months and it had not improved.

During an interview with the Administrator on 1/8/19 at 10:30 AM he stated he began working as the Administrator at this facility in June of 2018. He revealed that the facility had difficulty obtaining and maintaining enough NAs to staff all three shifts since he began as the Administrator. When asked what his definition of sufficient staffing was he stated that sufficient staffing was enough staff both in terms of quality and quantity to meet the needs of the residents.

During an interview with the Director of Nursing (DON) on 1/9/19 at 3:31 PM she stated she

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began working as the DON at the facility in June of 2018. She confirmed the Administrator ' s interview related to the facility having difficulty obtaining and maintaining enough NAs to staff all three shifts. She stated that third shift was normally staffed with 2 or 3 NAs. She revealed that one day recently she had to come in to work as an NA on the 3rd shift because 1 of the 2 NAs who were on the schedule called off and she was unable to find anyone else to fill in.

An interview was conducted with the Administrator on 1/9/19 at 10:20 AM. He indicated he spoke with Resident #49 on 1/8/19 after the grievance was reported by the HRC. He stated that Resident #49 reported to him that she had to wait a long time for her call bell to be answered. The Administrator indicated the investigation into this grievance was just beginning. He stated it was unacceptable for a resident to wait over 2 hours for a call bell to be answered.

2. Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included Multiple Sclerosis (MS).

The quarterly Minimum Data Set (MDS) assessment dated 11/28/18 indicated Resident #44 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #44 required the extensive assistance of 1 staff for bed mobility, dressing, toileting, and personal hygiene. She was dependent on 1 for bathing.

The medical record indicated Resident #44 had a hospital stay from 12/12/18 through 12/18/18.

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A review of the shower/bathing schedule indicated Resident #44 ' s shower/bath days were Wednesdays and Saturdays. A review of the hard copy shower/bath documentation from 12/1/18 through 1/7/19 for Resident #44 was conducted and revealed the following:
- Saturday 12/1/18: Resident #44 ' s shower/bath sheet was blank.
- Wednesday 12/5/18: Resident #44 ' s shower/bath sheet was blank.
- Saturday 12/8/18: Resident #44 had no shower/bath sheet for 12/8/18.
- Wednesday 12/12/18: Resident #44 was discharged to the hospital on 12/12/18.
- Saturday 12/15/18: Resident #44 remained in the hospital on 12/15/18.
- Wednesday 12/19/18: Resident #44 was readmitted on 12/18/18 and the 12/19/18 shower/bath sheet was blank.
- Saturday 12/22/18: Resident #44 had no shower/bath sheet for 12/22/18.
- Wednesday 12/26/18: Resident #44 ' s hair was documented as washed on the shower/bath sheet.
- Saturday 12/29/18: Resident #44 had no shower/bath sheet for 12/29/18.
- Wednesday 1/2/19: Resident #44 ' s shower/bath sheet was blank.
- Saturday 1/5/19: Resident #44 had no shower/bath sheet for 1/5/19.

The active care plan for Resident #44 indicated the focus area of an Activities of Daily Living (ADL) self-care deficit. The interventions indicated Resident #44 was dependent on 1 staff for bathing and grooming.

An interview and observation were conducted with Resident #44 on 1/7/19 at 12:00 PM.

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Resident #44 ' s hair appeared uncombed and greasy. She stated that she preferred to get bed baths over showers and that staff complied with this preference. She revealed that she had a concern with getting her hair washed. She stated that her hair was supposed to be washed on her shower/bath days which were scheduled twice per week. She indicated her shower/bath days were Wednesdays and Saturdays. She reported her hair was not always washed twice per week. Resident #44 indicated her hair got oily and her scalp was itchy when her hair wasn ' t washed twice per week. She stated that she was in the hospital in the middle of December for about a week and that she only had her hair washed once since she returned from the hospital.

An interview was conducted with Nursing Assistant (NA) #1 on 1/9/19 at 3:58 PM. He stated that he was originally hired to work the third shift, but that he frequently worked first and second shift as well. He reported he was familiar with Resident #44 and he stated that she was dependent on staff for her bathing and grooming needs. He indicated Resident #44 rarely got out of bed and she preferred to receive bed baths. He stated that hair washing was supposed to be provided for dependent residents twice per week on their shower/bath day. NA #1 revealed that the facility had difficulty obtaining and maintaining NA staff to fill all three shifts and that sometimes tasks such as hair washing were pushed to another shift or another day if the assigned NA was not able to get all of their tasks completed. He explained that the more critical tasks had to be prioritized first and that hair washing was not on the top of the priority list.

During an interview with the Administrator on

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1/8/19 at 10:30 AM he stated he began working as the Administrator at this facility in June of 2018. He revealed that the facility had difficulty obtaining and maintaining enough NAs to staff all three shifts since he began as the Administrator. When asked what his definition of sufficient staffing was he stated that sufficient staffing was enough staff both in terms of quality and quantity to meet the needs of the residents.

During an interview with the Director of Nursing (DON) on 1/9/19 at 3:31 PM she stated she began working as the DON at the facility in June of 2018. She confirmed the Administrator ' s interview related to the facility having difficulty obtaining and maintaining enough NAs to staff all three shifts. She indicated that staff members were asked to work additional shifts and/or to work double shifts. The DON indicated that this had been going on for several months and had caused some of the staff to be exhausted. She acknowledged her awareness that essential care needs had been missed.

A follow up interview with the Administrator and Director of Nursing on 1/10/19 at 2:31 PM. They both indicated that they expected residents ' ADL care needs to be met. They additionally indicated their expectation was to provide sufficient staffing to meet the residents ' needs.

3. Resident #36 was admitted on 10/1/18 with the diagnoses of neuropathy and need for assistance with activities of daily living.

A review of the residents care plan dated 10/1/18 revealed goals and interventions for activities of daily living self-care deficit. Goals was for the resident to receive personal care and to

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participate as able. Interventions were for bathing, grooming and incontinence care. The care plan included that the resident would also call out or whistle when assistance was needed in addition to using the call light.

A review of the admission Minimum Data Set (MDS) dated 10/8/18 revealed the resident had an intact cognition. The resident required extensive assistance of 2 persons for transfer, bathing and incontinence care.

3a.
A review of Resident #36 ' s documented shower sheets from admission 10/1/8 to 1/10/19 revealed the resident did not receive his scheduled two showers per week. The resident was documented as having had a shower on November 30, 2018 on second shift, December 18, 2018 on second shift, and January 4, 2019.

On 1/7/19 at 10:30 am an interview was conducted with Resident #36 who stated he had not received his two showers per week as scheduled. The resident stated that he only had one shower last week and none the week before.

On 1/7/19 at 11:00 am an interview was conducted with a family member of Resident #36 who stated she was informed by the resident that he had not received a shower during the last week in December 2018. The family member observed that the resident ' s hygiene was currently dirty, including his hair. The family member commented that she assisted her father to have a bath herself.

On 1/8/19 at 10:25 am an interview was conducted with the treatment nurse (TN) who

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stated that she was frequently being re-assigned for an entire shift as a nursing assistant due to staff shortages. It was not uncommon for an assignment to include 17 residents on day shift which included showers. The TN commented that if there was not enough time showers would be rescheduled. The treatment nurse stated if the resident ' s shower sheets were not documented then the shower was not done. The TN was aware that some residents had not received their showers, including Resident #36.

On 1/8/19 at 1:15 pm an interview was conducted with Nursing Assistant (NA) #8, who regularly cared for Resident #36. NA #8 stated that there was currently a nursing assistant shortage at the facility. NA #8 stated she had 17 residents assigned to her on two different halls. The NA felt she could handle the load by putting off showers until the afternoon. The NA also stated that not all NAs could handle the load, could not complete their assignment and required help. NA #8 stated that Resident #36 had not refused his shower for her. The resident was able to make his needs known. NA #8 stated that staff was required to document when the resident received a bath or shower on the resident ' s shower sheets and if refused to let the nurse know. The NA also commented that if the shower sheets were not completed the shower was considered not to be done.

On 1/8/19 at 1:57 pm an interview was conducted with Nurse #9, who regularly cared for Resident #36. Nurse #9 stated there was a shortage of nursing assistants so she assisted them during her shift and was reassigned as a nursing assistant for an entire shift more than one day a week. Nurse #9 was not aware that Resident #36

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had not received his scheduled showers each week and stated he had not refused his shower.

1/8/19 at 10:30 am an interview was conducted with the Administrator who stated that there had been several staff resignations and terminations. To temporarily resolve the nursing assistance shortage, licensed nurses have been assigned to the nursing assistant role, but not taken from a nursing assignment. The shortage had been over the past 3 months. The Administrator expected residents to receive showers as scheduled and if delayed to complete the shower on the next shift or next day.

On 1/10/19 at 2:00 pm an interview was conducted with the Director of Nursing (DON) who stated that she expected nursing assistants to provide showers to the residents twice a week and if there was a refusal to report this to the nurse for intervention. The DON further stated that there was a nursing assistant staff shortage and nurses where reassigned to assist. The DON stated that there were times when lesser important tasks such as showers were postponed due to the shortage. The DON commented that if the shower sheets were not completed/documented then the shower was not provided to the resident.

3b.
On 1/7/19 at 10:30 am an interview was conducted with Resident #36 who stated he had not always received incontinence care when needed and had gotten soaked through with urine to his bed on a few occasions. The last time was when his family member assisted him with a bath. The resident commented that at times he had to wait for staff to respond to his call light. The

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resident stated he would call out or whistle for assistance because the staff did not always respond to the light. The resident stated one a couple of occasion he had to wait up to 45 minutes for assistance.

On 1/7/19 at 11:00 am an interview was conducted with the family who stated she was informed by the resident he had to wait a long time for staff to answer the call light and when he called out for staff assistance. The family member had observed the last week in December that the resident was soaked through his undergarment and the bed was wet. The family member commented that she observed a 45-minute time frame for staff to answer Resident #36 ' s call light when he needed assistance with incontinence care.

On 1/8/19 at 10:25 am an observation was conducted of the resident ' s incontinence care by the TN who was assigned to nursing assistant duties today. The resident ' s undergarment was soaked through with urine. The resident commented that he had put his call light on for assistance.

On 1/8/19 at 1:15 pm an interview was conducted with Nursing Assistant (NA) #8 who regularly cared for Resident #36. NA #8 stated that there was currently a nursing shortage at the facility. NA #8 stated she had 17 residents assigned to her on two different halls. NA #8 stated that incontinence care was always completed but was sometimes delayed. NA #8 stated that she was aware Resident #36 used calling out or whistling to summon staff for assistance.

On 1/10/19 at 10:12 am an interview was

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F 677	Continued From page 116 conducted with the DON who stated she expected the staff to provide incontinence care on the 2-hour schedule and as needed. The DON also commented that if the resident was observed or requested incontinence care the staff should provide care	F 677		
F 686 SS=K	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 record review, observations, staff interview, resident and family interview, wound care Nurse Practitioner interview, and Nurse Practitioner interview, the facility failed to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation, and communication with the outside podiatrist who was also treating, resulting in worsening, increase in size and infection of the pressure ulcer (Resident #36); failed to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation resulting in a worsening pressure	F 686	F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. On 1/8/2019 resident #36 had wound care provided by a licensed nurse. Resident #36 had a pressure reducing mattress and pad on bed and wheelchair 10/1/18. Resident #36's heels were floated and he was provided an off loading boot for therapy 10/11/18. Wound care was provided to Resident #36's heel daily starting 1/10/19 as ordered by the physician and his wound was assessed weekly for signs of improvement by the	4/3/19

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F 686	Continued From page 117 ulcer (Resident #1); and failed to provide daily pressure ulcer wound care as ordered and weekly wound measurement/assessment and documentation (Resident #44) for 3 of 4 sampled residents reviewed for wound care. Immediate Jeopardy began on 11/6/18 when staff failed to provide pressure ulcer care with resulting infection for Resident #36. Immediate Jeopardy was removed on 3/6/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level to ensure monitoring of systems are put in place and to complete employee in-service training. The facility was also cited at a scope and severity of "H" (a deficiency that constitutes a pattern of actual harm that is not Immediate Jeopardy) for examples #2 (Resident #1). Example #3 (Resident #44) was cited at a scope and severity of "E." Findings included: 1. Resident #36 was admitted on 10/1/18 with the diagnoses of Parkinson's, neuropathy, diabetes, pressure ulcer of the right heel unstageable, and need for assistance with activities of daily living. A review of the resident ' s care plan dated 10/1/18 revealed goals and interventions for pressure ulcer prevention and status. A review of the admission Minimum Data Set (MDS) dated 10/8/18 revealed the resident had an intact cognition. The resident required extensive assistance of 2 persons for transfer, bathing and incontinence care. The resident had one unstageable pressure ulcer on the side of the	F 686	licensed nurse starting 1/23/19. Resident #36 was followed by his physician starting on admission to facility on 10/1/2018, and his care plan was updated on 1/29/19 by the MDS nurse. Resident #36's wound resolved on 2/8/2019 and he was discharged 2/20/2019. Daily wound care was provided starting 1/10/19 following doctors orders. Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).On 01/22/19 a root cause analysis was completed by the Regional Vice President of Operations, Regional Director of Clinical Services, the Director of Nursing and the Divisional Executive Director (acting administrator) and determined that the Executive Director failed to provide consistent staffing to ensure treatments were completed as ordered. Resident #1 was provided daily wound care beginning 1/12/19 by licensed nurse. Resident #1 and #44 wounds was measured and assessed weekly by licensed nurse beginning 1-23-19. Resident #44 was provided daily wound care beginning 1-10-19 by licensed nurse. 2. On 2/15/2019 the Director of Nursing completed a quality review of all current resident treatment sheets, compared them to the treatment orders and observed treatments to ensure that residents were provided wound care as ordered. There are three current residents	

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F 686	Continued From page 118 right heel. A review of the resident ' s physician progress note for admission dated 10/1/18 revealed the right side of right lateral heel had a small area with yellow/brown drainage, no erythema or odor. A review of the physician order dated 10/1/18 revealed right side of the heel cleanse with normal saline, pat dry, apply antibiotic ointment, and cover with dry sterile dressing each day. A review of the resident ' s October 2018 treatment administration record (TAR) for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care dates 10/6-8, 10/13-14, 10/17-18, 10/20-21, and 10/27-28. A review of the resident ' s wound culture lab dated 11/2/18 revealed an infection of methicillin resistant staphylococcus aureus (MRSA) of the side of right heel. A review of the residents November 2018 TAR for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care dates 11/15-16, 11/23-25, and 11/20. A review of the resident ' s physician progress note dated 11/6/18 revealed an unstageable pressure ulcer of the right heel which was present on admission had a positive MRSA culture. There was an order for Doxycycline 100 mg (antibiotic) ordered. A review of the resident ' s physician progress note dated 11/8/18 revealed the resident had a pressure ulcer to his right heel which was present	F 686	with pressure sores. Current residents with wounds are followed by wound physician associated with the medical director's practice or a Vascular Surgeon. Residents with wound care had their care plans reviewed on 2/27/19-2/28/19 to ensure that the facility addressed the pressure sores comprehensively to prevent worsening and promote healing of the pressure sores. Residents with pressure ulcers had their care plans reviewed on 2/28/19 by the divisional MDS nurse. Resident's wounds are observed weekly starting 1/23/19 and measured by the treatment nurse. The facility's treatment nurse coordinates outside services as needed and/or as ordered with collaboration with the physician. Current residents with wounds are followed by the wound physician associated with the Medical Directors practice, or a Vascular Surgeon. The physician notes are sent to the facility via secure server email for the Director of Nursing's review and then they are filed in the medical record. On 2/15/19 the Director of Nursing began observing treatments on 3 pressure wounds and 2 non-pressure related wounds (3 residents per day, 3 days per week).On 2/15/2019 the Director of Nursing completed a quality review of all current resident treatment sheets, compared them to the treatment orders and observed treatments to ensure that residents were provided wound care as ordered. There are three current residents with pressure sores. Current residents with wounds are followed by wound physician associated	

