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	345534	A. BUILDING _____ B. WING _____	C 03/25/2021

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted onsite 3/22/2021, offsite 3/23/2021 through 3/24/2021, and onsite 3/25/2021. As a result of the investigation 2 of the 20 complaint allegations were substanitated and deficiencies were cited at F810 and F686.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with residents and staff, the facility failed to turn and reposition 2 of 3 residents (Resident #6, Resident #7) as part of pressure ulcer treatment. Findings included: 1.Resident # 6 was admitted to the facility on 8/21/2020 with diagnoses that included dementia, diabetes type two, and cerebral infarct with hemiplegia and hemiparesis.	F 686	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. Resident # 6 and Resident #7 were observed by the Director of Nursing on March 22, 2021. for their need of	4/12/21

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

Electronically Signed | 04/16/2021

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F 686	Continued From page 1 Resident #6's most recent quarterly Minimum Data Set (MDS) dated 1/22/2021 indicated the resident was severely cognitively impaired, had functional hearing and vision, and could sometimes be understood. Resident #6 required extensive assistance with all activities of daily living and bed mobility. She was documented as being completely dependent with toileting and personal hygiene. Resident #6's 1/22/2021 MDS indicated the resident had a stage four wound during the assessment period. Resident #6's most recent comprehensive care plan dated 1/22/2021 indicated the resident was at risk for further skin breakdown secondary to functional and mobility deficits. Interventions for this included assisting resident with turning and repositioning on routine rounds. On 3/22/2021 at 9:35am Resident #6 was observed to be in semi fowler's position with head of the bed approximately 30 degrees. She was awake and called out to staff passing by her door. At 10:05am on 3/22/2021 an interview was conducted with Resident #6. During the interview the resident was observed to be in semi fowler's position with head of the bed approximately 30 degrees. She appeared clean, well groomed, and appropriately dressed. When asked, Resident #6 stated she did have a wound on her bottom and the facility was providing wound care for her wound. On 3/22/2021 at 11:25am a wound care observation was conducted. The DON entered the resident's room to provide wound care. The resident was in semi fowler's position with the	F 686	assistance of turning and repositioning. Turning and repositioning guidance was educated to all licensed nurses, medication aides, personal care assistance, and certified nursing assistants by the Staff Development Coordinator beginning on 3/22/21 and completed on 4/12/21. 100% audit was conducted on all in house residents on 4/8/21 to assess for the need of assistance with turning and repositioning. This audit was conducted by the Unit Coordinators (UC), Director of Nurses (DON) and the wound nurse on 4/8/21. The care plan and care guide were updated for all residents who required the need of assistance for turning and repositioning on 4/8/21 and 4/9/21. 100% of all nursing staff, to include all licensed nurses, medication aides, personal care assistance, and certified nursing assistants were in serviced on the need to turn and reposition residents when they are not able to do so on their own. This in-service was initiated on 3-22-21 and completed on 4/12/21by the Staff Development Coordinator. No staff will be allowed to work after 4/12/21 if the in service was not completed. This in service will be added to the new hire orientation of all nursing staff. The DON or designee will conduct 10 random turning and repositioning audits twice a day, to include off shifts and weekends to observe residents who need assistance with turning and repositioning.	

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F 686	Continued From page 2 head of the bed 30 degrees prior to wound care and was placed back in semi fowler's position with the head of the bed approximately 30 degrees after wound care was completed. At 12:05pm Resident #6 was observed eating her lunch while in semi fowler's position and the head of the be approximately 30 degrees. The resident was observed using a divided plate and adaptive utensils. At 2:15pm Resident #6 was observed in semi fowler's position with the head of the bed approximately 30 degrees and she was yelling out to staff as they passed her door. The resident repeatedly asked staff if she could go home. An interview was conducted with Nurse #1, assigned to the 300 hall, on 3/22/2021 at 2:20pm. Nurse #1 stated the NAs are responsible for turning and repositioning dependent residents therefore she had not turned or repositioned Resident #6. At 2:25pm on 3/22/2021 an interview was conducted with the medication aide assigned to the 300 hall. She stated she was working the medication cart and the task of turning residents who could not turn themselves is assigned to the NA on the hall. An interview was conducted with the personal care aide assigned to the 300 hall on 3/21/2021 at 2:35pm. She stated she was a personal care aide (PCA) and was not allowed to provide hands on care for residents. She stated she had not turned Resident #6 during the day. An interview was conducted with NA#2 on 3/22/2021 at 2:45pm. NA#2 stated she was	F 686	These audits will be conducted daily for 2 weeks, then three times a week x 4 weeks. The DON or designee will bring the audit results to two consecutive Quality Assurance Meetings, at which time a determination will made if further monitoring is needed.	

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F 686	Continued From page 3	F 686		

assigned to resident #6 but did not know her well because she did not work with her often. When asked if Resident #6 could move herself in the bed, the NA stated the resident could not. When the NA was asked if the resident had any pressure wounds, the NA stated the resident did have a pressure wound on her bottom. When asked if she had turned or repositioned the resident between 9:35am and 2:45pm, she stated she attempted to place a pillow behind the resident's back but she began yelling out. When asked if she had turned the resident in a position that would have gotten her off her bottom at any time between 9:35am and 2:45pm, she stated she had not.

