

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2015
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NAME OF PROVIDER OR SUPPLIER NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 000	INITIAL COMMENTS The re-certification survey and investigation of complaints #TN00034604, TN00035235, TN00035441, TN00035692 and TN00035746 was conducted from 3/9/15 through 3/26/15. There were no deficiencies cited related to the complaint allegations. The failure of the facility staff to complete weekly skin assessments on residents who were at risk for developing pressure ulcers and identify pressure ulcers before residents developed an unstageable pressure ulcer resulted in actual harm for Residents #14, 115, 196 and 277. This resulted in substandard quality of care. Refer to F314.	F 000	3. a. During a skills fair 4/30, 5/1, 5/2 & 5/4/15 facility staff members were in-serviced by the SDC/designee regarding the policy for dignity & respect. Any stakeholder not attending the skills fair will receive in-service prior to the next scheduled work day. The SDC/designee will conduct in-service with new hires during the general orientation process.	
F 241 SS=D	The extended survey was completed on 3/26/15. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on policy review and interview, the facility failed to ensure 1 of 26 staff members (Certified Nursing Assistant (CNA) #1) members treated residents with dignity and respect when residents who required assistance with meals were referred to as "feeders". The findings included:	F 241	b. ADONs/designee will conduct observation rounds beginning 5/4/15 to ensure that residents are treated with dignity & respect beginning every shift x 1 week then daily x 1 week. If compliance is achieved, then will decrease observation rounds to 3 x weekly. If compliance is achieved, then ADON will evaluate effectiveness of the observation rounds. If at any time noncompliance occurs, then observation rounds will resume every shift until compliance is achieved.	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Review of the facility's "Use of Courtesy Titles" policy documented, "...It shall be the policy of Nashville Community Care and Rehabilitation at Bordeaux that residents and staff will be addressed in a courteous, respectful manner..." Interview with CNA #1 on 3/9/15 at 12:25 PM in the B4 (Birmingham) dining room, CNA #1 was asked if there was another cart for the halls. CNA #1 stated, "We have another cart that comes up for feeders." This statement was made in the presence of several residents, staff members and a family member. Interview with the Administrator on 3/13/15 at 1:55 PM, in the conference room, the Administrator was asked if it is ever appropriate to refer to residents as "feeders". The Administrator stated, "No."	F 241	4. The ADONs & SDC will report current staff/new hire compliance and any non-compliance with resident dignity & respect issues to the monthly QAPI meeting monthly for 3 months & quarterly thereafter.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident council meeting minutes, the facility failed to follow up on the resident council's concerns for 2 of 3 (January and February 2015) months of resident council meeting minutes reviewed.	F 244	Compliance Date: 05/10/15 F244 483.15©(6) LISTEN/ACT ON GROUP GRIEVANCE /RECOMMENDATION SS=E Requirements: The facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. 1. On 3/19/15, the Resident Council Meeting minutes were reviewed by the SCC for the months of January and February, 2015 with the Resident Council President.	

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F 244	Continued From page 2 The findings included: 1. Interview with alert and oriented Resident #103 on 3/11/15 at 3:00 PM in Resident #103's room Resident #103 stated, staff does not listen to the resident council's view and act upon any grievances the resident/group has filed. Resident #103 stated, "I don't know if anyone follows up because [named the Recreational Therapist] put confidential on the minutes so we can't follow up at the next meeting." Resident #103 was asked if she gets a copy of the council meeting minutes. Resident #103 stated, "No." Resident #103 was asked how concerns are brought to the council meetings. Resident #103 stated, "I have them typed up and I give them to [named staff] a day before the meeting." 2. Review of the typed resident concerns prepared for the resident council meeting in January 2015 revealed, "...Who is taking the Minutes, and is there any way we can get them before the next meeting? We would like to refresh our memory on Old Business and make sure there is a place for New Business. Also in the Old Business we need to know that any concerns stated earlier have been handled, the action taken, and the date completed, and was the concerned person notified..." There were also concerns noted with staff behavior and assistance needed by residents. Review of the resident council minutes for 1/29/15 revealed that there was no discussion of the concerns with the meeting minutes and discussion of old business. There was no evidence that all of the residents concerns were addressed. There was no section for old business in the meeting minutes. The section for the	F 244	The SCC completed grievance forms were regarding the identified issues in the minutes for Jan/Feb 2015 & distributed to the appropriate department manager for follow up/resolution. 2. The results of all of the identified grievance/concerns (Jan/Feb) were brought before the Resident Council Committee by the SCC at the March 26, 2015 meeting for resolution and approval. March grievances were reviewed by the Chaplain at the 4/1/15 meeting. Grievances from resident council will be reviewed at the next scheduled resident council meeting ongoing.	

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F 244	<p>Continued From page 3</p> <p>council president to sign the minutes was blank. There was no evidence that a grievance was filed for the resident complaints in January 2015.</p> <p>3. Review of the typed resident concerns prepared for the resident council meeting in February 2015 revealed concerns noted with staff behavior and assistance needed by residents.</p> <p>Review of the resident council minutes for 2/27/15 revealed that there was no follow-up to concerns voiced during the resident council meeting on 1/29/15. There was no evidence that all of the residents concerns were addressed. There was no section for old business in the meeting minutes. The section for the council president to sign the minutes was blank. There was no evidence that a grievance was filed for the resident complaints in February 2015.</p> <p>4. Interview with the Recreational Therapist on 3/12/15 at 8:15 AM, in the Recreational Therapist's office, the Recreational Therapist was asked how the facility follows up on issues discussed during the resident council meetings. The Recreational Therapist stated, "I listen during the meeting and put it down in the minutes and pass it along to the department heads." The Recreational Therapist confirmed that old business was not discussed in the meeting, not all of the concerns she received in writing was addressed in the minutes and that the resident council president was not given a copy of the meeting minutes.</p> <p>Interview with the Administrator and the Nurse Consultant on 3/19/15 at 1:49 PM in the Administrators office, the Administrator and the Nurse Consultant confirmed that concerns raised</p>	F 244	<p>3. a. The Chaplain and Activity Director were in-serviced by the SCC on 3/23/15 regarding the purpose of the resident council/grievance process.</p> <p>b. The SDC/designee will conduct in-service with facility staff regarding the grievance/concern process during skills fair scheduled 4/30, 5/1, 5/2 & 5/4/15.</p> <p>c. The Chaplain assumed the responsibility of facilitator of the resident council as of 3/27/15. A new resident council minute form was implemented that reflects a space for "old business" and any grievance/concern the residents may have. The resident council meeting has been rescheduled for the 1st Wednesday of every month per residents' request.</p>	