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F 686	Continued From page 119 on admission. The resident was his own responsible party. A review of the physician ' s progress note dated 11/27/18 revealed the resident was treated for MRSA to the right heel. The resident finished his antibiotic medication and contact precautions were no longer needed (healed). A review of the resident ' s December 2018 TAR for dressing change of the right heel pressure ulcer revealed there was no documentation for wound care dates 12/1-2, 12/5, 12/7, 12/15-17, 12/21-23, 12/25, and 12/28-31. Physician progress note dated 12/27/18 revealed a resident decline secondary to Parkinson ' s disease. The resident was followed by wound care (Foot and Ankle Center outside the facility) for the side of the right heel pressure ulcer. On 1/7/19 at 10:45 am an interview was conducted with the resident who stated his right heel wound dressing was not always changed every day. On 1/8/19 at 1:57 pm an interview was conducted with Nurse #9 who stated that the resident had a pressure ulcer to right side of heel that was present on admission and the dressing change was completed by the treatment nurse. On 1/8/19 at 3:00 pm an observation was done of the resident ' s right heel pressure ulcer wound care by the treatment nurse (TN). The dressing of the right heel was dated 1/4/18 and was soaked through with yellow purulent drainage and the wound was macerated (wet, white, and peeling) around the edges.	F 686	with the medical director's practice or a Vascular Surgeon. Residents with wound care had their care plans reviewed on 2/27/19-2/28/19 to ensure that the facility addressed the pressure sores comprehensively to prevent worsening and promote healing of the pressure sores. Residents with pressure ulcers had their care plans reviewed on 2/28/19 by the divisional MDS nurse. Resident's wounds are observed weekly starting 1/23/19 and measured by the treatment nurse. The facility's treatment nurse coordinates outside services as needed and/or as ordered with collaboration with the physician. Current residents with wounds are followed by the wound physician associated with the Medical Directors practice, or a Vascular Surgeon. The physician notes are sent to the facility via secure server email for the Director of Nursing's review and then they are filed in the medical record. 3. The Director of Nursing and or Consulate Healthcare Executive Director and Director of Nursing provided re-education to facility licensed staff, including all shifts, part-time and prn, on providing treatments as ordered by the physician and recording the treatment on a TAR by 2/8/2019. The Divisional Quality Educator provided education to the Director of Nursing and Treatment Nurse on treatment procedures beginning on 02/28/19 and on an on-going basis. The Divisional Quality Educator provided additional one on one training and completed a clean dressing change	

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F 686	Continued From page 120 A review of the January 2019 TAR for dressing change of the right heel pressure ulcer revealed the dressing was documented as being done on 1/1, 1/4 and 1/8. On 1/8/19 at 10:25 am an interview was conducted with the TN who stated that she was responsible for all resident treatments but was frequently being re-assigned to nursing assistant due to staff shortage. The TN stated when she was not in the role of treatment nurse the assigned floor nurse was responsible to provide wound care for their residents. The TN stated that she had been reassigned for the past four months and residents had not received their daily wound care. On 1/8/19 at 3:10 pm an interview was conducted with the treatment nurse (TN) who stated the resident ' s right heel pressure ulcer dressing had the date she placed on the gauze from last week, dated 1/4/18. The TN stated she referred back to the treatment administration record (TAR) and was the last nurse to document/change the resident's right heel dressing on 1/4/18. The TN commented that if the TAR was not signed/documented the dressing was not changed which included this resident ' s care back to October 2018. 1/8/19 at 10:30 am an interview was conducted with the Administrator who stated that there had been several staff resignations as well as terminations. To temporarily resolve the nursing assistance shortage, licensed nurses have been assigned to the nursing assistant role since July of 2018.	F 686	competency evaluation with the Treatment Nurse on 02/28/19. Licensed nurses were re educated by the DON and Regional Director of Clinical Services on assessing status of wounds on a weekly basis and with treatments and providing wound care to improve wounds and promote healing by 3/3/2019. Licensed nurses notify the physician if there is a change to a wound, in collaboration with the physician a referral may be made to the wound doctor. Certified Nurse Assistants will be re educated on reporting changes in resident skin integrity, preventative measures for preventing wounds, following care plan related to devices and relieving pressure by Director of Nursing, Regional Director of Clinical Services and Divisional Executive Director by 3/3/19. Staff will not be allowed to return to work until education complete. New hires will be provided the same training on hire prior to getting an assignment. The facility employees a full time treatment nurse. If the treatment nurse is unavailable it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. Licensed staff has the capacity to complete their assignments, including treatments within the parameters of their work schedule. If the licensed nurse cannot complete the treatment within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing. The Director of Nursing will grant overtime to the licensed nurse to complete the task, delegate the	

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F 686	Continued From page 121 On 1/8/19 at 1:57 pm an interview was conducted with Nurse #9 who stated that the resident had a pressure ulcer to his right heel that was present on admission and the dressing change was completed by the treatment nurse. Nurse #9 also stated that she was not responsible to change the dressing. Nurse #9 stated that she was assigned to the resident on 1/7-9/19, she had not changed the resident ' s right heel dressing and later learned that the resident had not received his dressing change by the treatment nurse. If there was no documentation in the resident ' s record the wound care was not done which included prior months back to his admission of 10/1/18. On 1/8/19 at 2:21 pm an interview was conducted with the TN who stated the resident acquired an infection of the right heel pressure ulcer. Not changing the resident ' s pressure ulcer dressing placed him at risk for an infection. The treatment nurse stated that the right heel wound had worsened by becoming larger with increased drainage and the drainage that was scant serous was now moderate creamy yellow. The TN further commented that the family took the resident to a podiatrist for the right heel wound because they were aware the dressing was not being changed by the date on the dressing and by what the resident stated. On the weeks the resident saw the podiatrist the wound care Nurse Practitioner could not treat the resident. The resident ' s wound was not followed by the facility because there was no weekly measurement done at the facility nor did the facility obtain the podiatry notes, the resident ' s dressing was not changed, and when the wound had gotten larger with increased drainage the facility ' s medical nurse practitioner or wound care nurse practitioner had	F 686	responsibility to another nurse or assist with the task. The Director of Nursing and/or Minimum Data Set Nurse will complete the assessment and measurements if the treatment nurse is unavailable. The Director of Nursing will observe licensed nurses providing treatments, 3 times per week, to ensure competency and documentation are completed. The Director of Nursing will provide additional education on clean dressing and competency skills checklist beginning on 03/01/19. Licensed staff will not return to work until education is completed. Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).The Divisional Quality Educator provided education to the Director of Nursing and Treatment Nurse in regard to treatment procedures beginning on 02/28/19 and on an on-going basis. The Divisional Quality Educator provided additional one on one training and completed a competency evaluation with the Treatment Nurse on 02/28/19. The Regional Vice President of Operations and the Regional Director of Clinical will monitor staffing levels to ensure adequate staffing is maintained. On 2/7/19 the Regional Vice President of Operations and Regional Director of Clinical Services began monitoring daily staffing of direct care per resident per day using morning meeting and internal labor portal. If a staffing challenge presents itself and the treatment nurse is put on a	

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F 686	Continued From page 122 not assessed the wound. On 1/8/19 at 3:30 pm an interview was conducted with the Director of Nursing (DON) who stated that she expected staff to complete all treatments as ordered. On 1/10/19 at 9:00 am an interview was conducted with the wound care Nurse Practitioner who stated she rounded on the residents for wound assessment each week with the facility's treatment nurse. Due to staff shortage, the TN was not available to assist each week to measure the wounds and Resident #36 was being seen periodically by the podiatrist. The wound care Nurse Practitioner stated she observed Resident #36 ' s right heel pressure ulcer during nursing wound care today and assessed that the wound was larger and had increased drainage than last month (she had not measured the wound) but was not infected. She was aware that the resident had acquired a MRSA infection of the right heel wound last month but was not aware that the dressing was not changed as ordered until now. The failure to change the dressing placed the resident at high-risk to acquire a wound infection and would have contributed to his prior MRSA infection. MRSA was in the environment and a wound that was not cared for by dressing change was high-risk cause for MRSA to infect an open wound with accumulating wound drainage in the dressing. The wound care Nurse Practitioner went on to state that she asked the DON for the resident ' s podiatry notes and they were not provided to her nor available in the resident ' s medical record. She also stated that she was aware of the nursing staff shortage, made aware that wound	F 686	cart, the Director of Clinical Services will complete that day's treatments that are ordered. 4. Regional Director of Clinical Services and or Director of Nursing will conduct quality monitoring (audit) including observation of resident treatments and documentation for 3 residents (rotating residents), 3 times per week for 4 weeks, then weekly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting by the Director of Nursing for review of on going wound care monthly. The Executive Director will provide data on staffing to the QAPI committee for review of any staffing challenges. Quality Improvement monitoring schedule will be modified based on findings of monitoring. The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 02/22/19, including the Interim Executive Director, Director of Nursing, the SDC, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director and the Environmental Services Director regarding the plan of removal of	

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F 686	Continued From page 123 care and measurements were not completed, and had brought her concerns to the DON in the past couple of months. The wound care Nurse Practitioner stated that she could not evaluate, treat and measure the resident ' s wound on a regular basis because he was being seen outside the facility by a podiatrist (duplication of services). On 1/10/19 at 9:30 am an interview was conducted with the facility medical Nurse Practitioner who stated that the resident ' s right heel pressure ulcer wound was macerated around the edges and changed the wound care order due to the failure to change the dressing and wound status change and decline. The facility Nurse Practitioner stated she had not usually followed the right heel pressure ulcer wound because he was seen by an outside podiatrist and it was considered a duplication of services. On 1/10/19 at 2:00 pm an interview was conducted with the DON who stated there were no podiatry notes in the facility record for the resident. The DON stated she would attempt to obtain a copy from the podiatry office. On 1/10/19 at 10:10 am an interview was conducted with the TN who stated she was informed by the DON that she would be assigned as NA for 1/7, 1/8, and 1/9 and would not be responsible for facility treatments. The facility treatments would be assigned to the nurse on each hall responsible for their residents that required a treatment which included all wounds. On 1/10/19 at 10:12 am an interview was conducted with the DON with Nurse #7 and TN present. DON stated that she was aware that	F 686	immediacy. 5. Date of Compliance 4/3/2019.	

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treatments were not completed for Resident #36 on 1/7, 1/8, and 1/9 and expected the TN nurse to complete the treatments on all the facility residents in the afternoon after her NA day shift duties. On 1/9/18 the DON allowed the TN to accompany the surveyor to observe resident ' s right heel dressing change. The DON stated she was made aware that the dressing was dated 1/4/19 and that the dressing had not been changed for 4 days. The TN nurse stated that she was not aware that she was responsible to complete treatments including wound care after her NA day shift on the three days. Nurse #7 stated that she was not responsible for treatments and had not completed the resident ' s wound care on 1/7, 1/8, and 1/9. The DON stated she agreed there was a breakdown in communication as to who was responsible to complete the resident's treatments. The DON also stated that the resident was seen by an outside podiatrist and would obtain the records.

At the end of the survey on 1/10/19 at 5:00 pm there were no podiatry records for the resident provided by the facility.

The Administrator and DON were notified of the Immediate Jeopardy on 3/4/19 at 1:00 pm.

On 3/5/19 the facility provided the following credible allegation of Immediate Jeopardy removal:

The center Executive Director alleges abatement of immediate jeopardy on 03/05/19.
1. The corrective action for the alleged deficient practice was accomplished by:
On 1/8/2019 resident #36 had wound care provided by a licensed nurse. Resident #36 had a

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pressure reducing mattress and pad on bed and wheelchair 10/1/18. Resident #36 ' s heels were floated, and he was provided an off loading boot for therapy 10/11/18. Wound care was provided to Resident #36 ' s heel daily starting 1/10/19 as ordered by the physician, and his wound was assessed weekly for signs of improvement by the licensed nurse starting 1/23/19. Resident #36 was followed by his physician starting on admission to facility on 10/1/2018, and his care plan was updated on 1/29/19 by the MDS nurse. Resident #36 ' s wound resolved on 2/8/2019 and he was discharged 2/20/2019. Daily wound care was provided starting 1/10/19 following doctor ' s orders.

Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).

On 01/22/19 a root cause analysis was completed by the Regional Vice President of Operations, Regional Director of Clinical Services, the Director of Nursing and the Divisional Executive Director (acting administrator) and determined that the Executive Director failed to provide consistent staffing to ensure treatments were completed as ordered.

Residents with the potential to be affected by alleged deficient practice:

On 2/15/2019 the Director of Nursing completed a quality review of all current resident treatment sheets, compared them to the treatment orders and observed treatments to ensure that residents were provided wound care as ordered. There are

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three current residents with pressure sores. Current residents with wounds are followed by wound physician associated with the medical director ' s practice or a Vascular Surgeon. Residents with wound care had their care plans reviewed on 2/27/19-2/28/19 to ensure that the facility addressed the pressure sores comprehensively to prevent worsening and promote healing of the pressure sores. Residents with pressure ulcers had their care plans reviewed on 2/28/19 by the divisional MDS nurse. Resident ' s wounds are observed weekly starting 1/23/19 and measured by the treatment nurse. The facility ' s treatment nurse coordinates outside services as needed and/or as ordered with collaboration with the physician.

Current residents with wounds are followed by the wound physician associated with the Medical Directors practice, or a Vascular Surgeon. The physician notes are sent to the facility via secure server email for the Director of Nursing ' s review and then they are filed in the medical record.

On 2/15/19 the Director of Nursing began observing treatments on 3 pressure wounds and 2 non-pressure related wounds (3 residents per day, 3 days per week)

2. Systemic Changes:
The Director of Nursing and or Consulate Healthcare Executive Director and Director of Nursing provided re-education to facility licensed staff, including all shifts, part-time and prn, on providing treatments as ordered by the physician and recording the treatment on a TAR by 2/8/2019.
The Divisional Quality Educator provided

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education to the Director of Nursing and Treatment Nurse on treatment procedures beginning on 02/28/19 and on an on-going basis. The Divisional Quality Educator provided additional one on one training and completed a clean dressing change competency evaluation with the Treatment Nurse on 02/28/19.

Licensed nurses were reeducated by the DON and Regional Director of Clinical Services on assessing status of wounds on a weekly basis and with treatments and providing wound care to improve wounds and promote healing by 3/3/2019. Licensed nurses notify the physician if there is a change to a wound, in collaboration with the physician a referral may be made to the wound doctor. Certified Nurse Assistants will be reeducated on reporting changes in resident skin integrity, preventative measures for preventing wounds, following care plan related to devices and relieving pressure by Director of Nursing, Regional Director of Clinical Services and Divisional Executive Director by 3/3/19. Staff will not be allowed to return to work until education complete. New hires will be provided the same training on hire prior to getting an assignment. The facility employees a full-time treatment nurse. If the treatment nurse is unavailable it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. Licensed staff have the capacity to complete their assignments, including treatments within the parameters of their work schedule. If the licensed nurse cannot complete the treatment within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing. The Director of Nursing will grant overtime to the licensed nurse to complete the task, delegate the responsibility

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to another nurse or assist with the task. The Director of Nursing and/or Minimum Data Set Nurse will complete the assessment and measurements if the treatment nurse is unavailable. The Director of Nursing will observe licensed nurses providing treatments, 3 times per week, to ensure competency and documentation are completed.

The Director of Nursing will provide additional education on clean dressing and competency skills checklist beginning on 03/01/19. Licensed staff will not return to work until education is completed.
Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19). The Divisional Quality Educator provided education to the Director of Nursing and Treatment Nurse in regard to treatment procedures beginning on 02/28/19 and on an on-going basis. The Divisional Quality Educator provided additional one on one training and completed a competency evaluation with the Treatment Nurse on 02/28/19.

The Regional Vice President of Operations and the Regional Director of Clinical will monitor staffing levels to ensure adequate staffing is maintained. On 2/7/19 the Regional Vice President of Operations and Regional Director of Clinical Services began monitoring daily staffing of direct care per resident per day using morning meeting and internal labor portal.

If a staffing challenge presents itself and the treatment nurse is put on a cart, the Director of Clinical Services will complete that day ' s

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treatments that are ordered.

Regional Director of Clinical Services and or Director of Nursing will conduct quality monitoring (audit) including observation of resident treatments and documentation for 3 residents (rotating residents), 3 times per week for 4 weeks, then weekly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting by the Director of Nursing for review of ongoing wound care monthly. The Executive Director will provide data on staffing to the QAPI committee for review of any staffing challenges. Quality Improvement monitoring schedule will be modified based on findings of monitoring.

The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 02/22/19, including the Interim Executive Director, Director of Nursing, the SDC, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director and the Environmental Services Director regarding the plan of removal of immediacy.

The Medical Director was made aware of the of immediacy plan via telephone with the Executive Director and the Director of Nursing on 3/1/19.

The credible allegation of Immediate Jeopardy

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removal was validated on 3/6/19 at 12:30 PM which included:

The 2/15/19 facility audit was reviewed and confirmed 3 current residents with wounds were being followed by the wound physician associated with the medical director ' s practice or a Vascular Surgeon. Progress notes were documented in each resident ' s medical record. Care plans were reviewed and had been updated for each resident. Documentation revealed there were weekly observations, measurements beginning 1/23/19 for each resident, and wound care was completed as ordered.