On 3/22/2021 at 3:00pm and interview was conducted with the DON regarding turning and positioning of dependent residents. He stated there was no policy for turning/repositioning dependent residents with pressure ulcers because it is considered a standard of care. He further stated both residents were on alternating pressure low air loss mattresses to help treat existing pressure ulcers and prevent further skin breakdown.

A telephone interview was conducted with the wound care provider on 3/25/2021 at 10:58am. She stated was familiar with Resident #6 and treating the resident's stage four sacral wound. She further stated she evaluated the resident's sacral wound on 3/24/2021 and determined the wound required a higher level of care. The wound care provider stated turning and repositioning a resident was a standard of care when treating a resident with existing pressure ulcers and it was her recommendation and expectation the resident be turned per the facility's policy or often enough

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F 686	Continued From page 4	F 686		

to prevent further skin breakdown.

2.Resident #7 was admitted to the facility on 6/24/2017. The resident had diagnoses that included dementia, muscle weakness, feeding difficulties, and lack of coordination.

Resident #7's medical record revealed she entered hospice on 12/10/2020.

The resident's most recent quarterly Minimum Data Set (MDS) dated 2/16/2021 indicated Resident #7 was severely cognitively impaired, required extensive hands on assistance with all activities of daily living and bed mobility. The MDS further revealed Resident #7 was coded as having one stage three pressure ulcer and one unstageable pressure injury neither of which were present upon entry/reentry.

Resident #7's most recent care plan, dated 2/17/2021, indicated the resident required assistance from staff with all activities of daily living secondary to advanced age with dementia and functional mobility deficits. The care plan also identified the resident as high risk for skin breakdown. Interventions included assisting the resident with turning and positioning on routine rounds.

On 3/22/2021 at 9:35, Resident #7 was observed on her left side with pillow support behind her right shoulder and back with the head of the bed elevated approximately 20-30 degrees.

At 10:20am Resident #7 was observed on her left side with pillow support behind her right shoulder and back with the head of the bed approximately 20-30 degrees.

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F 686	Continued From page 5	F 686		

At 11:25am Resident #7 was observed on her left side with pillow support behind her right shoulder and back with the head of the bed approximately 20-30 degrees.

Resident #7 was observed at 12:30pm to be positioned on her left side with pillow support behind her right shoulder and back. She was attempting to eat her lunch with her right hand.

At 2:15pm Resident #7 was observed on her left side with pillow support behind her right shoulder and back and the head of the bed elevated approximately 20-30 degrees.

An interview was conducted with Nurse #1, assigned to the 300 hall, on 3/22/2021 at 2:20pm. Nurse #1 stated the NAs are responsible for turning and repositioning dependent residents therefore she had not turned or repositioned Resident #7.

At 2:25pm on 3/22/2021 an interview was conducted with the medication aide assigned to the 300 hall. She stated she was working the medication cart and the task of turning residents who could not turn themselves is assigned to the NA on the hall.

An interview was conducted with the personal care aide (PCA) assigned to the 300 hall on 3/21/2021 at 2:35pm. She stated she was a PCA and was not allowed to provide hands on care for residents. She stated she had not turned Resident #7 during the day.

An interview was conducted with NA#1 on 3/22/2021 at 2:40pm. The NA stated she was

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F 686	Continued From page 6	F 686		

assigned to Resident #7. When asked if the resident was able to move herself in the bed unassisted, the NA stated the resident was dependent upon staff for bed mobility. When asked about repositioning the resident during the day, NA#1 stated she repositioned the resident's pillows once. She further stated the resident was hospice and she had fragile skin, so she did not reposition her in fear she would have additional skin tears. When asked if Resident #7 had any wounds, NA#1 stated the resident has a pressure ulcer on her sacrum. When asked how pressure ulcers develop, NA #1 stated pressure ulcers develop when a person is left in one position for a long time. When NA#1 was asked if she repositioned Resident #7 off her left side at any point during the day between 9:30am and 2:40pm, the NA stated she had not. When NA#1 was asked about her facility's policy on repositioning dependent residents she stated she thought the policy was to reposition them on their regular rounds every 2-3 hours.

On 3/22/2021 at 3:00pm and interview was conducted with the DON regarding turning and positioning of dependent residents. He stated there was no policy for turning/repositioning dependent residents with pressure ulcers because it is considered a standard of care. He further stated both residents were on alternating pressure low air loss mattresses to help treat existing pressure ulcers and prevent further skin breakdown.