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F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 278	<p>F278 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED</p> <p>SS=D</p> <p><u>Requirements:</u></p> <p>The facility must ensure accurate coding of the Minimum Data Set (MDS) for incontinence.</p> <ol style="list-style-type: none"> Section H of the MDS assessment dated 02/15/15 for Resident #68 was reviewed for accuracy by the MDS Coordinator. The current care plan and MDS assessment reflects the current findings of this evaluation. Section H of MDS for other residents in the facility was reviewed between 4/30/15 & 5/5/15 for accuracy of coding. 	

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F 278	<p>Continued From page 5</p> <p>by: Based on medical record review, observation and interview, the facility failed to accurately code the Minimum Data Set (MDS) for incontinence for 1 of 36 (Residents #68) sampled residents of the 58 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #68 was admitted to the facility on 11/13/14 with diagnoses of Hypertension, Cardiomyopathy, Depression, Shortness of Breath, Congestive Heart Failure with Defibrillator Placement, Ejection Fraction of 20 percent, Debility, Dyslipidemia, Osteoporosis, Osteoarthritis, Constipation and Insomnia.</p> <p>The admission MDS dated 11/19/14, documented a Brief Interview for Mental Status (BIMS) score of 11 which indicated the resident was moderately impaired and was occasionally incontinent of bladder (less than 7 episodes during the 7 day look back period). The quarterly MDS dated 2/17/15, documented a BIMS score of 12 which indicated the resident was moderately impaired and was frequently incontinent of bladder (7 or more episodes during the 7 day look back period).</p> <p>Review of a care plan dated 11/24/14 documented Resident #68 had a problem with Activities of Daily Living] (ADL) self care deficit and was at risk for complications related to the deficit and "...Resident [#68] is occasionally incontinent with bladder/bowel... Approaches include: Assist with toileting as needed, Change brief/ pad as needed..."</p> <p>Review of the incontinent reports documented the</p>	F 278	<p>3. The SDC /designee conducted in-service with the Restorative Nurse & MDS Coordinator on 5/4/15 regarding appropriate coding of the MDS.</p> <p>4. MDS Coordinators will audit 10 MDS assessments (Section H regarding incontinence) monthly for 3 months (completed by Restorative Nurse) for accuracy of coding. MDS Coordinator/designee will report the findings of the audits for accuracy to monthly QAPI meeting monthly for 3 months and quarterly thereafter.</p> <p>Compliance Date: 05/10/15</p>		

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F 278	<p>Continued From page 6 following:</p> <p>a. Resident #68 had 7 episodes of incontinence during the 7 day look back period (11/13/14 through (-) 11/19/14) for the 11/19/14 admission MDS which indicated frequently incontinent.</p> <p>b. Resident #68 had 5 episodes of incontinence during the 7 day look back period (2/9/15 - 2/15/15) for the 2/15/15 MDS which indicated occasionally incontinent.</p> <p>Observations in Resident #68's room, on 3/12/15 at 9:18 AM, revealed Resident #68 lying in bed with a bedside commode beside the bed.</p> <p>Interview with Resident #68 on 3/13/15 at 2:45 PM in Resident #68's room, Resident #68 was asked if she used the bedside commode to urinate and have a bowel movement. Resident #68 stated, "Yes ma'am, the doctor doesn't want me to walk by myself so I use that. I hold on to the sides." She was asked if she wears briefs or pull ups and she pointed to a bag of pull ups on the dresser and stated, "I wear those." Resident #68 was asked if she ever urinates in the pull ups. Resident #68 stated, "Well sometimes, but not very often."</p> <p>Interview with Licensed Practical Nurse (LPN) #7 on 3/13/15 at 3:19 PM at the R2 (Riberio) nurses station, LPN #7 was asked about Resident #68's episodes of incontinence. LPN #7 stated, "She gets up by herself and she is continent. She can tell me when she has a BM [bowel movement] and when she doesn't want her Miralax. She is never incontinent."</p> <p>Interview with certified nursing assistant (CNA) #5 on 3/13/15 at 3:22 PM, CNA #5 was asked about Resident #68's incontinence. CNA #5 stated,</p>	F 278			

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F 278	Continued From page 7 "She changes her clothes, she has her own wipes and cleans herself up when she needs to." Telephone interview with LPN #8 on 3/13/15 at 3:48 PM, LPN #8 was asked if she completed the bowel and bladder section of the MDS. LPN #8 stated, "I do." LPN #8 was asked where she gets the information to put into the MDS. LPN #8 stated, "I get it from what the techs [technicians] put into [named kiosk program]... Let me look at the documentation. I will print them out. For the first MDS 1 bowel and 7 of incontinence, but I think the 2nd one. I may have that backwards in that coding. She went from 7 episodes to 5 episodes." Interview with LPN #8 on 3/13/15 at 3:57 PM at R2 nurses station, while reviewing the incontinence reports, LPN #8 stated, "I marked them. I evidently miss counted. That's what I would chalk that up to. I don't like making mistakes."	F 278	F280 483.20(d)(3), 483.10(k)(2)RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP SS=D <u>Requirements:</u> The facility must develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by and interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