Education regarding the responsibility for wound care treatments in-service documentation was reviewed and sign in sheets for nursing was provided.

A review of Resident #36 ' s discharge from the facility to home dated 2/20/19 revealed he was discharged to home with family, was scheduled to follow up with his physician, home care services were started, and medical supply was contacted. The first visit scheduled was for 2/25/19.
A review of Resident #36 ' s treatment administration record for January and February 2019 revealed documentation that he received his daily wound care since the last survey.

The resident was discharged to home and not available for observation and interview.

On 3/6/19 at 11:55 am an interview was conducted with the Director of Clinical Services/Director of Nursing (DON) who stated that Resident #36 ' s right heel wound was healed on 1/30/19, and he received a preventative

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dressing to prevent further pressure. The resident was discharged to home with family and home care services. To ensure wound care was completed daily the treatment nurse was dedicated to wound care and if unavailable the assigned staff nurse was required to complete the wound care, and if unable the assigned staff nurse was to inform the DON to complete care or reassign.

On 3/6/19 at 2:30 pm an interview was conducted with the Treatment Nurse (TN) who stated she was required to participate in recent education regarding abuse, neglect, and exploitation and how a failure to provide care was related. The TN stated that if she was unavailable to complete any care she was to inform the DON and the assigned staff nurse would be assigned and the scheduler notified. Nurses also received education on how to complete the treatments, wound measurement, and communication of new wounds. There has not been floating of nurses to the nursing assistant role. The care and timeliness to provide care for the residents has improved now that there is enough staff. Wounds are now healing because treatments are done as ordered.

On 3/6/19 at 4:30 pm interviews of 5 random staff members were conducted which revealed that "several newly employed nursing assistants had started over the past 2 months and the facility was fully staffed." The rate of grievances filed by residents and/or their family had dropped by half. The last resident council meeting in February 2019 identified that call lights and incontinence care were addressed timely to the satisfaction of the residents. All interviewed staff stated that they recently received training for abuse, neglect,

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exploitation and how not providing care (including wound care) to meet the resident ' s needs is related to neglect.

On 3/6/19 at 5:30 pm an interview was conducted with the Corporate Vice President of Operations who stated he conferenced with the Divisional Human Resources Director and implemented staffing plans including wage increases and recruitment and retention plans to ensure sufficient staffing. On 2/7/19 sufficient staff had been hired and received orientation prior to accepting an assignment. Daily staffing meetings have occurred to ensure sufficient staffing patterns.

2. Resident #1 was admitted to the facility 10/3/18 with cumulative diagnoses of Cirrhosis and a history of a Deep Vein Thrombosis.

Review of Resident #1's admission Minimum Data Set (MDS) dated 10/10/18 revealed that the Cognitive Pattern assessment (Section C) and the Mood (Section D) assessment was not completed. She was coded total staff assistance with bed mobility, toileting and personal hygiene. Resident #1 was coded as non-ambulatory and incontinent of bladder and bowel. She was coded for one stage 2 pressure ulcer and one Suspected Deep Tissue Injury (SDTI) both present on admission. Interventions included a pressure reducing mattress to her bed and pressure ulcer care. Resident #1 was coded for a prognosis of less than 6 months and for Hospice Services.

Review of Resident #1's Care Area Assessment dated 10/10/18 for pressure ulcers read she was

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a Hospice resident and she was admitted with a SDTI and she was dependent of the staff for her activities of daily living.

Review of Resident #1's skin/wound care plan dated initiated 10/17/18 read she had a SDTI to her left heel on 10/17/18. The goal was for Resident #1's wound was to show signs of healing. Interventions included the facility was to provide treatments as ordered.

Review of a Hospice nursing note dated 10/8/18 read Resident #1 had a blister to her left heel measuring approximately 10 centimeter (cm). New orders were written to apply Skin Prep to the blister daily and float her heels.

Review of a Hospice note dated 10/11/18 read no changes in Resident #1's left heel blister.

Review of an as needed (PRN) Hospice note read Resident #1 was seen on 10/12/18 because her left heel blister had ruptured. There were new orders dated 10/12/18 which read her left heel was to be cleansed with Normal Saline (NS), the area patted dry and the application of Mepitel (two-sided wound contact layer dressing), cover with area with padding and wrap with a gauze dressing. The dressing was ordered to be changed every Monday and Thursday by the Hospice nurse.

Review of the Hospice notes from 10/12/18 through 10/22/18 revealed the Hospice Nurse provided Resident #1's left heel wound care every Monday and Thursday as ordered.

Review of a Hospice note dated 10/22/18 read Resident #1's left heel Mepitel dressing was

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hanging off her heel but not on the wound. New orders were written to clean her left heel wound with NS, pat dry then apply a Vaseline gauze, cover with a non-adherent dressing, pad the heel and secure with a gauze wrap. The dressing change was to be done every Monday and Thursday and the Hospice Nurse would be completing Resident #1's wound care.

Review of the Hospice notes from 10/22/18 through 10/31/18 revealed the Hospice Nurse provided Resident #1's left heel wound care every Monday and Thursday as ordered.
Review of the weekly Skin Evaluation Report dated 10/12/18, read her Resident #1 an open area to her left heel.

Review of a Hospice note dated 10/31/18 read there was new orders for paint Resident #1's left heel wound with Betadine, cover the wound with a nonadherent dressing and wrap with a gauze dressing daily. The note indicated the new wound care orders were discussed with the Treatment Nurse at the facility.

Review of the facility November 2018 Treatment Administration Record (TAR) revealed no documented evidence of Resident #1's daily treatment to her left heel on 11/2/18, 11/3/18,11/4/18, 11/10/18, 11/13/18, 11/16/18, 11/21/18, 11/22/18 11/24/18 and 11/26/18.

There was no evidence of a facility weekly Skin Evaluation Report for the week of 11/09/18, the week of 11/16/18, 11/23/18, 12/7/18 and 12/26/18.

Review of the facility December 2018 TAR revealed no documented evidence of Resident

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#1's daily treatment to her left heel on 12/2/18, 12/7/18, 12/11/18 12/19/18, 12/25/18, 12/28/18 and 12/29/18.

Review of Resident #1's skin/wound care plan dated revised 1/3/19 read her area to the left heel was described as unstageable. The goal was for Resident #1's wound was to show signs of healing. Interventions included the facility was to provide treatments as ordered

Review of the facility January 2019 TAR revealed no documented evidence of Resident #1's daily treatment to her left heel on 1/1/19, 1/2/19, 1/4/19 and 1/8/19.

During an interview on 1/8/19 at 10:14 AM, the Treatment Nurse stated that she had been the Treatment Nurse at the facility since October 2017. She revealed that prior to sometime around July of August 2018, the facility began having difficulty obtaining and maintaining Nursing Assistants (NA). She further explained at that time due to the lack of NAs on staff, she was normally assigned as an NA and the floor nurses were supposed to complete the treatments.

Review of a Nurse Practitioner (NP) note dated 1/10/19 read Resident #1 was seen for wound follow up to her left heel. The NP assessed Resident #1's left heel pressure ulcer was described as unstageable with 90% eschar with 10% granulation, no odor with a small amount of serous drainage. New orders were given for Thera-honey (dressing impregnated with medical grade honey) daily to any granulated areas and continue to apply betadine daily to the dark eschar.

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During another interview on 1/10/19 at 8:40 AM, the Treatment Nurse revealed she had concerns that treatments were not being provided as ordered to Resident #1 by the floor nurses for over a month.

Review of the facility Weekly Wound Report revealed Resident #1 did not appear on the report for pressure ulcers until the week of 1/23/19.

Review of Resident #1's skin/wound care plan dated revised 1/30/19 read her left heel wound was described as a stage 3 pressure ulcer. The goal was for Resident #1's wound was to show signs of healing. Interventions included the facility was to provide treatments as ordered.

During a wound care observation on 3/6/19 at 10:00 AM, the Treatment Nurse provided Resident #1' pressure ulcer treatment to her left heel. There were no observed concerns with her technique or infection control. Resident #1's left heel appeared pale pink in color with white wound edges. There was no odor and evidence of bloody drainage after cleaning the wound with NS. The area was padded dry and Santyl was applied to the wound bed which measured approximately 3 cm by 2 cm by 0.5 cm. The area was covered with a nonadherent dressing and wrapped with gauze. Resident #1's voiced no pain. She was lying on a properly functioning air mattress and her heels were floated above the mattress surface.

During an interview on 3/6/19 at 12:20 PM, the Administrator stated he assumed the role of Administrator of the facility shortly after the recertification survey exit date of 1/10/19. He stated it was at that time he became aware of the

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residents not receiving all their ordered treatments due to issues with staffing. He stated it was his expectation that all the residents with pressure ulcers receive their treatments as ordered.

During an interview on 3/6/19 at 1:38 PM, the Director of Nursing (DON) validated she worked with Resident #1 on 11/3/18 and 12/7/18 where there was no documented evidence of pressure ulcer care to Resident #1's left heel. She stated she was unable to recall if she did treatments on 11/3/18 and 12/7/18 but if she didn't document, she likely didn't do. The DON stated if she did not complete Resident #1's treatments on 11/3/18 and 12/7/18 it would have been because she didn't have time to do it due to limited staff. When asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered, the DON stated she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.

During an interview on 3/6/19 at 1:48 PM, Nurse #9 verified she worked with Resident #1 on 11/4/18, 11/10/18 and 12/2/18. Nurse #9 stated she was unable to recall if she completed Resident #1's treatment to her left heel on the days in question but stated during November 2018 and December 2018, the facility was short staffed, and communication was bad. Nurse #9 stated she was pulled from the medication cart and served as an aide on multiple occasions. She stated the Treatment Nurse was also pulled from completing treatments and put on a medication cart and when that happened, each nurse was responsible for completing their own treatments. Nurse #9 stated if she did not have time to get

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her treatments done on the days the Treatment Nurse was pulled off treatments, she would let the DON know because overtime would have to be approved for her to stay over and complete the treatments. Nurse #9 stated the DON would either complete the omitted treatments, or the DON would approve the overtime for her to stay over and complete them.

During an interview on 3/6/19 at 1:52 PM, Nurse #8 verified she worked with Resident #1 on 12/28/18, 1/1/19, 1/2/19 and 1/8/19. Nurse #8 stated she was unable to recall if she completed Resident #1's treatment to her left heel on the days in question but stated during November 2018, December 2018 and January 2019, she was often pulled from the medication cart to work as an aide due to short staffing. She stated the Treatment Nurse was usually pulled from completing treatments and she was put on a medication cart or worked as an aide too. Nurse #8 stated when the Treatment Nurse was pulled from completing treatments, the nurses were responsible for completing their own treatments. Nurse #8 stated it was very confusing and sometimes she would not know until the end of her shift working as an aide that her resident's treatments were not done. Nurse #8 stated she would inform the DON and it was up to her to either approve the overtime to allow her to stay and do the resident treatments. Nurse #8 stated she would either tell the oncoming shift to complete the treatments or the DON would tell her she would complete the missed treatments.

During an interview on 3/6/19 at 2:00 PM, the Treatment Nurse stated due to staffing she was pulled from completing treatment and either worked on a medication cart or as an aide up until

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recently. She stated when she was pulled from completing treatments, the nurses were responsible for completing their own treatments. The Treatment Nurse stated at times she would ask the DON for approval for overtime to stay over and complete any missed treatments and there were other times, she would stay over and complete the treatments to the worst wounds and not ask for the overtime. She stated she did this because she was worried about the wounds getting worse. She stated now she was able to perform her duties as the Treatment Nurse.

During an interview on 3/6/19 at 2:10 PM the DON and Treatment Nurse verified Resident #1 was not on the Weekly Wound Report for Pressure Ulcers prior to the week of 1/23/19 therefore, there was no evidence of the facility's weekly assessment of her left heel pressure ulcer prior to 1/23/19.

During a telephone interview on 3/6/19 at 2:25 PM, the Hospice Nurse stated there were occasions she knew Resident #1's treatments were not getting done due to staffing. She stated she tried to discuss her concerns with the Treatment Nurse and the floor nurses, but they were not working as aides, so she did not know if management was aware of her concerns. The Hospice Nurse stated Resident #1's left heel wound did worsen to the point it had to be debrided by the wound physician but there had been a lot of improvement since the staffing situation had improved.

During a telephone interview on 3/6/19 at 2:45 PM, the Nurse Practitioner (NP) stated she was aware the facility had experienced staffing issues and the nurses were working as aides. The NP

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also stated she was aware that the treatment Nurse was unable to perform her duties due to having to work as an aide or on a medication cart. The NP stated the lack of staff contributed to worsening of Resident #1's left heel wound but she could not say that staffing was the sole reason for the wound decline.

During a telephone interview on 3/6/19 at 4:20 PM, the Medical Director stated it was expectation that all treatments were completed as ordered. He stated Resident #1 had several terminal comorbidies that contributed to the worsening of her pressure ulcer but not receiving her treatments as ordered would have also contributed to the wound worsening.

3. Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included Multiple Sclerosis (MS) and stage 4 pressure ulcer of sacral region.

A physician ' s order for Resident #44 dated 10/23/18 indicated Dakin ' s Half Strength (antimicrobial cleanser) cleanse sacral wound with normal saline and pack with Dakin ' s solution, gauze, and cover with dressing twice daily.

The quarterly Minimum Data Set (MDS) assessment dated 11/28/18 indicated Resident #44 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #44 required extensive assistance of 1 staff for bed mobility, dressing, toileting, and personal hygiene.

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No transfers had no occurred during the MDS look back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel. She had one Stage 4 pressure ulcer that was present on admission. Resident #44 had a pressure reducing device for her bed and chair and she received pressure ulcer care.

A Wound Nurse Practitioner (WNP) note dated 12/6/18 indicated Resident #44 was seen for a follow up visit for a chronic stage 4 pressure ulcer to the sacrum. Resident #44 was on Dakin ' s wet to dry dressings. The Treatment Nurse reported the wound healing had stalled. Resident #44 was noted to be anemic and refused iron supplements but was agreeable to prenatal vitamins with iron. The resident also declined protein supplementation. She refused to eat the facility food and consumed large amounts of unhealthy fast food as well as junk food such as chips and candy. Resident #44 ' s sacral ulcer was noted with no improvement. The WNP ' s wound assessment indicated there was stool in the wound and on the dressing upon observation. The wound was noted to have stalled regarding healing secondary to anemia and poor protein supplementation per Resident #44 ' s dietary habits and lack of appropriate iron and protein supplementation. The wound showed no signs or symptoms of infection. The WNP noted to make a repeat advisement to Resident #44 to consider a colostomy because of the persistent wound contamination with stool which was also hindering the wound healing.

The medical record indicated Resident #44 was hospitalized for an unrelated condition from 12/12/18 through 12/18/18.

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A WNP note dated 12/26/18 indicated Resident #44 continued to have persistent fecal contamination of her wound which was a hinderance to healing. The resident continued to be nonadherent with diet recommendations. She was also noted to be nonadherent to turning and repositioning. The WNPs assessment of the Stage 4 sacral ulcer indicated no signs of improvement nor signs of infection. A recommendation was again made for a colostomy.

A review of Resident #44 ' s hard copy Treatment Administration Record (TAR) for December 2018 related to her Stage 4 sacral ulcer indicated the treatment was not consistently administered as ordered. A review of the facility ' s nursing schedule was conducted, and this was compared to the December 2018 TAR to reveal the following nursing staff assigned to Resident #44 on the dates and shifts that the treatment was not administered as ordered:

12/19/18 2nd shift - Nurse #11
12/21/18 1st shift - Nurse #12
12/22/18 2nd shift - Nurse #5
12/28/18 1st shift - Nurse #12
12/28/18 2nd shift - Nurse #5
12/29/18 1st shift - Nurse #3
12/29/18 2nd shift - Nurse #5
12/30/18 1st shift - Nurse #13
12/30/18 2nd shift - Nurse #5
12/31/18 1st shift - Nurse #3

A WNP note dated 1/3/19 indicated Resident #44 continued to have fecal contamination in the wound, nonadherence with diet recommendations, and nonadherence with turning and repositioning. The WNPs

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assessment of the wound continued to show no healing nor infection. A treatment order change was made for the sacral ulcer from Dakin ' s twice daily to Anasept (antimicrobial gel) wet to dry dressings once daily and as needed if the facility was able to acquire the gel from the pharmacy.

A physician ' s order for Resident #44 dated 1/3/19 indicated a discontinuation of the current sacral ulcer treatment (Dakin ' s Half Strength cleanse sacral wound with normal saline and pack with Dakin ' s solution, gauze, and cover with dressing twice daily) and initiation of Anisept wet to dry dressing daily and as needed if the facility was able to acquire the gel from the pharmacy.