A phone interview was conducted with Resident #7's provider, Doctorate of Osteopathic medicine (DO), on 3/25/2021 at 10:35am. She stated she was familiar with the resident and the resident did have skin tears on her arms. She further stated

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F 686	Continued From page 7 the resident was on hospice and receiving wound care for her sacral wound by the facility's wound care provider. The DO stated it was her expectation the staff turn and reposition the resident to prevent further skin breakdown, the exception would be if the hospice resident was actively dying. A telephone interview was conducted with the wound care provider on 3/25/2021 at 10:58am. She stated was familiar with Resident #7 and treating the resident's stage three sacral wound. She stated turning and repositioning the resident was a standard of care when treating a resident with pressure ulcers and it was her recommendation and expectation the resident be turned per the facility's policy or often enough to prevent further skin breakdown.	F 686		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with staff, the facility failed to provide adaptive equipment for 1 of 3 residents reviewed for nutrition (Resident #7). The findings included: Resident #7 was admitted to the facility on 6/24/2017. The resident had diagnoses that	F 810	Resident #7 was screened by the Director of Rehabilitation Services on 4/1/21 to determine most appropriate needs for adaptive equipment for feeding assistance to ensure resident maintains the highest level of independence. Between 4/1/21 and 4/12/21, residents receiving adaptive feeding equipment	4/12/21

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F 810	Continued From page 8 included dementia, muscle weakness, feeding difficulties, and lack of coordination. The resident's most recent quarterly Minimum Data Set (MDS) dated 2/16/2021 indicated Resident #7 was severely cognitively impaired, required extensive hands on assistance with all activities of daily living, bed mobility, and eating. Resident #7's most recent care plan, dated 2/17/2021, indicated the resident was at risk for decreased independence with meal intake. Interventions included the resident was to receive verbal cues and supervision to extensive assist during meals as needed. Additionally, the care plan indicated the resident required assistance from staff with all activities of daily living secondary to advanced age with dementia and functional mobility deficits. Interventions included resident was to be assisted with all meals as needed. The intervention was dated 2/9/2021. On 3/22/2021 at 12:30pm Resident #7 was observed positioned on her left side with the head of the bed elevated between 20-30 degrees. She had two pillows positioned behind her on her right side for support. The resident was observed eating her meal with her fingers on her right hand and wiping her mouth with her bed sheet. Utensils and napkins were observed on the right side of the tray. No staff were observed in the room at the time. The resident had consumed 50-75% of food. The resident's meal tray ticket indicated the resident required a suction scoop plate and a two-handle sippy cup with meals. The resident was observed to have a divided plate. A two- handle sippy cup was not observed on the tray. The resident had two clear cups without handles and both were observed to be full.	F 810	were screened to ensure each resident was receiving the appropriate adaptive feeding equipment to ensure the highest level of independence. All care plans and physician orders were updated by MDS and Regional Clinical Manager to include the most appropriate adaptive feeding equipment by 4/12/21. An in-service was initiated on 3/22/21 by the Staff Development Coordinator to all licensed nurses, medication aides, personal care assistance, and certified nursing assistants on checking meal card, to the adaptive feeding equipment on the resident tray prior to delivering to resident. This was completed on 4/12/21. The Dietary Manager initiated an in service on 3/22/21 to all dietary staff, to include cooks and dietary aides in the placement of appropriate feeding adaptive equipment on resident trays. This in service was completed on 4/12/21. No staff, to include all licensed nurses, medication aides, personal care assistance, certified nursing assistants, cooks and dietary aides will be allowed to work after 4/12/21 if this in service was not completed. The Dietary Manager or designee will monitor the tray card and resident meal tray for the appropriate adaptive feeding equipment at least two meals a day x 30 days. The Dietary Manager or designee will bring the audit results to two consecutive Quality Assurance Meetings, at which time a determination will made if further	

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F 810	Continued From page 9 On 3/22/2021 at 12:35pm an interview was conducted with Resident #7. When asked about her meal she stated she ate as much as she could get to but she could not get it all. When asked if she typically got assistance with her meals from staff, she shook her head no. At 12:45pm on 3/22/2021 nursing assistant (NA) #1 was observed entering Resident #7's room and removing the meal tray. When asked if Resident #7 required assistance with meals, she stated the resident only required tray set up. When asked to read the resident's meal tray card for assistive devices she stated the resident required a suction scoop plate and a two-handle sippy cup according to her meal tray ticket. When asked if she saw either present on the tray, she stated she did not. The dietary manager entered Resident #7's room at 12:50pm on 3/22/2021 and approached NA#1 who was holding the resident's tray. She stated the assistive devices were not present and were the responsibility of the cook and kitchen staff. At 1:15pm on 3/22/2021 and interview was conducted with the facility cook. He stated he was responsible for reading the meal tray ticket and providing the suction scoop plate. He further stated not providing a suction scoop plate was an oversight. The dietary manager was present at the interview and stated the two-handle sippy cup would have been the responsibility of the dietary aide. She stated she spoke with the dietary aide and it was an oversight as well. In interview with the Director of Nursing (DON) on 3/22/2021 at 3:00pm he stated all residents	F 810	monitoring is needed.	

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F 810	Continued From page 10 should have the appropriate adaptive devices on their meal tray for each meal and it was an oversight.	F 810		