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F 280	<p>Continued From page 8</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to revise the care plan to include the interventions put in place for pressure ulcers for 1 of 36 (Resident #14) sampled residents reviewed of the 58 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #14 was admitted to the facility on 2/10/15 with diagnoses of Paraplegia, Acute Respiratory Failure, Status Post Tracheostomy, Methicillin Resistant Staphylococcus Aureus (MRSA) Pneumonia, Urinary Tract Infection with Vancomycin-Resistant Enterococcus (VRE), Iron Deficiency Anemia, Dysphagia and Depression. Review of the Braden scale dated 2/10/15 revealed a score of 11 indicating Resident #14 was a high risk for pressure ulcers.</p> <p>Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 2/17/15 revealed, Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact and at risk for pressure ulcers.</p>	F 280	<ol style="list-style-type: none"> 1. Resident #14 care plan and bedside care guide were revised on 4/27/15 by the IDT to reflect the resident's current status and appropriate interventions for pressure ulcers. 2. Licensed nurses implemented new skin integrity care plans 4/10-4/13/15 for current residents with pressure ulcers. Care plans were revised to include residents' refusal of interventions to help prevent pressure ulcers or worsening of current pressure ulcers. Bedside care guides have been updated to reflect the current status of the residents' skin integrity. Beginning 4/16 & 4/17/15 care plans/bedside care guides will be reviewed/revised weekly at the SNAR (skin/nutrition at risk) meeting to reflect the residents' current skin integrity status. 	

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F 280	<p>Continued From page 9</p> <p>Review of the pressure ulcer report dated 2/24/15 documented, "...Date of Origin 2/24/15... Site Location: Buttocks... [checked] Facility acquired... [checked] Unstageable... MEASUREMENTS Length (cm) [centimeters] 12.5 x [by] Width (cm) 5.0 Depth (cm) 0.1..."</p> <p>The care plan dated 2/24/15 documented, "...Resident is with pressure ulcer (s) Classified as... [checked] Unstageable Location: Rt [right] Buttocks... Interventions... 1. Assess & [and] monitor for s/s [signs and symptoms] of Infection... 2. Provide low AF [air loss surface]... Tx [treatment] Skin prep & medihoney..."</p> <p>Review of pressure ulcer reports documented the following:</p> <p>a. 3/2/15 - "STAGE... [checked] Unstageable... MEASUREMENTS Length (cm): 12.5 x Width (cm): 5.5 Depth (cm) 0.1... Pt [patient] sets up in bed on coccyx during the day to play on computer instructed pt that he needs to turn get off buttocks to heal..."</p> <p>b. 3/9/15 - "STAGE... [checked] Unstageable... MEASUREMENTS Length (cm) 13.0 x Width (cm) 7 x Depth (cm) 2... Pt sets straight up in bed every day all day that causes pressure. Instructed pt not to do it all day. Pt. stated "I have to do something..."</p> <p>Observations in Resident #14's room on 3/13/15 at 2:31 PM, revealed Resident #14 sitting up in bed playing a car garage game on his computer tablet.</p> <p>Interview with the Director of Nursing (DON) on 3/18/15 at 3:51 PM, in the conference room, the DON was asked if the resident teaching in the progress notes of the the pressure ulcer record</p>	F 280	<p>3. a. The SDC/designee conducted in-service with licensed nurses during a skills fair 3/23-3/26/15 and will repeat during a skills fair 4/30, 5/1, 5/2, & 5/4/15 regarding updating and revising care plans & bedside care guides for current condition of pressure ulcers and interventions implemented to prevent /reduce pressure ulcers.</p> <p>b. The SDC/designee conducted in-service with nursing staff regarding turning / repositioning residents at least every 2 hours and explaining to residents / family members the importance of not lying/ sitting on bony prominence for an extended period of time.</p> <p>c. ADON/unit managers will audit orders daily beginning 5/4/15 ongoing to identify new pressure ulcers or revised treatments of pressure ulcers and audit care plans and bedside care guides for</p>	

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F 280	Continued From page 10	F 280	new or revised documentation.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, the facility failed to assess skin conditions for non pressure ulcers for 1 of 36 (Resident #232) sampled residents of the 58 residents included in the stage 2 review. The findings included: 1. The facility's "Skin Management and Prevention At - A - Glance" policy documented, "...weekly skin..." will be utilized to determine if any new skin alterations have developed..." 2. Medical record review revealed Resident #232 was admitted to the facility on 5/28/14 and readmitted on 11/5/14 with diagnosis of Subarachnoid Hemorrhage, Chronic Respiratory Failure, Diabetes Mellitus, Flaccid Hemiplegia, General Nonconvulsive Epilepsy, Tracheostomy, Hypertension and Joint Contractures.	F 309	4. ADON/designee will report audit findings to the monthly QAPI meeting on a monthly basis until compliance is achieved and then quarterly Compliance Date: 05/10/15	

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F 309 SS=D	<p>on 3/2/15 and 3/9/15 was appropriate for the care plan. The DON stated, "Yes, I don't see anything about that on there [care plan]. I don't see it."</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, the facility failed to assess skin conditions for non pressure ulcers for 1 of 36 (Resident #232) sampled residents of the 58 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> The facility's "Skin Management and Prevention At - A - Glance" policy documented, "...weekly skin..." will be utilized to determine if any new skin alterations have developed..." Medical record review revealed Resident #232 was admitted to the facility on 5/28/14 and readmitted on 11/5/14 with diagnosis of Subarachnoid Hemorrhage, Chronic Respiratory Failure, Diabetes Mellitus, Flaccid Hemiplegia, General Nonconvulsive Epilepsy, Tracheostomy, Hypertension and Joint Contractures. 	F 309	<p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>SS=D</p> <p><u>Requirements:</u></p> <p>The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <ol style="list-style-type: none"> A skin integrity review was completed for resident #232 by a licensed nurse on 3/12/15 to document identification of any skin related issues. A team of licensed nurses completed a skin integrity review of current residents on 4/29 & 4/30/15 to document any skin related issues. 	