A review of Resident #44 ' s hard copy TAR for January 2019 from 1/1/19 through 1/8/19 related to her Stage 4 sacral ulcer indicated her treatments had not been administered as ordered. This TAR showed that the 1/3/19 order for Anasept gel once daily and as needed was added to the TAR on 1/3/19 with a notation that read, "when Anasept comes in". The previous order for the Dakin ' s twice daily was to be continued until the Anasept came in. The Treatment Nurse ' s documentation on the TAR indicated that Anasept was received and applied for the first time on 1/9/19. A review of the facility ' s nursing schedule was conducted, and this was compared to the January 2019 TAR to reveal the following nursing staff assigned to Resident #44 on the dates and shifts that the treatment was not administered as ordered:

1/1/19 1st shift - Nurse #12
1/1/19 2nd shift - Nurse #14
1/2/19 1st shift - Nurse #3

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F 686	Continued From page 144 1/2/19 2nd shift - Nurse #5 1/3/19 2nd shift - Nurse #2 1/4/19 2nd shift - Nurse #5 1/5/19 1st shift - Nurse #15 1/5/19 2nd shift - Nurse #5 & Nurse #15 (split shift) 1/6/19 1st shift - Nurse #15 1/6/19 2nd shift - Nurse #5 & Nurse #15 (split shift) 1/7/19 2nd shift - Nurse #12 1/8/19 1st shift - Nurse #3 1/8/19 2nd shift - Nurse #5 The active care plan for Resident #44 indicated the focus area of skin/wound and identified the continued presence of a Stage 4 pressure ulcer to her sacrum that was acquired prior to her admission (8/21/18). The interventions included, in part, administer treatments as ordered. An interview was conducted with Resident #44 on 1/7/19 at 12:00 PM. She reported she had a pressure ulcer on her sacrum that developed prior to her admission. She stated that her treatment orders included the changing of her dressing twice daily, once during the first shift (7:00 AM to 3:00 PM) and once during the second shift (3:00 PM to 11:00 PM). She stated that her dressing was not always changed as ordered. She indicated that she believed it was normally Nurse #5 who had not changed her dressing as ordered. Resident #44 stated that she was unsure if Nurse #5 just forgot to change the dressing or if she ran out of time during her shift and didn ' t get to it. An interview was conducted with the Treatment Nurse on 1/8/19 at 10:14 AM. She stated that she had been the Treatment Nurse at the facility	F 686		

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since October 2017. She revealed that since June or July of 2018 she was only working in the role of Treatment Nurse once weekly when the WNP came to the facility. She explained the facility had been having difficulty obtaining and maintaining Nursing Assistants (NA). She further explained that due to the lack of NAs on staff, she was normally assigned as an NA and the floor nurses were supposed to complete the treatments.

An observation of wound care that was provided by the Treatment Nurse for Resident #44 ' s sacral pressure ulcer was conducted on 1/9/19 at 11:14 AM. The Treatment Nurse provided the wound care as ordered.

A second interview was conducted with the Treatment Nurse on 1/10/19 at 8:40 AM. The Treatment Nurse confirmed Resident #44 ' s interview that the treatment for her sacral pressure ulcer was not consistently provided as ordered. She additionally confirmed Resident #44 ' s statement that she was aware Nurse #5 had not consistently provided the sacral ulcer treatment as ordered when she was assigned to the resident. The Treatment Nurse revealed that there were multiple occasions that she had worked on a Friday, changed Resident #44 ' s sacral ulcer dressing, and returned to work the following Monday to find the same dressing on the sacral ulcer that she put in place on Friday. She explained that she dated each of her dressings and this was how she knew it was the same dressing. She further revealed that she provided treatment to Resident #44 ' s sacral ulcer on 1/7/19 with Dakin ' s during the first shift and that when she provided the treatment to her sacral ulcer today (1/9/19) the same dressing

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from 1/7/19 was in place.

This interview with the Treatment Nurse continued. She stated that Resident #44 ' s sacral ulcer was easily contaminated by stool and that inconsistent dressing changes could have a negative impact on the wound healing. She stated that Resident #44 ' s sacral ulcer ' s healing had stalled and remained stable. She indicated the WNP made a change to Resident #44 ' s sacral ulcer treatment on 1/3/19 to discontinue Dakin ' s twice daily and start Anasept wet to dry dressings once daily and as needed. She indicated the Anasept took several days to obtain pharmacy approval for and they just received the medication on 1/9/19. She reported that the Dakin ' s twice daily was supposed to be continued until the Anasept was received, but this had not occurred. The Treatment Nurse stated that she informed the Director of Nursing (DON) of this issue with treatments not consistently being provided as ordered.

A phone interview was conducted with Nurse #5 on 1/10/19 at 10:17 AM. Nurse #5 was assigned to Resident #44 on 9 instances when her sacral ulcer treatment was not provided as ordered. She was asked if she provided wound care treatment to Resident #44 ' s sacral ulcer when she was assigned to her. She stated that Resident #44 ' s wound care for the sacral ulcer was normally provided on the first shift. She revealed that she changed the resident ' s dressing if needed in the evening or if incontinent care was required. Nurse #5 revealed she was unaware Resident #44 ' s previous treatment order for Dakin ' s was supposed to be provided twice daily. She additionally stated that she was unaware that the treatment order for Dakin ' s

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was supposed to continue until the Anasept gel from the 1/3/19 treatment order was received at the facility.

An interview was conducted with Nurse #3 on 1/10/19 at 11:39 AM. Nurse #3 was assigned to Resident #44 on 4 instances when her sacral ulcer treatment was not provided as ordered. She stated that she was responsible for providing wound care treatment to Resident #44 when she was assigned to her. She explained that the facility had a Treatment Nurse on staff, but that for the past several months the Treatment Nurse had been assigned as an NA on the floor and had not been providing treatments unless the WNP was in the facility. Resident #44 ' s TARs were reviewed with Nurse #3. She stated that if she had completed Resident #44 ' s treatment she would have marked it on the TAR as completed. She revealed that sometimes there were things that got missed. She explained that some days she worked as a Nurse and sometimes she was assigned as an NA. She further explained that things got very hectic at times.

A phone interview was attempted with Nurse #11 on 1/10/19 at 10:18 AM. She was unable to be reached for interviewed.

An interview was conducted with the WNP on 1/10/19 at 9:15 AM. She stated that she came to the facility once per week for wound assessments. She indicated that Resident #44 had a large sacral ulcer, Stage 4, that was present on her admission to the facility. She reported that the sacral ulcer is easily contaminated by stool due to its location and the resident ' s bowel incontinence. She indicated that on each of her assessments the dressing

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and wound had fecal contamination. She stated that she had recommended a colostomy for the resident due to the difficulty with keeping the wound free of fecal contamination. The WNP indicated that Resident #44 ' s wound had been stable, with no signs of improvement and no signs of infection. She verified her notes that reported on resident #44 ' s nonadherence to diet recommendations and turning/repositioning recommendations. She discussed Resident #44 ' s previous sacral ulcer treatment order for Dakin ' s twice daily (initiated 10/23/18). She reported that Dakin ' s had a 12-hour half-life, meaning that if the Dakin ' s was not reapplied every 12 hours it ' s effect was gone. She then spoke about the 1/3/19 order for a treatment change to Anasept once daily. She stated that because Resident #44 ' s wound was not healing she wanted to try a change in treatment to the Anasept. She explained that she was unsure if the Anasept was going to be approved by the pharmacy, so she indicated that the Dakin ' s twice daily was to continue until the Anasept was received at the facility. The WNP indicated she was not aware the Anasept was not received until 1/9/19. The treatment records that showed inconsistent administration of the treatments for Resident #44 ' s sacral ulcer was reviewed with the WNP. She stated that she expected for treatments to be provided as ordered. She added that due to the location of Resident #44 ' s sacral ulcer, it was pertinent that treatments were provided as ordered and the dressing was regularly changed to reduce the risk of infection. The WNP stated that she was going to assess Resident #44 ' s sacral ulcer on this date (1/10/19).

A follow up interview was conducted with the

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F 686	Continued From page 149 WNP on 1/10/19 at 11:37 AM. She stated that she observed Resident #44 ' s sacral wound and completed an assessment. She revealed that this assessment showed the wound had some improvement and she contributed the change to the Anasept. An interview was conducted with the Administrator and DON on 1/10/19 at 2:31 PM. They both indicated that they expected wound care treatments to be provided as ordered. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.	F 686		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		4/3/19

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F 690	Continued From page 150 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, and Nurse Practitioner, the facility failed to provide urinary catheter care as ordered for 1 of 1 sampled residents (Resident #44) reviewed for urinary catheter care. The findings included: Resident #44 was initially admitted to the facility on 8/21/18 and most recently readmitted on 12/18/18 with diagnoses that included neurogenic bladder, chronic urinary retention, and personal history of Urinary Tract Infections (UTIs). A physician ' s order dated 8/30/18 indicated cleanse Resident #44 ' s suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily. The quarterly Minimum Data Set (MDS) assessment dated 11/28/18 indicated Resident	F 690	F690- Bowel/Bladder Incontinence, Catheter, UTI 1. On 1/8/2019 Resident # 44 received catheter care by a licensed nurse. 2. The Regional Director of Clinical Services completed a quality review (audit) of residents with catheters to ensure treatment is provided as ordered by on 3-14-19. All residents with catheters received catheter care as ordered. 3. The DON will provide re-education to licensed nurses, including all shifts, part-time and prn, on providing and documenting treatments to residents with catheters by 3/21/19. No staff will be allowed to work until education complete. 4. RDCS and or DON will conduct quality	

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F 690	Continued From page 151 #44 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #44 required extensive assistance of 1 staff for bed mobility, dressing, toileting, and personal hygiene. No transfers had occurred during the MDS look back period. Resident #44 had an indwelling catheter and was frequently incontinent of bowel. A Nurse Practitioner (NP) note dated 12/4/18 indicated Resident #44 had her catheter irrigated on this date and the nurse reported the presence of a large amount of sediment that was flushed clear. The NP indicated a plan to flush the suprapubic catheter twice weekly and as needed for increased sedimentation. A physician ' s order dated 12/4/18 for Resident #44 indicated irrigation to suprapubic catheter twice weekly (Tuesday and Friday) and as needed for increased sedimentation. The physician ' s order dated 8/30/18 to cleanse Resident #44 ' s suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily remained an active order. A physician ' s order dated 12/27/18 repeated the same order that was initiated on 8/30/18 to cleanse Resident #44 ' s suprapubic catheter site with normal saline, pat dry, and apply silver alginate and dressing once daily. A review of Resident #44 ' s hard copy Treatment Administration Record (TAR) and Medication Administration Record (MAR) for December 2018 was conducted and revealed the physician ' s order related to cleansing of the suprapubic catheter once daily (first shift) was not consistently provided as ordered. The order for	F 690	monitoring (audit) including observation of treatments and documentation for residents with catheters, 3 times per week for 4 weeks, then weekly for 3 months. The DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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irrigation of the catheter was placed on the TAR for the 1st shift staff on Tuesdays and Fridays and also was placed on MAR for the 2nd shift on Tuesdays and Fridays. This order for irrigation of the catheter was also not provided as ordered. A review of the facility ' s nursing schedule was conducted, and this was compared to the December 2018 TAR & MAR to reveal the following nursing staff assigned to Resident #44 on the dates and shifts that the catheter treatment was not provided as ordered:

12/19/18 1st shift - Nurse #3 failed to provide the order for cleansing
12/20/18 1st shift - Nurse #12 failed to provide the order for cleansing
12/21/18 1st shift - Nurse #12 failed to provide the order for cleansing
12/21/18 1st shift/2nd shift - Nurse #12 and Nurse #5 failed to provide the order for irrigation
12/27/18 1st shift - Nurse #3 failed to provide the order for cleansing
12/28/18 1st shift - Nurse #12 failed to provide the order for cleansing
12/28/18 1st shift/2nd shift - Nurse #12 and Nurse #5 failed to provide the order for irrigation
12/30/18 1st shift - Nurse #13 failed to provide the order for cleansing
12/31/18 1st shift - Nurse #3 failed to provide the order for cleansing

A review of Resident #44 ' s hard copy TAR and MAR for January 2019 from 1/1/19 through 1/8/19 was conducted and revealed the physician ' s order related to cleansing of the suprapubic catheter once daily (first shift) was not provided as ordered. A review of the facility ' s nursing schedule was conducted, and this was compared to the January 2019 TAR & MAR to reveal the

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following nursing staff assigned to Resident #44 on the dates and shifts that the catheter treatment was not provided as ordered:

1/1/19 1st shift - Nurse #12
1/2/19 1st shift - Nurse #3
1/3/19 1st shift - Nurse #3
1/4/19 1st shift - Nurse #3
1/5/19 1st shift - Nurse #15
1/6/19 1st shift - Nurse #15
1/7/19 1st shift - Nurse #3
1/8/19 1st shift - Nurse #3

The active care plan, reviewed 1/8/19, for Resident #44 indicated the focus area of the risk for altered bladder elimination related neurogenic bladder, suprapubic catheter, chronic urinary retention, and recurrent UTIs. The interventions included, in part, suprapubic catheter care as ordered by the physician and irrigation of the suprapubic catheter twice weekly and as needed.

An interview was conducted with Resident #44 on 1/7/19 at 12:00 PM. She reported she had a suprapubic catheter.
She stated that her treatment orders, including irrigation and cleansing, were not always provided as ordered.
Resident #44 stated that she was unsure if the nurses just forgot to provide the treatments or if they ran out of time during the shifts and didn ' t get to it. She indicated that she often had a lot of sedimentation which required regular irrigation to be completed.

A phone interview was conducted with Nurse #5 on 1/10/19 at 10:17 AM. Nurse #5 was assigned to Resident #44 on 2 instances when irrigation of the catheter was not provided as ordered. She

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was asked if she provided catheter care for Resident #44 when she was assigned to her. She initially stated that she had not provided catheter care to Resident #44 as it was normally provided by the first shift. She then stated that she may have provided catheter care if the first shift staff had not gotten to it. Nurse #5 was unable to recall if she had irrigated Resident #44 ' s catheter. She revealed that there were times that things got really "hectic" and she couldn ' t get to everything.

An interview was conducted with Nurse #3 on 1/10/19 at 11:39 AM. Nurse #3 was assigned to Resident #44 on 8 instances when cleansing of the catheter site was not provided as ordered. She stated that she was responsible for providing catheter care as ordered to Resident #44 when she was assigned to her. Resident #44 ' s TARs and MARs were reviewed with Nurse #3. She stated that if she had completed Resident #44 ' s treatment she would have marked it complete on the TAR or the MAR (as applicable). She revealed that sometimes there were things that got missed. She explained that some days she worked as a Nurse and sometimes she was assigned as an NA due to the facility ' s difficulty obtaining and maintaining enough NAs to staff all three shifts. Nurse #3 also shared that the reason the order for the catheter irrigation was on both the December 2018 TAR for the 1st shift and the MAR for the 2nd shift was because it had been identified that the irrigation was not always provided as ordered for Resident #44 so they put it down for both shifts to ensure it was completed by 1 of the 2 shifts.