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F 309 SS=D	<p>on 3/2/15 and 3/9/15 was appropriate for the care plan. The DON stated, "Yes, I don't see anything about that on there [care plan]. I don't see it."</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, the facility failed to assess skin conditions for non pressure ulcers for 1 of 36 (Resident #232) sampled residents of the 58 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. The facility's "Skin Management and Prevention At - A - Glance" policy documented, "...weekly skin..." will be utilized to determine if any new skin alterations have developed..." 2. Medical record review revealed Resident #232 was admitted to the facility on 5/28/14 and readmitted on 11/5/14 with diagnosis of Subarachnoid Hemorrhage, Chronic Respiratory Failure, Diabetes Mellitus, Flaccid Hemiplegia, General Nonconvulsive Epilepsy, Tracheostomy, Hypertension and Joint Contractures. 	F 309	<p>3. a. The SDC/designee conducted in-service with licensed nurses during a skills fair 3/23-3/26/15 & will be repeated during a skills fair 4/30, 5/1, 5/2, & 5/4/15 regarding completion of weekly skin integrity review to document any skin related issues.</p> <p>b. The ADON/designee will conduct 100% audits of weekly skin integrity review sheets daily beginning 5/4/15 & will continue daily by the ADON/designee for each unit x 4 weeks. If 100% compliance is achieved, then audits will decrease to 1 x weekly ongoing to ensure that weekly skin integrity reviews are completed & any identified skin issues are addressed. If at any time during the audit process, noncompliance occurs, 100% daily audits will resume.</p>	

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F 309 SS=D	<p>on 3/2/15 and 3/9/15 was appropriate for the care plan. The DON stated, "Yes, I don't see anything about that on there [care plan]. I don't see it."</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, the facility failed to assess skin conditions for non pressure ulcers for 1 of 36 (Resident #232) sampled residents of the 58 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. The facility's "Skin Management and Prevention At - A - Glance" policy documented, "...weekly skin..." will be utilized to determine if any new skin alterations have developed..." 2. Medical record review revealed Resident #232 was admitted to the facility on 5/28/14 and readmitted on 11/5/14 with diagnosis of Subarachnoid Hemorrhage, Chronic Respiratory Failure, Diabetes Mellitus, Flaccid Hemiplegia, General Nonconvulsive Epilepsy, Tracheostomy, Hypertension and Joint Contractures. 	F 309	<p>4. ADONs will report audit findings monthly x 3 at the QAPI meeting & quarterly thereafter.</p> <p>Compliance Date: 05/10/15</p>	

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F 309	Continued From page 11 The facility was unable to provide weekly skin integrity reviews completed between 2/3/15 through 3/8/15.	F 309		
F 312 SS=D	Interview with the Assistant Director of Nursing (ADON) / Registered Nurse (RN) #2 on 3/12/15 at 10:12 AM, at the B2 (Birmingham) nurses station confirmed the weekly skin integrity reviews between 2/3/15 and 3/8/15 had not been completed. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 medical record review and interview, the facility failed to provide assistance with daily oral hygiene for 1 of 5 (Resident #196) sampled residents reviewed for activities of daily living (ADL) of the 58 residents included in the stage 2 review. The findings included: 1. Medical record review revealed Resident #196 was admitted to the facility on 1/6/15 with diagnoses of Open Wound, Kidney Malignant Neoplasm, Diabetes Mellitus, History of Pulmonary Embolism, Peripheral Vascular Disease, Depression, Hypertension, Morbid Obesity, Esophageal Reflux, Peripheral	F 312	F 312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS SS=D Requirements: The facility must ensure that 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. 1. Oral care was provided for resident #196 by a CNA immediately 3/12/15. 2. On 5/4/15 ADONs conducted observation rounds on each unit to determine if oral care is being performed during ADL care as needed.	

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F 312	<p>Continued From page 12</p> <p>Neuropathy and History of Rectal and Anal Malignancy.</p> <p>Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/13/15 documented, the Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact and required extensive to total assistance for all activities of daily living (ADL).</p> <p>Review of the care plan dated 1/6/15 documented, "...Problem... Resident has ADL Self Care Deficit & [and] is at risk for complication related to Morbid Obesity and stated bed bound status... Resident requiring various levels of staff assistance for the completion of his daily ADL's... Approaches... Provide oral care daily and as needed... Call light w/in [within] reach... arrive promptly when in use..."</p> <p>Interview with Resident #196 on 3/10/15 at 1:27 PM, in Resident #196's room, Resident #196 was asked how often are your teeth / dentures / mouth cleaned. Resident #196 stated, "Every 2 to 3 days."</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on 3/12/15 at 4:00 PM, outside Resident #196's room, CNA #2 was asked if she had provided oral care for Resident #196. CNA #2 stated, "Yes, this morning." CNA #2 was asked if there was any charting in the kiosk specific to oral care. CNA #2 stated, "No, it falls under personal hygiene."</p> <p>Interview with Resident #196 on 3/12/15 at 4:02 PM, in Resident #196's room, Resident #196 was asked if his teeth had been brushed today.</p>	F 312	<p>3. a. The SDC/designee conducted in-service with nursing staff during a skills fair 4/30, 5/1, 5/2 & 5/4/15 regarding the policy for oral care as a standard of practice.</p> <p>b. ADONs/designee will conduct observation rounds beginning 5/4/15 on 10 residents daily per unit x 1 week to ensure that oral care is being provided as needed. If compliance is achieved then decrease observation rounds to 5 residents daily x 1 week, if compliance is achieved then decrease observation rounds to once weekly of 2 residents ongoing to ensure oral care is provided as needed. ADON will assess the effectiveness of the rounds. If at any time noncompliance occurs, then the audit process will resume.</p> <p>4. ADONs will report findings at the QAPI committee monthly meeting x 3 & quarterly thereafter.</p> <p>Compliance Date: 05/10/15</p>	

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F 312	Continued From page 13 Resident #196 stated, "No." Resident #196 was asked if he had his teeth brushed yesterday. He stated, "No." Resident #196 was asked if his teeth had been brushed the day before yesterday. He stated, "No, it's been a long time."	F 312		
F 314 SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on review of the National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Prevention quick reference guide, policy review, medical record review, review of the facility's weekly pressure ulcer tracking forms, observation and interview, the facility failed to ensure nurses completed weekly skin assessments and identify pressure ulcers timely, identify the correct anatomical location of a pressure ulcer, obtain a	F 314	F 314 483.25 © TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES SS-H <u>Requirements:</u> The facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	

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F 314	Continued From page 14 physician's order prior to treatment and/or provide treatments as ordered for 8 of 9 (Residents #14, 115, 196, 277, 65, 96, 163 and 248) sampled residents reviewed of the 17 residents with pressure ulcers. The failure of the facility staff to complete weekly skin assessments on residents who were at risk for developing pressure ulcers and identify pressure ulcers before residents developed an unstageable pressure ulcer resulted in actual harm for Residents #14, 115, 196 and 277. This resulted in substandard quality of care. An extended survey was completed on 3/26/15. The findings included: 1. Review of the NPUAP Pressure Ulcer Prevention quick reference guide revealed, "...Ongoing assessment of the skin is necessary to detect early signs of pressure damage... Skin inspection should include assessment for localized heat, edema, or induration (hardness)... Accurate documentation is essential for monitoring the progress of the individual and to aiding communication between professionals..." 2. Review of the facility's "Skin Management and Prevention" policy revealed, "...weekly skin..." will be utilized to determine if any new skin alterations have developed... Any new skin condition(s) found during the weekly skin rounds will be documented..." 3. Medical record review revealed Resident #14 was admitted to the facility on 2/10/15 with diagnoses of Acute Respiratory Failure, Status Post Tracheostomy, Methicillin-Resistant Staphylococcus Aureus (MRSA) Pneumonia,	F 314	1. a. A skin integrity review was completed by a licensed nurse on resident #14 on 3/11/15 & repeated on 4/30/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/ revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15. b. A skin integrity review was completed by a licensed nurse on resident #115 on 3/12/15 & repeated 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/ revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.		

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F 314	<p>Continued From page 15</p> <p>Urinary Tract Infection with Vancomycin-Resistant Enterococcus (VRE), Iron Deficiency Anemia, Paraplegia, Dysphagia and Depression. Review of the Braden scale dated 2/10/15 revealed a score of 11 indicating Resident #14 was a high risk for pressure ulcers.</p> <p>Review of the nursing admission information revealed, "...2/11/15 11:00... Pt. [patient] assessed head to toe by wound care. No skin breakdown or alteration in skin integrity at this time..." Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/15 revealed Resident #14 did not have any pressure ulcers.</p> <p>Review of the interim care plan (developed on admission) dated 2/10/15 documented, "...Skin assessment weekly..."</p> <p>The facility was unable to provide documentation of weekly skin integrity reviews were completed from the date of admission (2/10/15) until 2/24/15.</p> <p>The weekly skin integrity review dated 2/24/15 documented, "[checked] Rash... [checked] Redness... Open Area... [checked] Old... 2/24/15... [checked] Open Area (black) area... [checked] Old... 12.5x [by] 5.0... black eschar... soft..."</p> <p>Review of a physician's order dated 2/24/15 at 10:15 AM documented, "Wound Care to Rt [right] Buttocks Unstageable Pressure Ulcer: Cleanse [symbol for with] wound cleanser apply skin prep and MediHoney cover with dry dressing 4 x [times] / wk [week]... Assess and monitor Daily..."</p>	F 314	<p>c. A skin integrity review was completed by a licensed nurse on resident #196 on 3/12/15 & repeated on 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p> <p>d. A skin integrity review was completed by a licensed nurse on resident #277 on 3/12/15 by a member of nurse management to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15. Pt was discharged on 4/18/15.</p>	