An interview was conducted with the NP on 1/10/19 at 12:05 PM. She stated that Resident

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F 690	Continued From page 155 #44 had a very complicated medical history. She reported she had suprapubic catheter and a long history of chronic UTIs. She indicated Resident #44 was chronically positive for UTIs and that she had a tendency to become septic rapidly. She stated that she expected her orders to be followed related to catheter care and revealed she was unaware that the orders were inconsistently implemented. The NP expressed that she believed no negative consequences occurred for Resident #44 related to the inconsistent provision of her catheter care orders. An interview was conducted with the Administrator and DON on 1/10/19 at 2:31 PM. They both indicated that they expected catheter care to be provided as ordered. The DON was asked who was responsible for monitoring the TARs to ensure that treatments were administered as ordered. She revealed that she had been monitoring the Medication Administration Records (MARs), but no one had been monitoring the TARs.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		4/3/19

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F 692	Continued From page 156 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a Physician ordered dietary supplement to prevent unexpected weight loss and failed to assist a dependent resident with eating for 1 (Resident #4) of 5 sampled residents reviewed for weight loss. The findings include: Resident #4 was admitted on 10/1/18 with cumulative diagnoses of Cerebral Vascular Accident and Dysphagia. Review of Resident #4's Nutrition Assessment dated 10/4/18 indicated his admission diet order was pureed food, No Added Salt (NAS), honey thick liquids, divided plate, maroon spoon (a spoon with narrow, shallow bowl to allow food to slide off easily for a resident with poor lip closure and tongue thrust) and staff dependence for eating. Resident #4's admission Minimum Data Set (MDS) dated 10/8/18 indicated the Cognitive Pattern assessment (Section C) was incomplete with exhibited physical behaviors and rejection of care. He was coded for extensive assistance with eating. Resident #4 was coded for no known weight loss or weight gain, a mechanically	F 692	F692- Nutrition/Hydration Status Maintenance 1. On 1/7/2019 the Dietary Manager and DON audited Resident #4's diet order to tray ticket to ensure resident received the meal supplements as ordered. The audit revealed the meal supplements are being received as ordered. Resident #4 was provided assistance with meals on 1/10/19. 2. The Dietary Manager, DON and RDCS completed a quality review (audit) of all diet orders and compared to resident tray cards on 2/18/2019 to ensure supplements was provided to residents as ordered. The RDCS, DON and Divisional Director of Nursing (DDCS) completed a quality review of all residents by observation to ensure appropriate assistance provided during meal times on 3-27-19. No negative findings were identified. 3. The Dietary Manager re-educated dietary staff, including all shifts, part-time, prn and weekends, on providing supplements based on the tray card by	

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F 692	Continued From page 157 altered, therapeutic diet and a weight of 145 pounds. Review of Resident #4's undated nutrition/swallowing problems care plan indicated interventions included was monthly weight, Register Dietician (RD) as needed and assistance with eating as needed. Review of Resident #4's undated Nurse Tech Communication Kardex indicated he was dependent on staff for eating. Review of a Diet Requisition Form dated 10/29/18 read Resident #4 was to be up in his wheelchair for all meals and he was dependent on staff for eating using a divided plate and maroon spoon. Review of Resident #4's weight on 11/9/18 was 150 pounds and 141 pounds on 12/5/18 (6% weight loss in one month). Review of Resident #4's weight for the week of 12/16/18 through 12/22/18 was 143.6 pounds. Review of a RD note dated 12/21/18 read Resident #4 was seen due to weight loss. The note indicated he was spoon fed. The note read Resident #4 may benefit from magic cup and double portions at breakfast. Review of a written Physician Order dated 12/21/18 was written for Resident #4 to receive a frozen nutritional supplement on lunch and dinner tray and double portions at breakfast. Review of Resident #4's medical record did not reveal a Diet Requisition Form for the frozen nutritional supplement at lunch and dinner or	F 692	3/27/19. The DON, Divisional ED and or RDCS will re-educate nursing staff, including all shifts, part-time and prn, on validating supplements on tray cards to ensure the resident receives supplements as ordered and providing assistance with meals per plan of care by 3/27/2019. No staff will be allowed to work until education complete. 4. The Dietary Manager and or DON will conduct quality monitoring (audit) and observation of 5 tray cards and residents with feeding assistance 5 times a week for 4 weeks, 2 times a week for 4 weeks then weekly for 8 weeks to ensure supplements are provided as ordered. The DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/19.	

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double portions at breakfast.

Review of Resident #4's January 2019 monthly Physician Orders included orders for the frozen nutritional supplement at lunch and dinner with double portions at breakfast.

In an observation on 1/7/19 at 12:40 PM in the main dining room, Resident #4 was sitting in a reclining chair pushed up next to the table to allow him to feed himself using his right hand. He was using a maroon spoon and divided plate. Food was observed on his shirt and on the table. Nursing Assistant (NA) #9 was also sitting at the table assisting another resident with her lunch. NA #9 stated Resident #4 was able to feed himself using the maroon spoon and divided plate with verbal cueing.

In an observation on 1/8/19 at 12:15 PM in the main dining room, Resident #4 was sitting in a reclining chair pushed up next to the table to allow him to feed himself using his right hand. He was using a maroon spoon and divided plate. There was no observed the frozen nutritional supplement on his tray and on review of his tray ticket, the nutritional supplement was not listed as ordered. NA #9 stated Resident #4 was able to feed himself, but she would intervene if needed. NA #9 stated she was not aware that Resident #4 should have the nutritional supplement with lunch and dinner.

In an interview on 1/8/19 at 12:15 PM, the Dietary Manage r(DM) reviewed Resident #4's medical record and stated there was no Diet Requisition Form completed on 12/21/18 when the nutritional supplement was ordered. The DM stated if no Diet Requisition Form was completed, the kitchen

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would not know that the frozen nutritional supplement was ordered for lunch and dinner.

In an interview and observation on 1/9/19 at 12:30 in the main dining room, Nurse #10 was observed feeding Resident #4. Observation of his tray included a frozen nutritional supplement and his tray ticket also reflected the frozen nutritional supplement and lunch and dinner. Nurse #10 stated Resident #4 was not able to feed himself and had to be fed all meals.

In an interview on 1/9/19 at 1:45 PM, the Director of Nursing (DON) stated Resident #4's weight on 1/4/19 was 145 pounds.

In an interview on 1/9/19 at 3:10 PM, the DON stated it was her expectation that Resident #4 receive his nutritional supplement for lunch and dinner to prevent unexpected weight loss. She stated the RD wrote the order on 12/21/18 for the frozen nutritional supplement and the nurse who took off the order did not complete the Diet Requisition Form to be forwarded to the kitchen. The DON stated it was the responsibility of the RD to complete the Diet Requisition Form.

In a telephone interview on 1/9/19 at 3:50 PM, the RD stated she was new to the facility but in her other facilities, the nurse who took off the Physician order completed the Diet Requisition Form and forwarded it to the kitchen. The RD stated she would clarify with the DON her expectations. The RD stated it was her expectation that Resident #4 receive the nutritional supplement at lunch and dinner and double portions at breakfast to prevent unexpected weight loss.

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F 692	Continued From page 160 In an observation on 1/10/19 at 8:30 AM, NA #1 was feeding Resident #4 his breakfast. NA #1 stated Resident #4 needed staff assistance with eating. Observation of the tray revealed double portions and double portions was indicated on the tray ticket. In an interview on 1/10/19 at 9:30 AM, the Nurse Practitioner stated it was her expectation that Resident #4 receive all supplements and staff assistance with eating to prevent unexpected weight loss. In an interview on 1/10/19 at 2:30 PM, the Administrator stated since he was not a nurse, he was not sure of who was responsible for completing the Diet Requisition Form when the new orders for the nutritional supplement and double portions was ordered on 12/21/18. He stated it was his expectation that Resident #4 receive all supplements and staff assistance with eating to prevent unexpected weight loss.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and resident interviews, the facility failed to have a	F 695	F695- Respiratory/Tracheostomy Care and Suctioning	

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F 695	Continued From page 161 physician order for oxygen administration (Resident #19) and failed to store a reuseable nebulizer mask and date nebeulizer tubing in accordance with professional standards of practice (Resident #2) for 2 of 2 sampled residents reviewed for respiratory care. Findings included: 1. Resident #19 was admitted on 8/4/18 with the diagnosis of chronic obstructive pulmonary disease. A review of the resident ' s quarterly Minimum Data Set dated 10/18/18 revealed the resident had an intact cognition, required extensive assist of 1 staff for all activities of daily living except meals and locomotion. The MDS did not indicate the resident received oxygen treatments. A review of the resident ' s care plan dated 10/08/18 revealed respiratory deficit with intervention for continuous positive airway pressure (CPAP) at night and that the resident refused. A review of the resident ' s physician orders revealed there was not an order in place for the resident to use oxygen. On 1/7/19 at 3:50 pm an interview was conducted with the resident who stated that she used the oxygen by nasal cannula 2 liters every night and was independent. The resident commented that she did not use the pressure mask (continuous positive airway pressure, CPAP) at night any longer. The resident stated she had been using oxygen in the facility at night since November 2018. The resident stated she used the oxygen	F 695	1. On 1/9/2019 the DCS assessed Resident #□s 19 and 2, and an order was received for Resident #19 to receive oxygen; and Resident #2 was provided new tubing which was dated and stored. 2. On 1/18/2019 the DCS completed a quality review (audit) of residents using oxygen to ensure orders were in place and oxygen/nebulizer equipment is dated and stored appropriately when not in use. No negative findings were identified. 3. The DCS will provide re-education to direct care and licensed nurses, including all shifts, part-time and prn, on ensuring orders for oxygen are received and in place as well as proper storage of oxygen/nebulizer masks and tubing when not in use by 2/8/2019. Staff will not be allowed to work until education complete. 4. RDCS and or DCS will conduct random quality monitoring (audit) of physician orders for oxygen and, oxygen and or nebulizer tubing is dated and stored when not in use, 3 times per week for 4 weeks, then weekly for 3 months. The DCS will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 2/20/2019.	

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at night instead of the CPAP because she was short of breath.

On 1/7/19 at 3:50 pm an observation was of the oxygen concentrator that was in the resident ' s room. The concentrator was observed to be next to the resident ' s bed.

A review of the resident ' s nurses' notes from 12/8/18 to 01/08/19 revealed no documentation of oxygen administration. The resident had a pulse oximetry documented of greater than 92% on room air for each day January 2019.

A review of the resident ' s physician progress note dated 12/27/18 revealed no mention of oxygen administration.

A review of the resident ' s respiratory therapy note dated 1/7/19 revealed the resident was on room air with a 98%, oxygen saturation and the oxygen concentrator was at the bedside. The resident reported the resident used the oxygen at night. The oxygen concentrator was checked and cleaned. (no mention of oxygen tubing or humidification change).

On 1/8/19 at 10:30 am an interview was conducted with the treatment nurse who stated that she was aware that the resident used oxygen at night since she was no longer using the CPAP for a couple of months. The resident refused to use the CPAP. The treatment nurse was not aware the resident did not have an order for oxygen.

On 1/8/19 at 1:57 pm an interview was conducted with Nurse #9 who stated the she was aware that the resident used the oxygen at night but was not

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aware there was not an oxygen order in place and did not know why there was no order.

On 1/9/19 at 9:55 am an interview was conducted with the Director of Nursing who stated she was not aware that the resident did not have an order for oxygen but was aware that the resident was using the oxygen at night instead of her CPAP.

2. Resident #2 was re-admitted to the facility on 9/23/18 with diagnoses, in part, of congestive heart failure and chronic obstructive pulmonary disease.

A review of the facility policy titled "Equipment Change Schedule" revised 8/28/17 read, in part, under procedure, nebulizer set-up, "once, every 7 days along with equipment bag labeled with name, date and room number".

A review of a significant change in assessment dated 10/1/18 revealed Resident #2 was cognitively intact, required extensive to total dependence for her activities of daily living and had no behaviors.

A review of the physician orders for December 2018 revealed an order for Duoneb-Albuterol, inhale contents of 1 vial via nebulizer every 6 hours for 7 days than continue as needed.

An observation on 1/7/19 at 3:11 PM revealed a

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F 695	Continued From page 164 nebulizer mask, tubing and machine on Resident #2 ' s nightstand. The nebulizer mask and tubing was not bagged, labeled or dated. An observation on 1/8/19 at 8:30 AM revealed a nebulizer mask, tubing and machine on Resident #2 ' s nightstand. The nebulizer mask and tubing was not bagged, labeled or dated. Two attempts to call the night shift nurse for Resident #2 on 1/9/19 and 1/10/19 were unsuccessful. An interview on 1/10/10 at 10:08 AM with the Director of Nursing revealed the night shift nurse on the hall was responsible for changing the nebulizer masks and making sure it was bagged, labeled and dated. She stated her expectation was that it be done weekly. She did not know why it had not been done for Resident #2.	F 695		
F 725 SS=K	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		4/3/19

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F 725	Continued From page 165 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident, family, staff, Department of Social Services, and Nurse Practitioners, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer wound care, urinary catheter care, assistance with Activities of Daily Living (ADLs), and respond to call bells. The facility also failed to provide sufficient nursing staff to honor resident preferences, treat residents with dignity and respect, resolve individual and resident council grievances, and ensure Nursing Assistant involvement in the development of the comprehensive care plan. This affected 14 of 24 sampled residents (Residents #1, #30, #32, #36, #44, #47, #49, #50, and 6 members of the resident council). The repeated failure to provide sufficient staffing for pressure ulcer care to Resident #36 resulted in his pressure ulcer worsening and the development of MRSA (Methicillin-resistant Staphylococcus) infection. Immediate Jeopardy began on 11/6/18 when Resident #36 developed a MRSA infection in a pressure ulcer that had worsened as a result of	F 725	F725- Sufficient Nursing Staff 1. Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/08/19).The Divisional Executive Director, Regional Vice President of Operations, Regional Director of Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources conferred to discuss Root Cause Analysis and develop an action plan. The action plan included the following: Recruit, with incentives, CNA, LPN and RN staff from sister center in Triad market, Referral Bonus for existing staff with immediate pay out, Recruit and hire Personal Care Assistants, Retrain staff scheduler and ensure schedule is accurate, Sign on bonus for CNA position. On 01/22/19 a root cause analysis was completed by the Regional Vice President of Operations, Regional Director of	

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F 725	Continued From page 166 the facility's repeated failure to follow physician orders for daily pressure ulcer wound care, the repeated failure to complete weekly wound measurements/assessments, and the failure to coordinate care with the resident's external podiatrist. Immediate Jeopardy was removed on 3/6/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of "H" (actual harm that is not immediate jeopardy) for Examples #1a and #1b. Examples #2, #3, and #4 were cited at a scope and severity of "G", examples #5 and #6 were cited at scope and severity of "E", and examples #7 and #8 were cited at a scope and severity of "D". The findings included: This tag is cross-referred to: 1a. F600: Based on record review, observations, staff interview, resident interview, family interview, wound care Nurse Practitioner interview, Nurse Practitioner interview, and Department of Social Services interview, the facility neglected to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation, and communication with the outside podiatrist who was also treating, resulting in a worsening pressure ulcer and infection (Resident #36); neglected to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation resulting in a worsening pressure ulcer (Resident #1); and neglected to provide daily pressure ulcer	F 725	Clinical Services, the Director of Nursing and the Divisional Executive Director (acting administrator) and determined that the Executive Director failed to provide consistent staffing to ensure treatments were completed as ordered. By 2/7/19 sufficient staffs were provided to ensure residents receiving pressure ulcer treatment, urinary catheter care, ADLs, timely response of call bells and CNA involvement in the development of the comprehensive care plan. 2. On 1/22/2019 the ED, Regional Vice President of Operations (RVPO), Divisional Human Resources Director of Human Resources conferenced and implemented staffing plans including wage increases, recruitment and retention plans to ensure sufficient staffing. On 2/7/19 sufficient staffs have been hired and have or are completing orientation. 3. The Executive Director will work with facility and corporate Human Resources staff to fulfill staffing needs through appropriate recruitment and retention programs by 2/20/2019 and on-going. Executive Director will monitor staff openings, recruitment, training and scheduling of staff through review of daily staffing levels at morning and evening meetings, review of open positions and validation of staffing levels daily. Executive Director will monitor staffing 5 times a week then 3 times a week for 4 weeks then 1 time a week for 8 weeks to ensure all resources are utilized. The ED will report on the results of the quality	

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F 725	Continued From page 167 wound care as ordered and weekly wound measurement/assessment and documentation (Resident #44) for 3 of 4 residents reviewed; the facility neglected to provide catheter care (Resident #44) for 1 of 1 resident reviewed; and the facility also neglected to answer a call light related to a request for incontinence care (Resident #49) for 1 of 1 resident reviewed. 1b. F686: Based on record review, observations, staff interview, resident and family interview, wound care Nurse Practitioner interview, and Nurse Practitioner interview, the facility failed to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation, and communication with the outside podiatrist who was also treating resulting in a worsening pressure ulcer and infection (Resident #36); failed to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation resulting in a worsening pressure ulcer (Resident #1); and failed to provide daily pressure ulcer wound care as ordered and weekly wound measurement/assessment and documentation (Resident #44) for 3 of 4 sampled residents reviewed for wound care. During an interview with the Administrator on 1/8/19 at 10:30 AM he stated he started as the Administrator in June of 2018. He revealed that the facility had been having difficulty obtaining and maintaining enough NAs to staff all three shifts since that time. He reported that nurses had been assigned to work as Nursing Assistants (NAs) to fill in the gaps on the schedule. The Administrator stated that the Treatment Nurse	F 725	monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels through internal portal and weekly visits to ensure adequate staffing is maintained. The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 03/06/19, including the Interim Executive Director, Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director, the Environmental Services Director, the Regional Vice President of Operations and Regional Director of Clinical Services regarding the plan of removal of immediacy. 4. Executive Director will monitor staffing 5 times a week then 3 times a week for 4 weeks then 1 time a week for 8 weeks to ensure all resources are utilized. The ED will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels through internal portal and weekly visits to ensure adequate staffing is	

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F 725	Continued From page 168 was one of the nurses who frequently had been assigned as an NA. A follow up interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He stated that sufficient staffing meant having enough staff both in terms of quality and quantity to meet the needs of the residents. He acknowledged his awareness that sufficient staffing was an issue at the facility. He stated that the facility was currently working with the corporate office to develop employment incentives to obtain and maintain additional staff to meet the needs of the residents. An interview was conducted with the Treatment Nurse on 3/6/19 at 12:04 PM. She indicated the facility was insufficiently staffed to meet the needs of the residents. She revealed this insufficient staffing resulted in a failure to provide pressure ulcer care as ordered by the physician. An interview was conducted with the Director of Nursing (DON) on 3/6/19 at 11:50 AM. She revealed the facility was insufficiently staffed to meet the needs of the residents. She stated this insufficient staffing resulted in a failure to provide pressure ulcer care as ordered by the physician. An interview was conducted with the Interim Administrator on 3/6/19 at 12:20 PM. He reported he began working at the facility as an Interim Administrator on 1/18/19. He revealed the Regional Vice President of Operations (RVPO), the Corporate Human Resources Director, and himself identified insufficient staffing as the root cause of the facility's failure to meet the needs of the residents. He further revealed this insufficient staffing resulted in a failure to provide pressure ulcer care as ordered by the physician.	F 725	maintained. The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 03/06/19, including the Interim Executive Director, Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director, the Environmental Services Director, the Regional Vice President of Operations and Regional Director of Clinical Services regarding the plan of removal of immediacy. 5. Date of Compliance 4/3/2019.	

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F 725	Continued From page 169 An interview was conducted with the RVPO on 3/6/19 at 1:34 PM. He confirmed the Treatment Nurse's, DON's, and Interim Administrator's interviews that indicated the facility had been insufficiently staffed to meet the needs of the residents. He verified that this insufficient staffing resulted in a failure to provide pressure ulcer care as ordered by the physician. The RVPO stated the previous Administrator made him aware of some difficulties with the facility obtaining staff, but he had not described the extent of these difficulties. He revealed he had been unaware that residents' needs were unable to be met because the facility was insufficiently staffed. The RVPO stated that the root cause of the facility's failures was two-fold: 1. A lack of oversight 2. Insufficient staff The RVPO explained that the facility's previous Administrator failed to provide oversight of processes and policies and effective leadership to ensure residents were free from neglect, received pressure ulcer care as ordered by the physician, and maintained sufficient nursing staffing to provide necessary care and services. The Interim Administrator, DON, and RVPO were notified of the Immediate Jeopardy on 3/6/19 at 11:29 AM. On 3/6/19 at 5:17 PM the facility provided the following credible allegation of Immediate Jeopardy removal: The center Executive Director alleges abatement of immediate jeopardy on 03/06/19.	F 725		

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F 725	Continued From page 170 Deficient Practice: The facility failed to provide sufficient staff to ensure residents received pressure ulcer treatment. A Root Cause Analysis was completed 01/22/2019 by the Divisional Executive Director, Regional Vice President of Operations, Regional Director of Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources. The preliminary investigative information to determine root cause was the center wage scale and a competitive wage analysis. The competitive wage analysis revealed that the center needed to increase the lower end of the wage scale for new hires as compared to other centers in the market. The contributing factors identified the following issues: - The Executive Director's failure to follow guidance for keeping recruitment software up to date. The recruitment software provides real-time open positions to online job websites (Indeed, Monster, etc.); additionally, the software pulls resumes and applications to ensure a flow of applicants to the center for interview. - The Executive Director's failure to hire staff at an approved higher wage rate, and - The Executive Director's failure to report staffing issues to regional and corporate Human Resources staff. 1. The corrective action for the alleged deficient practice was accomplished by: Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center	F 725		

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achieved appropriate staffing on 02/07/19).
Recruitment practices include:
a. Update ICISMs software (recruitment software mentioned above) for Certified Nursing Assistants (CNAs) and Personal Care Assistants,
b. Incentives for staffs from sister centers to work PRN (as needed) or full-time schedules,
c. Referral bonuses for current staff to refer new qualified applicants,
d. Sign on bonuses for new CNAs.

The Divisional Executive Director, Regional Vice President of Operations, Regional Director of Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources conferred on 01/22/19 to discuss Root Cause Analysis and develop an action plan. The action plan included the following:
- Recruit, with incentives, CNA, Licensed Practice Nursing (LPN) and Registered Nurse (RN) staff from sister center in Triad market,
- Referral Bonus for existing staff with immediate pay out,
- Recruit and hire Personal Care Assistants,
- Retrain staff scheduler and ensure schedule is accurate,
- Sign on bonus for CNA position.

By 02/07/19 sufficient staff was provided to ensure residents are receiving pressure ulcer treatment.

2. Residents with the potential to be affected by alleged deficient practice:
On 01/22/2019 the ED, Regional Vice President of Operations, Divisional Human Resources Director of Human Resources conferenced and implemented staffing plans including wage increases, recruitment and retention plans to

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ensure sufficient staffing. On 02/07/19 sufficient staff have been hired and have or are completing orientation. Sufficient staffing is measured as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the required facility assessment.

3. Systemic Changes:
The Executive Director will work with facility and corporate Human Resources staff to fulfill staffing needs through appropriate recruitment and retention programs. Sufficient staffing was achieved on 02/07/19.

Executive Director will monitor staff openings, recruitment, training and scheduling of staff through review of daily staffing levels at morning and evening meetings, review of open positions and validation of staffing levels daily.

The Director of Nursing will monitor daily staffing levels at morning and evening meetings, review of open positions and validation of staffing levels daily to ensure wound care will be completed. If the treatment nurse is unavailable it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. Licensed staff have the capacity to complete their assignments, including treatments within the parameters of their work schedule. If the licensed nurse cannot complete the treatment within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing. The Director of Nursing will grant overtime to the licensed nurse to complete the task, delegate the responsibility to another nurse or assist with the task. The

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Director of Nursing and/or Minimum Data Set Nurse will complete the assessment and measurements if the treatment nurse is unavailable.

The schedulers, when there is a call out, is instructed to message all staff through OnShift (scheduling software that texts staff) and inform the Director of Nursing. The Director of Nursing will assist the scheduler in making calls and if unable to fill a certain shift, the scheduler or Director of Nursing will fill the open shift themselves.

Executive Director will monitor staff openings, recruitment, training and scheduling of staff through review of daily staffing levels at morning and evening meetings, review of open positions with scheduler and validation of staffing levels daily through rounds and staff interviews.

Executive Director will monitor staffing 5 times a week then 3 times a week for 4 weeks then 1 time a week for 8 weeks to ensure all resources are utilized. The ED will report on the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.

The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels through internal portal and weekly visits to ensure adequate staffing is maintained. Sufficient staffing is measured as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's

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resident population in accordance with the required facility assessment. The staff scheduler will inform the Executive Director and Director of Nursing when there are open positions. The Executive Director will inform the Human Resource Director of open positions and to update ICISMs (recruitment software). The Director of Nursing will work with the staff scheduler to fill open positions to ensure care is delivered.

The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 03/06/19, including the Interim Executive Director, Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director, the Environmental Services Director, the Regional Vice President of Operations and Regional Director of Clinical Services regarding the plan of removal of immediacy.

The Medical Director was made aware of the of immediacy plan via telephone with the Executive Director and the Director of Nursing on 3/6/19. The Executive Director will be responsible for the execution of the plan and communicating progress to the region team. The region team will monitor the facility weekly through observation and communication to ensure the center is sufficiently staffed.

The credible allegation of Immediate Jeopardy removal was validated on 3/6/19 at 5:18 PM.

Record review confirmed multiple new staff had

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been hired, including a new scheduler, Personal Care Assistants, NAs, and Nurses. Staff interviews verified recruitment incentives were implemented and multiple new staff had been hired. These staff interviews revealed the staff now felt equipped to meet the residents' needs. An interview with the Treatment Nurse confirmed she was now able to provide pressure ulcer care as ordered by the physician due to the increase in staff. Interviews with the scheduler, DON, Interim Administrator, and RVPO indicated they all felt the residents' needs were being met and the facility was sufficiently staffed as of 2/7/19. An interview with the Medical Director confirmed he had been made aware of the facility's credible allegation action plan for F725 on 3/6/19.

2. F550: Based on record review, observation, resident interview, Department of Social Services (DSS) interview, and staff interview, the facility failed to treat residents in a dignified manner as evidenced by inappropriate staff to resident verbal statements (Resident #32 and #49) and by not answering a call light related to a request for incontinence care (Resident #49). This failure caused Resident #49 to cry and to feel "humiliated" and "helpless". The facility also failed to cover Resident #47 ' s urinary catheter drainage bag to promote dignity for 3 of 5 sampled residents reviewed for dignity and respect.

3. F561: Based on record review, resident interview, observation, Nurse Practitioner interview, and staff interview, the facility failed to consistently honor a resident's choice of getting out of bed at his preferred time in the morning for a resident who required extensive assistance with transfers (Resident #32) and failed to trim, clean

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and file resident's nails (Resident #30) for 2 of 2 residents reviewed for choices. Resident #30's nails were long, jagged, dirty and the left thumb nail was painful and cracked down past the nail bed.

4. F677: Based on record review, observation, and interviews with resident, family, Department of Social Services, and staff, the facility failed to provide incontinence care, showers, and/or bathing for 3 of 4 dependent residents reviewed for the provision of activity of daily living (ADL) care (Residents #36, #49 and #44). Resident # 49 was upset and teary for staying soaked with urine before the facility staff responded to the call bell to provide incontinence care.

5. F565: Based on record review, and interviews with residents and staff, the facility failed to resolve the repeat concern reported during Resident Council meetings for 4 of 4 consecutive months regarding call lights not being answered timely.

6. F690: Based on record review and interviews with the resident, staff, and Nurse Practitioner, the facility failed to provide urinary catheter care as ordered for 1 of 1 sampled residents (Resident #44) reviewed for urinary catheter care.

7. F585: Based on record review, staff interview, resident and family interview, and Department of Social Services (DSS) staff interview, the facility failed to provide a written summary for grievances reported (Resident #36) and failed to write and investigate a grievance that was reported verbally to staff (Resident #49) for 2 of 2 residents reviewed for grievances.

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8. F657: Based on record review, resident interview, and staff interview, the facility failed to incorporate a Nursing Assistant in the care planning process for 1 of 4 residents reviewed for the care planning process (Resident #50).

During an interview with the Administrator on 1/8/19 at 10:30 AM he stated he started as the Administrator in June of 2018. He revealed that the facility had been having difficulty obtaining and maintaining enough NAs to staff all three shifts since that time. He reported that nurses had been assigned to work as Nursing Assistants (NAs) to fill in the gaps on the schedule. The Administrator stated that the Treatment Nurse was one of the nurses who frequently had been assigned as an NA.
During an interview with NA #1 on 1/9/19 at 3:58 PM he stated that he was hired to work the third shift, but he frequently worked other shifts as well due to the facility's difficulty obtaining and maintaining NA staff. He revealed there were several times in the past few months that he had been asked to work a double shift to fill in a gap in the NA schedule. NA #1 spoke specifically about the third shift NA staffing and stated that when only 2 NAs were working on the third shift he had difficulty answering resident call bells timely, providing timely incontinence care, and honoring a resident's choice to get out of bed early in the morning.

During an interview with NA #2 on 1/10/19 at 6:20 AM she stated she normally worked the third shift. NA #2 revealed that over the past several months third shift was staffed with 2 NAs. She indicated that when only 2 NAs were working on

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the third shift she had difficulty answering resident call bells timely, providing timely incontinence care, and honoring a resident's choice to get out of bed early in the morning.

During an interview with NA #3 on 1/10/19 at 6:25 AM she stated that she normally worked the third shift. NA #3 indicated that when only 2 NAs were working on the third shift she had difficulty answering resident call bells timely, providing timely incontinence care, and honoring a resident's choice to get out of bed early in the morning.

During an interview with the Director of Nursing (DON) on 1/9/19 at 3:31 PM she stated she began working as the DON at the facility in June of 2018. She confirmed the Administrator's report related to the facility having difficulty obtaining and maintaining enough NAs to staff all three shifts. The DON stated that staff members had been asked to work additional shifts and/or to work double shifts. She revealed that this had been going on for several months and had caused some of the staff to be exhausted. She acknowledged her awareness that essential care needs had been missed because of insufficient staffing.

A follow up interview was conducted with the Administrator on 1/10/19 at 2:31 PM. He stated that sufficient staffing meant having enough staff both in terms of quality and quantity to meet the needs of the residents. He acknowledged his awareness that sufficient staffing was an issue at the facility. He stated that the facility was currently working with the corporate office to develop employment incentives to obtain and maintain additional staff to meet the needs of the

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F 725	Continued From page 179 residents. An interview was conducted with the Interim Administrator on 3/6/19 at 12:20 PM. He reported he began working at the facility as an Interim Administrator on 1/18/19. He revealed the Regional Vice President of Operations (RVPO), the Corporate Human Resources Director, and himself identified insufficient staffing as the root cause of the facility's failure to meet the needs of the residents. An interview was conducted with the RVPO on 3/6/19 at 1:34 PM. He confirmed the Interim Administrator's interview that indicated the facility had been insufficiently staffed to meet the needs of the residents. The RVPO stated the previous Administrator made him aware of some difficulties with the facility obtaining staff, but he had not described the extent of these difficulties. He revealed he had been unaware that residents' needs were unable to be met because the facility was insufficiently staffed. The RVPO stated that the root cause of the facility's failures was two-fold: 1. A lack of oversight 2. Insufficient staff The RVPO explained that the facility's previous Administrator failed to provide oversight of processes and policies and effective leadership to ensure the facility had sufficient nursing staff to meet the needs of the residents.	F 725		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		4/3/19

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F 756	Continued From page 180 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident, Nurse Practitioner (NP) and Pharmacist Consultant interviews and record review, the Consultant	F 756	F756- Drug Regimen Review, Report Irregular, Act On 1. The DON assessed Resident #35 and	

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F 756	Continued From page 181 Pharmacist failed to identify the continued use of an antianxiety (Ativan) medication that was not time limited in duration for 1 (Resident #35) of 6 sampled residents reviewed for unnecessary medications. The findings included: Resident #35 was admitted 7/3/15 and readmitted 8/12/18 with cumulative diagnoses of Congestive Heart Failure, anxiety and Diabetes. Review of Resident #35's readmission Physician Orders dated 8/13/18 indicated an order for Ativan 1 milligram (mg) by mouth every 8 hours as needed for anxiety. Review of Resident #35's September 2018 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety. Review of Resident #35's Medication Administration Record for September 2018 indicated she did not receive any doses of the PRN Ativan. Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 9/13/18 revealed no documented recommendations regarding the PRN Ativan. Review of Resident #35's October 2018 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety. Review of Resident #35's Medication Administration Record for October 2018 indicated she received the PRN Ativan on 10/3/18, 10/5/18, 10/10/18, 10/11/18, 10/18/18 and 10/20/18 due to	F 756	received an order to discontinue as needed (PRN) Ativan on 1/22/2019. 2. The DON completed a quality review (audit) of current residents on PRN Ativan, to ensure a time limit is received on the physician order on 2/19/19. No negative findings were identified. The Divisional Director of Clinical Services reviewed the last 30 days of pharmacy consultant report to ensure all residents were reviewed on 3/22/19. 3. Omnicare Pharmacy clinical manager provided consultant pharmacist with re-education on the requirements and expectations of F tag 756 to include monitoring all PRN psychotropic orders for appropriate indications and durations as part of the monthly drug regimen review and irregularities will be communicated to the facility and or prescribers as part of the monthly consultation report on 3/22/19. The DON will provide re-education to licensed nurses, including all shifts, part-time and prn to ensure time limited orders for PRN Ativan are received on initial order by 2/8/2019. Staff will not be allowed to work until education complete. 4. RDCS and or DON will conduct quality monitoring (audit) of residents receiving PRN Ativan to ensure time limits are ordered, 3 times per week for 4 weeks, then weekly for 3 months. The DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by	

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F 756	Continued From page 182 increased anxiety. Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 10/10/18 noted the PRN Ativan prescribed but revealed no documented recommendations regarding the PRN Ativan being time limited in duration. Review of Resident #35's November 2018 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety. Review of Resident #35's Medication Administration Record for November 2018 indicated she received the PRN Ativan 11/4/18, 11/5/18, 11/6/18, 11/8/18 and 11/10/18 due to increased anxiety. Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 11/15/18 revealed no documented recommendations regarding the PRN Ativan. Resident #35 quarterly Minimum Data Set (MDS) dated 11/16/18 indicated she was cognitively intact and exhibited no behaviors. Her mood assessment on the MDS did not indicated any signs or symptoms of anxiety. Resident #35 was coded as having received one dose of the as needed Ativan during the 7 days look back period. Review of Resident #35's care plan dated last revised 11/29/18 indicated she was receiving Ativan (antianxiety medication) as needed. Interventions included monitoring for behaviors to include appetite changes, memory impairment, muscle weakness, sedation and a gradual dose reduction as clinically indicated.	F 756	QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 183	F 756		

Review of Resident #35's December 2018 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety.