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F 314	<p>Continued From page 16</p> <p>Review of the pressure ulcer report dated 2/24/15 documented, "...Date of Origin 2/24/15... Site Location: Buttocks... [checked] Facility acquired... [checked] Unstageable... MEASUREMENTS Length (cm) [centimeters] 12.5 x Width (cm). 5.0 Depth (cm) 0.1..."</p> <p>Observations in Resident #14's room on 3/13/15 at 2:43 PM, revealed Licensed Practical Nurse (LPN) #1 (wound care nurse) performed wound care as ordered by the physician for of Resident #14. Resident #14's coccyx wound was the size of a small toy football with brown loose slough covering the wound bed.</p> <p>Interview with the Medical Director on 3/17/15 at 3:50 PM at the B2 (Birmingham) nurses station, the Medical Director was asked about Resident #14's unstageable pressure ulcer. The Medical Director stated, "The wound could have come on suddenly but with the size and the black eschar you would think someone would have noticed it when they were cleaning him up. Black eschar takes some time to develop."</p> <p>Interview with the Director of Nursing (DON) on 3/17/15 at 4:35 PM in the conference room, the DON was asked if she expected the staff to identify a wound before it was noted to be unstageable. The DON stated, "Yes."</p> <p>Failure of the facility to complete weekly skin assessments and to identify a pressure ulcer before it was unstageable resulted in actual harm to Resident #14.</p> <p>4. Medical record review revealed Resident #115 was admitted to the facility on 12/22/14 with diagnoses of Paraplegia, Spinal Cord Injury,</p>	F 314	<p>e. A skin integrity review was completed by a licensed nurse on resident #65 on 3/12/15 & repeated on 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/ revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p> <p>f. A skin integrity review was completed by a license nurse on resident # 96 on 3/12/15 & repeated on 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/ revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p>	

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F 314	<p>Continued From page 17</p> <p>Anxiety, Anemia, Hypertension, Insomnia, Chronic Rhinitis and Muscle Atrophy. The Braden scale dated 12/22/14 for Resident #115 was 16 indicating the resident was a mild risk of developing a pressure ulcer.</p> <p>The significant change MDS assessment with an ARD of 1/4/15 documented, a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact and required extensive assistance for activities of daily living (ADL) with functional limitation in range of motion (ROM) in upper and lower and extremities on both sides.</p> <p>The comprehensive care plan dated 1/12/15 documented, "...Problem... Increased potential for impaired skin integrity R/T [related to] Dx [diagnosis] paraplegia and related weakness with presence of incontinence and impaired ROM/Mobility... Goal... Skin will remain intact... Approach... assess for prompt intervention s/s [signs and symptoms] of further impaired skin integrity and report prn [as needed] to MD [medical doctor] as per facility practice and consult with wound care nsg [nursing] prn [as needed]..."</p> <p>A care plan dated 3/9/15 documented, "...Resident is with pressure ulcer(s) Classified as: Unstageable Location: Lt [left] posterior L.E. [lower extremity] below base of buttocks... Goals... Will address all needed treatment to specific ulcer(s) / wound(s) to facilitate healing thru [through] next review date... Interventions... assess and monitor daily... Use clean technique for wound care... Tx [treatment] 3/9/15 calcium alginate hydrocolloid..."</p>	F 314	<p>g. A skin integrity review was completed by a license nurse on resident #163 on 3/12/15 & repeated on 4/30/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/ revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p> <p>h. A skin integrity review was completed by a licensed nurse on resident #248 on 3/12/15 by a member of nurse management to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. Pt expired 4/16/15.</p> <p>2. a. 100% skin integrity review was conducted of other residents by a licensed nurse on 4/29/15 through 4/30/15 to ensure that a skin integrity review was performed to accomplish early identification of pressure</p>		

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F 314	<p>Continued From page 18</p> <p>A physician's order dated 3/9/15 documented, "...Wound care to Lt posterior L.E. below base of buttocks as follows. Clean c [with] wound cleanser gauze, apply Calcium alginate, hydrocolloid 4 x wk assess and monitor daily..."</p> <p>Review of the weekly skin integrity review sheets dated 12/1/14 through 3/9/15 revealed skin assessments were not done on 12/8/14, 12/15/14, 12/22/14, 12/19/14, 2/9/15, 2/16/15, 2/23/15, and 3/2/15.</p> <p>The weekly skin integrity review form dated 3/9/15 documented, "...skin intact..." completed by Licensed Practical Nurse (LPN) #3.</p> <p>The pressure ulcer record dated 3/9/15 documented, "...Lt Posterior L.E. @ [at] base of buttocks... Facility acquired... Unstageable... Length (cm)... 2 x Width (cm)... 2.5... Depth (cm)... 0.5... Wound Bed... Slough... 80% [percent]... Eschar... 20%... Consult received noted new wound treatment orders..."</p> <p>Review of the nurse's notes dated 3/9/15 documented, "...Observed open area on Lt posterior L.E. Under base of buttocks new orders to treat wound. Instructed pt [patient] importance to reposition to help c [with] healing and off load pressure. Pt verbalizes understanding..."</p> <p>LPN #1 and LPN #2 (wound nurses) entered Resident #15's room, on 3/14/15 at 10:45 AM to allow the surveyor to observe Resident #115's pressure ulcer. While observing the pressure ulcer LPN #2 stated to LPN #1, "This left buttock wound actually looks like a stage III. I think you [LPN #1] miss-staged this."</p>	F 314	<p>ulcers, that any identified pressure ulcers were staged appropriately, anatomical location was accurate & treatment orders were obtained & followed as ordered. Care plans were implemented / revised as needed.</p> <p>b. The schedule for weekly skin integrity review was revised for the licensed nurses by a member of nurse management on 3/12/15 & placed in the front of the weekly skin integrity review binder on the nursing units.</p> <p>c. A new Braden Scale was completed on 100% of residents on 3/19-3/20/15 & on 5/5/15. Residents with a Braden score of 14 or less that utilize a chair were provided a preventative cushion. Residents with a special chair that would not accommodate the cushion were evaluated for alternatives or risk versus benefit. Fifty-five cushions were implemented. Any new residents identified with a</p>	