Review of Resident #35's Medication Administration Record for December 2018 indicated she did not receive any doses of the PRN Ativan.

Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 12/5/18 revealed no documented recommendations regarding the PRN Ativan.

Review of Resident #35's January 2019 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety.

Review of Resident #35's Medication Administration Record for January 2019 to present indicated she did not receive any doses of the PRN Ativan.

In a second interview and observation on 1/9/19 at 3:15 PM, Resident #35 stated she received PRN Ativan but reported no anxiety in several months. She stated when she becomes anxious, she has trouble breathing and had trouble concentrating. Resident #35 appeared clam, relaxed with no difficulty breathing.

In an interview on 1/9/19 at 4:24 PM, the Director of Nursing (DON) confirmed the facility had not received any documented recommendations from the Consultant Pharmacist about Resident #35's PRN Ativan not being time limited in duration.

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F 756	Continued From page 184 In an interview on 1/10/19 at 9:30 AM, the NP stated it was her expectation that Resident #35's PRN Ativan be time limited induration. She stated she had not received any Pharmacy Recommendation addressing the continued order for the PRN Ativan. In a telephone interview on 1/10/19 at 1:27 PM, the Consultant Pharmacist stated he could not explain why he made no recommendations regarding PRN Ativan with no time limited duration. He stated he had not been to the facility yet for January 2019 and he would have addressed it on his next scheduled visit. In an interview on 1/10/19 at 2:30 PM, the Administrator stated it was his expectation that Resident #35's PRN Ativan order was time limited in duration.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		4/3/19

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F 758	Continued From page 185 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident, Nurse Practitioner and Pharmacy Consultant interviews and record review, the facility failed to ensure an as needed (PRN) antianxiety (Ativan) medication was time limited in duration (Resident #35) and failed to identify and monitor target behaviors for psychotropic medications (Residents #35 and	F 758	F758- Free of Unnec Psychotropic Med/PRN use 1. The DON assessed Resident #35 and received an order to discontinue PRN Ativan on 1/22/2019. On 1/30/2019 the licensed nurse completed a Behavior Monitoring Sheet for Resident #50.	

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F 758	Continued From page 186 #50) for 2 of 6 sampled residents reviewed for unnecessary medications. The findings included: 1. Resident #35 was admitted 7/3/15 and readmitted 8/12/18 with cumulative diagnoses of Congestive Heart Failure, anxiety and Diabetes. Review of Resident #35's readmission Physician Orders dated 8/13/18 indicated an order for Ativan 1 milligram (mg) by mouth every 8 hours as needed for anxiety. Review of Resident #35's September 2018 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety. Review of Resident #35's Medication Administration Record for September 2018 indicated she did not receive any doses of the PRN Ativan. Review of Resident #35's September 2018 Behavior/Intervention Monthly Flow Record indicated no identified targeted behaviors or any evidence of any documented behaviors. Review of Resident #35's nursing notes for September 2018 did not include any documented behaviors. Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 9/13/18 revealed no documented recommendations regarding the PRN Ativan, targeted behaviors or behaviors monitoring. Review of Resident #35's October 2018 Physician Orders indicated an order to Ativan 1	F 758	2. The DON completed a quality review of current residents on PRN Ativan to ensure a time limit is received on 2/19/19. The DON completed a quality review of residents receiving psychotropic medications to ensure monitor in place for target behaviors on 2-15-19. No negative findings were identified. 3. The DON will provide re-education to licensed nurses, including all shifts, part-time and prn, to ensure time limited orders for PRN Ativan are received on initial order and monitoring of target behaviors for psychotropic medications by 3/27/2019. 4. RDCS and or DON will conduct quality monitoring (audit) of residents receiving PRN Ativan to ensure time limits are ordered and behavior monitoring sheets are in place, 3 times per week for 4 weeks, then weekly for 3 months. The DON will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	

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mg by mouth every 8 hours as needed for anxiety.

Review of Resident #35's Medication Administration Record for October 2018 indicated she received the PRN Ativan on 10/3/18, 10/5/18, 10/10/18, 10/11/18, 10/18/18 and 10/20/18 due to increased anxiety.

Review of Resident #35's October 2018 Behavior/Intervention Monthly Flow Record indicated no identified targeted behaviors or any evidence of any documented behaviors. Review of Resident #35's nursing notes for October 2018 did not include any documented behaviors.

Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 10/10/18 noted the PRN Ativan prescribed but revealed no documented recommendations regarding the PRN Ativan being time limited in duration, targeted behaviors or behaviors monitoring.

Review of Resident #35's November 2018 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety.

Review of Resident #35's Medication Administration Record for November 2018 indicated she received the PRN Ativan 11/4/18, 11/5/18, 11/6/18, 11/8/18 and 11/10/18 due to increased anxiety.

Review of Resident #35's November 2018 Behavior/Intervention Monthly Flow Record indicated no identified targeted behaviors or any evidence of any documented behaviors. Review of Resident #35's nursing notes for November

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2018 did not include any documented behaviors.

Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 11/15/18 revealed no documented recommendations regarding the PRN Ativan, targeted behaviors or behaviors monitoring.

Resident #35 quarterly Minimum Data Set (MDS) dated 11/16/18 indicated she was cognitively intact and exhibited no behaviors. Her mood assessment on the MDS did not indicated any signs or symptoms of anxiety. Resident #35 was coded as having received one dose of the as needed Ativan during the 7 days look back period.

Review of a Nurse Practitioner (NP) note dated 11/20/18 revealed no documentation regarding Resident #35's PRN Ativan or anxiety.

Review of Resident #35's care plan dated last revised 11/29/18 indicated she was receiving Ativan (antianxiety medication) as needed. Interventions included monitoring for behaviors to include appetite changes, memory impairment, muscle weakness, sedation and a gradual dose reduction as clinically indicated.

Review of Resident #35's December 2018 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety.

Review of Resident #35's Medication Administration Record for December 2018 indicated she did not receive any doses of the PRN Ativan.

Review of Resident #35's December 2018

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Behavior/Intervention Monthly Flow Record indicated no identified targeted behaviors or any evidence of any documented behaviors. Review of Resident #35's nursing notes for December 2018 did not include any documented behaviors.

Review of a NP note dated 12/4/18 revealed no documentation regarding Resident #35's PRN Ativan or anxiety.

Review of the Consultant Pharmacist Monthly Medication Regimen Review dated 12/5/18 revealed no documented recommendations regarding the PRN Ativan, targeted behaviors or behaviors monitoring.

Review of a Physician note dated 12/10/18 revealed no documentation regarding Resident #35's PRN Ativan or anxiety.

Review of a NP note dated 12/31/18 revealed no documentation regarding Resident #35's PRN Ativan or anxiety.

Review of Resident #35's January 2019 Physician Orders indicated an order to Ativan 1 mg by mouth every 8 hours as needed for anxiety.

Review of Resident #35's Medication Administration Record for January 2019 to present indicated she did not receive any doses of the PRN Ativan.

Review of Resident #35's January 2019 to present Behavior/Intervention Monthly Flow Record indicated no identified targeted behaviors or any evidence of any documented behaviors. Review of Resident #35's nursing notes for January 2019 did not include any documented

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behaviors.

In an interview and observation on 1/7/19 at 10:33 AM, Resident #35 reported no anxiety and appeared calm and relaxed. She reported no depression and voiced no concerns with her care or with the facility.

In a second interview and observation on 1/9/19 at 3:15 PM, Resident #35 stated she received PRN Ativan but reported no anxiety in several months. She stated when she becomes anxious, she has trouble breathing and had trouble concentrating. Resident #35 appeared clam, relaxed with no difficulty breathing.

In an interview on 1/9/19 at 4:24 PM, the Director of Nursing (DON) confirmed the facility had not received any documented recommendations from the Consultant Pharmacist about Resident #35's PRN Ativan not being time limited in duration. The DON stated there was no documentation of Resident #35's targeted behaviors and no specific targeted behaviors were ever identified for the resident's use of Ativan.

In an interview on 1/10/19 at 9:30 AM, the NP stated it was her expectation that Resident #35's PRN Ativan be time limited induration with targeted behavior monitoring. She stated she had not received any Pharmacy Recommendation addressing the continued order for the PRN Ativan.

In a telephone interview on 1/10/19 at 1:27 PM, the Consultant Pharmacist stated he could not explain why he made no recommendations regarding PRN Ativan with no time limited duration. He stated he had not been to the facility

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yet for January 2019 and he would have addressed it on his next scheduled visit.

In an interview on 1/10/19 at 2:30 PM, the Administrator stated it was his expectation that Resident #35's PRN Ativan order was time limited in duration and that the facility identify targeted behaviors with ongoing documented behavior monitoring.

2. Resident #50 was admitted to the facility on 12/11/18 with diagnoses that included mood disorder, Alzheimer ' s, dementia with behavioral disturbance, and psychosis.

A physician ' s order dated 12/11/18 indicated Seroquel (antipsychotic medication) 100 milligrams (mg) once daily at bedtime.

The Admission Minimum Data Set (MDS) assessment dated 12/18/18 indicated Resident #50 ' s cognition was severely impaired. She had no behaviors and no rejection of care. Resident #50 was administered antipsychotic medication on 7 of 7 days during the MDS review period.

The Care Area Assessment (CAA) related to psychotropic medication for Resident #50 ' s 12/18/18 MDS indicated she had diagnoses of Alzheimer ' s, dementia, psychosis, and mood disorder. Resident #50 was noted as alert with confusion and disorientation daily. She was on Seroquel. This CAA indicated that Social Work (SW) was to refer Resident #50 for psychiatric consultation.

Resident #50 ' s comprehensive care plan, last reviewed 12/27/18, indicated the focus area of antipsychotic medication for diagnoses of mood

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disorder and psychosis. She was noted to be easily angered. The interventions included, in part, monitor behavioral symptoms and side effects related to the antipsychotic medication.

A review of the December 2018 Medication Administration Record (MAR) for Resident #50 indicated she received Seroquel 100 mg once daily as ordered.

A review of the December 2018 Behavior/Intervention Monthly Flow Record related to Resident #50 ' s Seroquel identified no target behaviors. The form additionally had no staff documentation of behaviors or side effect monitoring. This form was completely blank except for the documentation of Resident #50 ' s name, the month (December 2018), and the medication (Seroquel 100 mg).

A review of the January 2019 MAR from 1/1/19 through 1/8/19 indicated Resident #50 was administered Seroquel as ordered.

There was no Behavior/Intervention Monthly Flow Record for January 2019 for Resident #50 in the medical record.

An observation was conducted of Resident #50 on 1/7/19 at 4:20 PM. Resident #50 was alert and was seated in a wheelchair. There were no signs or symptoms of behaviors noted.

An observation was conducted of Resident #50 on 1/8/19 at 1:45 PM. Resident #50 was alert and was lying in bed. There were no signs or symptoms of behaviors noted.

During an interview with Medical Records staff on

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1/9/19 at 11:30 AM he verified there was no January 2019 Behavior/Intervention Monthly Flow Record for Resident #50.

An interview was conducted with Nurse #3 on 1/9/19 at 12:05 PM. She stated that all MARs were completed on hard copy forms. She indicated that behaviors and side effect monitoring related to psychotropic medications were documented on the hard copy Behavior/Intervention Monthly Flow Record that was kept in the same binder with the MARs. Nurse #3 confirmed that no target behaviors were identified for Resident #50 ' s December 2018 Behavior/Intervention Monthly Flow Record and no documentation was completed related to behavior monitoring or side effect monitoring. Nurse #3 additionally confirmed there was not a January 2019 Behavior/Intervention Monthly Flow Record for Resident #50. She revealed that Medical Records staff just brought out a "stack" of blank Behavior/Intervention Monthly Flow Record forms as it had been identified today (1/9/19) that several residents had not had this form in their chart for January 2019. She was asked who was responsible for ensuring the Behavior/Intervention Monthly Flow Records were in the charts and were completed. She indicated that the third shift nurses completed the monthly changeover at the end of each month and they were also responsible for placing the form in the chart. She additionally indicated that all nursing staff who administered medications were ultimately responsible for ensuring the Behavior/Intervention Monthly Flow Record was in the chart and was completed. Nurse #3 revealed she had not realized that this form for January 2019 was not in Resident #50 ' s chart until Medical Records staff requested a copy of

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F 758	Continued From page 194 the form this morning (1/9/19). She was unable to explain why the December 2018 form for Resident #50 was incomplete. An interview was conducted with Resident #50 ' s Nurse Practitioner (NP) on 1/10/19 at 12:05 PM. She stated it was her expectation that target behaviors were identified and that behavior monitoring, and side effect monitoring were completed for the use of psychotropic medications. When asked why Resident #50 was prescribed Seroquel the NP indicated that the resident was on Seroquel at home prior to her admission and she had wanted to wait until a psychiatric consultation had been conducted before making any psychotropic medication changes. An interview was conducted with the Social Worker (SW) on 1/8/19 at 2:47 PM. She stated that Resident #50 had not seen the facility ' s psychiatric provider yet. She reported that the psychiatric Nurse Practitioner came to the facility once per month and her most recent visit was on 12/10/18 prior to Resident #50 ' s admission (12/11/18). An interview was conducted with the Director of Nursing (DON) on 1/10/19 at 2:31 PM. She stated it was her expectation that target behaviors were identified and that behavior monitoring, and side effect monitoring were completed for the use of psychotropic medications. She indicated this monitoring was to be documented on Behavior/Intervention Monthly Flow Record.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

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F 812	Continued From page 195 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired food items stored in the kitchen's dry storage area and to discard expired food items and date open food items stored in 2 of 2 reach-in refrigerators observed. Findings included: On 1/7/19 at 10:05 am an observation of the kitchen's dry storage area with the Dietary Manager revealed 12 apple muffins not in their original wrapping with an expired hand-written expiration date of 12/15/18. On 01/07/19 at 10:15 am an observation of the kitchen's two reach in refrigerators with the Dietary Manager revealed expired and undated food items in both reach-in refrigerators. These expired and undated food items included: a	F 812	F812- Food Procurement, Store/Prepare/Serve-Sanitary 1. On 1/7/2019 the Dietary Manager (DM) identified expired foods the in the kitchen and kitchen coolers were discarded by kitchen staff. 2. On 1/29/2019 the ED and DM inspected the kitchen storage facilities to ensure expired foods are discarded. No negative findings were identified. 3. On 2/6/19 the Dietary Contractor provided re-education to the DM in safe storage, preparation and serving of foods. The dietary contractor will provide education to the dietary staff on safe storage, preparation and service of foods by 2/13/2019. Staff will not be allowed to	

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F 812	Continued From page 196 container of tuna fish mixed with mayonnaise with a hand-written expired expiration date of 1/2/19, a container of chicken salad with a hand-written expired expiration date of 1/3/19, a pork loin with a hand written expired expiration date of 1/2/19, an opened pineapple in a plastic container with no date, an opened container of juice with no date, and an opened container of tarter sauce with no date. All items were half-full or more in their container. On 1/7/19 at 10:20 am an interview was conducted with the Dietary Manager who stated that he and the assigned cook for the day were responsible to check kitchen refrigerators and the kitchen's dry storage area each day for expired and undated items and to discard any expired food and drink items and to discard open undated items. The Dietary Manager stated that the hand-written date on open or re-wrapped food and drink items were the discard date. The Dietary Manager stated that this task had not been done since the previous Friday and then discarded the expired and undated items observed in the two reach in refrigerators. On 1/7/19 at 11:00 am an interview was conducted with the fill-in Cook who was assigned today to check the kitchen refrigerator units or expired and undated food items. The cook stated he had not checked the kitchen ' s refrigerators for expired and undated food items today. On 1/10/19 at 2:00 pm an interview was conducted with the Administrator who stated he expected the kitchen staff to date opened food and drink items and to discard expired food and drink items.	F 812	work until education complete. . 4. ED will conduct quality monitoring (audit) of the kitchen area and dietary storage facilities, 3 times per week for 4 weeks, then weekly for 3 months. The ED will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 2/20/2019.	