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F 314	<p>Continued From page 19</p> <p>Interview with the Assistant Director of Nursing (ADON) / Registered Nurse (RN) #1 on 3/13/15 at 9:55 AM, at R2 (Riberio 2nd floor) nurses station, ADON/RN #1 was asked to explain the difference between the weekly skin integrity review and the pressure ulcer record. The ADON/RN #1 stated, "I really can't." ADON/RN #1 was asked what she expected from her nursing staff when performing skin assessments. The ADON/RN #1 stated, "I expect them to do the weekly skin assessments and notify the MD [medical doctor], treatment nurse and family if something is discovered." The ADON/RN #1 was asked whose responsibility was it to make sure the skin assessments were being done weekly. The ADON/RN #1 stated, "Mine." The ADON/RN #1 was shown the weekly skin integrity review sheets for the months 12/1/14 through 3/9/15 and was asked if weekly skin assessments had been completed. The ADON/RN #1 stated, "No."</p> <p>Interview with LPN #3 on 3/13/15 at 10:08 AM, at R2 nurses station, LPN #3 was shown the weekly skin integrity review form dated 3/9/15 and was asked if she completed the skin assessment on 3/9/15 for Resident #115. LPN #3 stated, "Yes." LPN #3 was shown the pressure ulcer record dated 3/9/15 and asked if her assessment was accurate. LPN #3 stated, "Other than I didn't see it [the pressure ulcer]. I just didn't see it, that's all I can say."</p> <p>Failure of the facility to complete weekly skin assessments and to identify a pressure ulcer before it was unstageable resulted in actual harm to Resident #115.</p> <p>5. Medical record review revealed Resident #196 was admitted to the facility on 1/6/15 with</p>	F 314	<p>Braden Score of 14 or less will be evaluated for a preventative cushion & the cushion will be implemented as appropriate. Care plans & bedside care guides were updated to reflect current interventions during the weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16 & 4/17/15.</p> <p>d. The Corporate WOCN nurse, SCC, DON & Medical Director (WCC) collaborated in the development of a new skin integrity care plan to be utilized by the IDT & kept in the medical record for use by the entire team. The Medical Director approved a Physician Based Wound Order for implementation by the licensed nurses upon identification of wounds until a wound consult can be performed by the wound team within 24 hours.</p> <p>e. CNA skin care alert sheets were implemented on 3/12/15 by nurse management for documentation of any skin</p>		

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F 314	<p>Continued From page 20</p> <p>diagnoses of Open Surgical Wound, Kidney Malignant Neoplasm, Diabetes Mellitus, History of Pulmonary Embolism, Peripheral Vascular Disease, Depression, Hypertension, Morbid Obesity, Esophageal Reflux, Peripheral Neuropathy and History of Rectal and Anal Malignancy. The Braden scale dated 1/6/15 documented a score of 14 indicating the resident was a moderate risk for developing a pressure ulcer.</p> <p>The admission MDS assessment with an ARD of 1/13/15 documented, a BIMS score of 15, indicating the resident was cognitively intact, required extensive to total assistance for all ADL's, had no functional limitations in ROM, had an indwelling catheter and an ostomy.</p> <p>The pressure ulcer record dated 2/4/15 documented, "...Lt. Buttocks... Facility acquired... Unstageable... 3.0cm x 7.5cm x 0.1cm... Exudate... Serous... Scant... 100% slough..."</p> <p>A wound care note dated 2/5/15 documented, "...Unstageable wound on L [left] [circled] buttox [buttock]... Drainage... Large amount... Foul..."</p> <p>A physician's order dated 2/6/15 documented, "...Lt buttocks unstageable pressure ulcer: cleanse c [with] wound cleanser Apply Dakin's moistened gauze. cover c dry drsg. [dressing] 4x/wk..."</p> <p>The facility was unable to provide weekly skin integrity review sheets from 2/23/15 to 3/12/15.</p> <p>Observations in Resident #196's room on 3/12/15 at 8:50 AM revealed a large unstageable left buttock wound. There was 20% eschar and 80%</p>	F 314	<p>issues identified during residents' showers & or daily care by the CNAs. The licensed nurses' weekly skin integrity review schedule was revised to coincide with the residents' shower schedule on 3/12/15.</p> <p>f. A process was developed for completion of skin integrity review from admission / readmission, weekly & upon identification of skin issues by CNAs or licensed nurses & consultation to the wound nurse to ensure early identification of pressure ulcers and implementation of treatment orders.</p> <p>3. a. The SDC/designee conducted in-service with licensed nurses during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15 regarding the processes for completion of weekly skin integrity review, admission / readmission skin integrity</p>	

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F 314	<p>Continued From page 21</p> <p>slough with slight bright red bleeding from around the edges.</p> <p>Interview with LPN #2 (wound nurse) on 3/12/15 at 1:59 PM, in the conference room, LPN #2 was asked who discovered the unstageable buttocks wound. LPN #2 stated, "When you are doing treatments in the area [of the body where the wound is] sometimes we will start treating [a second wound]." LPN #2 was asked how often do you treat Resident #196. LPN #2 stated, "Four times a week. I'm pretty sure it [left buttock wound] started out red. He [Resident #196] wouldn't stay off his left side. The nursing staff probably wouldn't notice anything wrong as it was probably covered with a dressing. It could have been I just missed it or forgot to start documentation. Yep, I think I missed that."</p> <p>Interview with RN #2/ADON on 3/12/15 at 4:00 PM, at the B4 nurses desk, RN #2/ADON was asked what she expected from her nursing staff regarding skin assessments. RN #2/ADON stated, "I expect my staff to complete skin assessments per policy which is weekly or normally in the shower since the residents are in their birthday suits."</p> <p>Interview with the Medical Director on 3/24/15 at 4:00 PM, in the conference room, the Medical Director was asked about Resident #196's pressure ulcer. The Medical Director stated, "Based on what the wound nurse told me, she [wound nurse] was treating the new area that was close to the surgical coccyx wound, but she did not document on the new area until it was open. She [wound nurse] knows it was started as a DTI [deep tissue injury] and used skin prep until it opened, but I have no supporting documentation.</p>	F 314	<p>review, wound team consult within 24 hours of admission / readmission & with new skin issues identified by licensed nurses/CNAs during showers/ADLs. In-service education will be completed with licensed nurses by 5/4/15. Any licensed nurse not attending the scheduled in-services will not be scheduled to work until in-service education is completed prior to working the next scheduled shift. New hires will be in-serviced during orientation by SDC/designee.</p> <p>b. The SDC/designee conducted in-service with CNAs during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15 regarding the process for completing CNA skin alert sheets during showers & daily care In-service education will be completed with CNA by 5/4/15. Any CNA not attending the</p>	