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F 835	Continued From page 197	F 835		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interview, resident and family interview, and wound care Nurse Practitioner interview, the facility ' s Administrator failed to provide oversight of processes and policies and effective leadership to ensure residents were free from neglect as evidenced by not providing wound care for 3 of 4 residents with wounds (Resident # 1, #36, and #44); not providing catheter care for 1 of 1 residents reviewed (Resident #44); and by not answering a call light related to a request for incontinence care for 1 of 1 resident reviewed (Resident #49). The facility's administrator also failed to provide sufficient nursing staff to honor resident preferences, treat residents with dignity and respect, resolve individual and resident council grievances, and ensure Nursing Assistant involvement in the development of the comprehensive care plan. This affected 14 of 24 sampled residents (Residents #1, #30, #32, #36, #44, #47, #49, #50, and 6 members of the resident council). The repeated failure to provide sufficient staffing for pressure ulcer care to Resident #36 resulted in his pressure ulcer worsening and the development of MRSA (Methicillin-resistant Staphylococcus) infection.	F 835	F835- Administration 1. On 1/18/19 effective leadership (an interim administrator Divisional Executive Director) was installed by Regional Vice President of Operations to ensure proper Administration of the center including the oversight of processes and policies and to ensure resident were free from neglect, received pressure ulcer care as ordered and maintained sufficient nursing staffing to provide necessary care and service for all residents of the center. Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/07/19).The Divisional Executive Director, Regional Vice President of Operations, Regional Director of Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources conferred 01/22/19 to discuss Root Cause Analysis and develop an action plan. The action plan included the following: Recruit, with incentives, CNA, LPN and RN staff from sister center in	4/3/19

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F 835	Continued From page 198 Immediate Jeopardy began on 11/6/18 when due to insufficient staffing and failed oversight, staff neglected to provide pressure ulcer care resulting in increase in size and infection of Resident #36's wound. Immediate Jeopardy was removed on 3/6/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of "H" (actual harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. Findings included: This tag is cross referenced to: 1a. Tag F-600: Based on record review, observations, staff interview, resident interview, family interview, wound care Nurse Practitioner interview, Nurse Practitioner interview, and Department of Social Services interview, the facility neglected to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation, and communication with the outside podiatrist who was also treating resulting in a worsening pressure ulcer and infection (Resident #36); neglected to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation resulting in a worsening pressure ulcer (Resident #1); and neglected to provide daily pressure ulcer wound care as ordered and weekly wound measurement/assessment and documentation (Resident #44) for 3 of 4 residents reviewed; the facility neglected to provide catheter care (Resident #44) for 1 of 1 resident reviewed; and	F 835	Triad market, Referral Bonus for existing staff with immediate pay out, Recruit and hire Personal Care Assistants, Retrain staff scheduler and ensure schedule is accurate, Sign on bonus for CNA position, and that sufficient staff is provided to ensure that pressure sores care and treatment is done per physician orders and that the residents are free from neglect. On 01/22/19 a root cause analysis was completed by the Regional Vice President of Operations, Regional Director of Clinical Services, the Director of Nursing and the Divisional Executive Director (acting administrator) and determined that the former Executive Director failed to provide consistent staffing to ensure treatments were completed as ordered, and failed to provide oversight to make sure that care and services were delivered per physician order. By 02/07/19 sufficient staff was provided to ensure residents receiving pressure ulcer treatment. 2. On 01/22/2019 the Executive Director, Regional Vice President of Operations, Divisional Human Resources conferenced and implemented staffing plans including wage increases, recruitment and retention plans to ensure sufficient staffing. On 02/07/19 sufficient staff was hired and have completed orientation. The Executive Director will provide oversight of the delivery of care and services of wounds to prevent neglect through routine rounds, communication with Director of Nursing and daily review of staffing levels.	

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F 835	Continued From page 199 the facility also neglected to answer a call light related to a request for incontinence care (Resident #49) for 1 of 1 resident reviewed. b. Tag F-686: Based on record review, observations, staff interview, resident and family interview, wound care Nurse Practitioner interview, and Nurse Practitioner interview, the facility failed to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation, and communication with the outside podiatrist who was also treating resulting in a worsening pressure ulcer and infection (Resident #36); failed to provide daily pressure ulcer wound care as ordered, weekly wound measurement/assessment and documentation resulting in a worsening pressure ulcer (Resident #1); and failed to provide daily pressure ulcer wound care as ordered and weekly wound measurement/assessment and documentation (Resident #44) for 3 of 4 sampled residents reviewed for wound care. c. Tag F-725: Based on observation, record review, and interviews with resident, family, staff, Department of Social Services, and Nurse Practitioners, the facility failed to provide sufficient nursing staff to ensure residents received pressure ulcer wound care, urinary catheter care, assistance with Activities of Daily Living (ADLs), and respond to call bells. The facility also failed to provide sufficient nursing staff to honor resident preferences, treat residents with dignity and respect, resolve individual and resident council grievances, and ensure Nursing Assistant involvement in the development of the comprehensive care plan. This affected 13 of 24 sampled residents (Residents #1, #30, #32, #36,	F 835	3. On 01/18/19 the Regional Vice President of Operations and the Regional Director of Human Resources began recruiting and interviewing qualified Administrators to fill the Executive Director position at the center. The Executive Director worked with the facility and corporate Human Resources staff to fulfill staffing needs through appropriate recruitment and retention programs. The facility achieved sufficient staffing on 02/07/19. The Director of Nursing will monitor daily staffing levels at morning and evening meetings, review of open positions and validation of staffing levels daily to ensure wound care will be completed. If the treatment nurse is unavailable it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. Licensed staff has the capacity to complete their assignments, including treatments within the parameters of their work schedule. If the licensed nurse cannot complete the treatment within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing. The Director of Nursing will grant overtime to the licensed nurse to complete the task, delegate the responsibility to another nurse or assist with the task. The Director of Nursing and/or Minimum Data Set Nurse will complete the assessment and measurements if the treatment nurse is unavailable. Executive Director will monitor staff openings, recruitment, training and scheduling of staff through review of daily staffing levels at morning	

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F 835	Continued From page 200 #44, #49, #50, and 6 members of the resident council). The repeated failure to provide sufficient staffing for pressure ulcer care to Resident #36 resulted in his pressure ulcer worsening and the development of MRSA (Methicillin-resistant Staphylococcus) infection. The Administrator and DON were notified of the Immediate Jeopardy on 3/6/19 11:29 am. On 3/6/19 the facility provided the following credible allegation of Immediate Jeopardy removal: The center Executive Director alleges abatement of immediate jeopardy on 03/06/19. Deficient Practice The facility Administrator failed to provide oversight of processes and policies and effective leadership to ensure residents were free from neglect, received pressure ulcer care as ordered and maintained sufficient nursing staffing to provide necessary care and services. A Root Cause Analysis of 01/22/19 was completed by the Divisional Executive Director, Regional Vice President of Operations, Regional Director of Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources. The preliminary investigative information to determine root cause was the center wage scale and a competitive wage analysis. The competitive wage analysis revealed that the center needed to increase the lower end of the wage scale for new hires as compared to other centers in the market. 1. The corrective action for the alleged deficient practice was accomplished by: On 1/18/19 effective leadership (an interim	F 835	and evening meetings, review of open positions and validation of staffing levels daily. Executive Director will monitor staffing and the delivery of wound care 5 times a week then 3 times a week for 4 weeks then 1 time a week for 8 weeks to ensure all resources are utilized. The Executive Director and Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels and the delivery of wound care through internal portal, communication with Executive Director/Director of Nursing and weekly visits to ensure adequate staffing is maintained. The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 03/06/19, including the Interim Executive Director, Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director, the Environmental Services Director, the Regional Vice President of Operations and Regional Director of Clinical Services regarding the plan of removal of immediacy. 4. Executive Director will monitor staffing	

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F 835	Continued From page 201 administrator Divisional Executive Director) was installed by Regional Vice President of Operations to ensure proper Administration of the center including the oversight of processes and policies and to ensure resident were free from neglect, received pressure ulcer care as ordered and maintained sufficient nursing staffing to provide necessary care and service for all residents of the center. Corporate Human Resources and Regional staff worked with the Interim Executive Director to implement staff recruitment practices to ensure the center was appropriately staffed (center achieved appropriate staffing on 02/07/19). The Divisional Executive Director, Regional Vice President of Operations, Regional Director of Clinical Services, Regional Director of Human Resources and the Senior Vice President of Human Resources conferred on 01/22/19 to discuss Root Cause Analysis and develop an action plan. The action plan included the following: · Recruit, with incentives, Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN) and Registered Nurse (RN) staff from sister center in Triad market, · Referral Bonus for existing staff with immediate pay out, · Recruit and hire Personal Care Assistants, · Retrain staff scheduler and ensure schedule is accurate, · Sign on bonus for CNA position, and · That sufficient staff is provided to ensure that pressure sores care and treatment is done per physician orders and that the residents are free from neglect.	F 835	and the delivery of wound care 5 times a week then 3 times a week for 4 weeks then 1 time a week for 8 weeks to ensure all resources are utilized. The Executive Director and Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels and the delivery of wound care through internal portal, communication with Executive Director/Director of Nursing and weekly visits to ensure adequate staffing is maintained. The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 03/06/19, including the Interim Executive Director, Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director, the Environmental Services Director, the Regional Vice President of Operations and Regional Director of Clinical Services regarding the plan of removal of immediacy. 5. Date of Compliance 4/3/19.	

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F 835	Continued From page 202 On 01/22/19 a root cause analysis was completed by the Regional Vice President of Operations, Regional Director of Clinical Services, the Director of Nursing and the Divisional Executive Director (acting administrator) and determined that the former Executive Director failed to provide consistent staffing to ensure treatments were completed as ordered, and failed to provide oversight to make sure that care and services were delivered per physician order. By 02/07/19 sufficient staff was provided to ensure residents receiving pressure ulcer treatment. 2. Residents with the potential to be affected by alleged deficient practice: On 01/22/2019 the Executive Director, Regional Vice President of Operations, Divisional Human Resources conferenced and implemented staffing plans including wage increases, recruitment and retention plans to ensure sufficient staffing. On 02/07/19 sufficient staff were hired and have completed orientation. The Executive Director will provide oversight of the delivery of care and services of wounds to prevent neglect through daily routine rounds, daily communication with Director of Nursing and daily review of staffing levels. 3. Systemic Changes: On 01/18/19 the Regional Vice President of Operations and the Regional Director of Human Resources began recruiting and interviewing qualified Administrators to fill the Executive Director position at the center.	F 835		

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The Executive Director worked with the facility and corporate Human Resources staff to fulfill staffing needs through appropriate recruitment and retention programs. The facility achieved sufficient staffing on 02/07/19.

The Director of Nursing will monitor daily staffing levels at morning and evening meetings, review of open positions and validation of staffing levels daily to ensure wound care will be completed. If the treatment nurse is unavailable it will be communicated to the licensed nurses by the Director of Nursing to provide treatments as ordered by the physician. Licensed staff have the capacity to complete their assignments, including treatments within the parameters of their work schedule. If the licensed nurse cannot complete the treatment within the parameter of their work schedule, the licensed nurse will report the issue to the Director of Nursing. The Director of Nursing will grant overtime to the licensed nurse to complete the task, delegate the responsibility to another nurse or assist with the task. The Director of Nursing and/or Minimum Data Set Nurse will complete the assessment and measurements if the treatment nurse is unavailable and report to the Executive Director.

Executive Director will monitor staff openings, scheduling of staff and delivery of care through review of daily staffing levels at morning and evening meetings, review of open positions with scheduler and validation of staffing levels daily through rounds and staff interviews.

Executive Director will monitor staffing and the delivery of wound care 5 times a week then 3 times a week for 4 weeks then 1 time a week for 8 weeks to ensure all resources are utilized. The

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Executive Director and Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.

The Regional Vice President of Operations and the Regional Director of Clinical Services will monitor staffing levels and the delivery of wound care through internal portal, communication with Executive Director/Director of Nursing and weekly visits to ensure adequate staffing is maintained.

The center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting 03/06/19, including the Interim Executive Director, Director of Nursing, Director of Rehab, MDS Nurse, Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records, Central Supply Clerk, Admissions Director, Dietary Manager, Activity Director, the Environmental Services Director, the Regional Vice President of Operations and Regional Director of Clinical Services regarding the plan of removal of immediacy.

The Medical Director was made aware of the of immediacy plan via telephone with the Executive Director and the Director of Nursing on 3/6/19.

The credible allegation of Immediate Jeopardy removal was validated on 3/6/19 at 5:30 PM which included:

Human resources record review indicated there were 17 new employees documented as starting employment as nursing assistant and licensed

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nurse between 1/12/19 and 2/27/19.

On 3/6/19 at 4:30 pm interviews of 5 random staff members were conducted which revealed that "several newly employed nursing assistants had started over the past 2 months and the facility was fully staffed." The rate of grievances filed by residents and/or their family had dropped by half. The last resident council meeting held February 2019 identified that call lights and incontinence care were addressed timely to the satisfaction of the residents.

On 3/6/19 at 5:10 pm an interview was conducted with the Corporate Vice President of Operations who stated he conferenced with the Divisional Human Resources Director and implemented staffing plans including wage increases and recruitment and retention plans to ensure sufficient staffing. On 2/7/19 sufficient staff had been hired and had received orientation prior to accepting an assignment. Daily staffing meetings have occurred to ensure sufficient staffing patterns.

The Corporate Vice President further commented that he was not aware of staffing to the significance level it had reached. He had communication from the facility Administrator who discussed recruitment of nursing assistants and that current nursing staff were covering shifts but not that care was not completed. The nursing assistant wage scale was higher for experience and the Administrator was informed to offer the higher wage scale to all staff. The Administrator did not follow the direction well. There was a lack of oversight and understanding the urgency. The Administrator was new in training under the direction of a seasoned Administrator. Feedback

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F 835	Continued From page 206 provided during training indicated that the Administrator was doing well. Corporate staff visits were made to the facility and the Administrator did not follow directions and things fell apart quickly. Staffing was tied in to every citation on the annual survey. The Administrator did not communicate to facility Human Resources that the salary scale offered to nursing assistants was higher. The Administrator was unable to state why staffing deteriorated and was not adequately addressed. There is now a heightened oversite in the process of staffing.	F 835		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident, Nurse Practitioner and Consultant Pharmacist interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implanted procedures and monitor interventions that the committee put into to place following a recertification and complaint survey dated 2/15/18 which was recited on the current recertification and complaint survey of 3/6/19. This was for one recited deficiency in the area of Pharmacy Services at F758 for not identifying and not monitoring behaviors for a resident prescribed Ativan (Resident #35). The continued failure of the facility during two surveys of record in the same area showed a pattern of	F 867	F867- QAPI/QAA Improvement Activities 1. The ED conducted a QAPI meeting to discuss findings from annual survey and audited an action plan to address the facilities failure to identify and monitor for target behaviors for psychotropic medications on 1/25/2019. The ED informed the IDT team members (ED, DCS, SSD, MDS Coordinator, Business Office Manager, Housekeeping Supervisor, Medical Records Coordinator, Activities Director, Rehab Manager, Dietary Manager, Human Resource Coordinator, CNA, Medical Director and Division DCS) of the survey findings.	4/3/19

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WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 207 the facility's inability to sustain an effective Quality Assurance Program. The findings included: This citation is cross referenced to: F758-. Based on observations, staff, resident, Nurse Practitioner and Pharmacist Consultant interviews and record review, the facility failed to identify and monitor for target behaviors for psychotropic medications (Residents #35 and #50) for 2 of 6 sampled residents reviewed for unnecessary medications. During the facility's 2/15/18 recertification and complaint survey the facility was cited for failure to monitor the side effects and behaviors with the use of pschotropic medications for 2 of 6 sampled residents reviewed (Residents #40 & #5). In an interview on 1/10/19 at 2:30 PM, the Administrator was unable to offer an explanation regarding the repeat citation at F758 for monitoring targeted behaviors associated with the use of psychotropic medications. The Administrator stated he was new to the facility as of June 2018 and had been making efforts to improve other areas of concern and had not focused on the Pharmacy issues or the nurses not monitoring resident behaviors for the use of psychotropic medications.	F 867	2. On 3/26/2019 the RDCS completed quality review (audit) of QAPI meeting minutes and quality audit implemented to ensure identifying and monitoring target behaviors for psychotropic medications. The review (audit) revealed the meeting was held and the minutes were accurate. 3. The RDCS will provide re-education to QAPI Committee on the federal regulations and guidelines for QAPI/QAA procedures by 3/26/19. 4. RDCS and or ED will conduct quality monitoring (audit) of QAPI meetings to ensure QAPI Committee will meet a minimum of monthly to review areas of improvement per guidelines, monthly x 4 monthly, and then quarterly for 2 quarters. The ED and DCS will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 4/3/2019.	