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F 314	<p>Continued From page 22</p> <p>I did not sign it [determination that development of pressure sore is unavoidable form] because I had no verification of documentation. She [wound nurse] said right in front of me that she forgot to document it."</p> <p>Failure of the facility to identify a pressure ulcer before it was unstageable resulted in actual harm to Resident #196.</p> <p>6. Medical record review revealed Resident #277 was admitted to the facility on 2/27/15 with diagnoses of Chronic Respiratory Failure, Gastroesophageal Reflux Disease, Dysphagia, Tracheostomy, Diabetes Mellitus, Generalized Pain, Congestive Heart Failure, Depression and Deep Vein Thrombosis.</p> <p>The admission nurses note dated 2/27/15 documented, "...Multiple bruises noted on abdomen and BUE [bilateral upper extremities]... Skin warm and dry no lesions or rash noted..."</p> <p>The admission nurses note dated 3/1/15 at 9:00 AM documented, "Wound care full skin assessment done at admission... pressure ulcer on buttocks/coccyx noted wound care orders wrote for treatment..."</p> <p>There is no evidence in the medical record that Resident #277 was admitted to the facility with a pressure ulcer on 2/27/15.</p> <p>Review of the pressure ulcer record dated 3/1/15 revealed, "...Date of Origin 3/1/15... Site Location: Coccyx... [checked] Admitted with... Date 3/1/15... STAGE... [checked] Unstageable... Length (cm) 9 x Width (cm) 7.5 Depth (cm) 0.5... [checked] Slough... 80%... [checked] Eschar... 20%... SPECIALTY INTERVENTIONS... [checked]"</p>	F 314	<p>scheduled in-services will not be scheduled to work until in-service education is completed prior to working the next scheduled shift. New hires will be in-serviced during orientation by SDC/designee.</p> <p>c. The SDC/designee conducted in-service during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15 with licensed nurses & CNAs regarding pressure ulcer prevention, early identification of pressure ulcers, immediate intervention when pressure ulcers develop, and utilization of appropriate support surfaces (mattresses & cushions). In-service education will be completed with licensed nurses & CNAs by 5/4/15. Any licensed nurse/CNA not attending the scheduled in-services will not be scheduled to work until in-service education is</p>	
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F 314	<p>Continued From page 23</p> <p>Mattress... PROGRESS NOTES... Upon assessment on admission noted pt has unstageable coccyx wound new orders... gave over phone..."</p> <p>A physician's order dated 3/1/15 documented, "Wound care to coccyx unstageable wound as follows clean with wound cleanser, gauze, apply skin prep, calcium alginate cover with dry dressing 3x week assess and monitor daily."</p> <p>A nutritional progress note dated 3/2/15 at 2:58 documented, "...skin intact..."</p> <p>Observations in the Resident #277's room on 3/24/15 8:36 AM with LPN #2 (wound nurse) present revealed Resident #277's coccyx pressure ulcer was irregular shaped the size of a small plum, with yellow slough in the wound bed. LPN #2 stated, "It [the pressure ulcer] is unstageable due to slough, you can't see the wound bed."</p> <p>Interview with the DON on 3/23/15 at 4:45 PM in the DON's office, the DON was asked what she expected of her nurses regarding skin assessments on admission. The DON stated, "To fill out the skin assessment sheet within 24 hours." The DON was asked what she expected of her wound nurses as far as completing a skin assessment. The DON stated, "The policy says 24 [hours] but sometimes they don't get around to it until 48 hours." The DON was asked why the coccyx wound was documented as being present when admitted when it was not discovered until 3/1/15 and the resident was admitted 2/27/15. The DON stated, "I can't answer that question."</p> <p>Interview with the Medical Director on 3/24/15 at</p>	F 314	<p>completed prior to working the next scheduled shift. New hires will be in-serviced during orientation by SDC/designee.</p> <p>d. The Corporate WOCN/SCC conducted in-service with the wound nurses, MDS director, SDC director & admission nurse regarding implementation of the new skin integrity care plan on 4/13/15.</p> <p>e. The SDC/designee conducted in-service during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15 with licensed nurses regarding implementation of the new skin integrity care plan. In-service education will be completed with licensed nurses by 5/4/15. Any licensed nurse not attending the scheduled in-services will not be scheduled to work until in-service education is completed prior to working the next shift.</p>	

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F 314	<p>Continued From page 24</p> <p>4:05 PM in the conference room, the Medical Director was asked about Resident #277's unstageable pressure ulcer. The Medical Director stated, "If it [the pressure ulcer] was from [named hospital] they would have written wound orders. [Nurses] Have to open up the folds during the assessment."</p> <p>The failure of the facility to identify a pressure ulcer before it became unstageable resulted in actual harm to Resident #277.</p> <p>7. Medical record review revealed Resident #65 was admitted to the facility on 5/27/08 with diagnoses of Diabetes Mellitus, Neuropathy in Diabetes Mellitus, Legal Blindness, Macular Degeneration, Hypertension and End Stage Parkinson's Disease.</p> <p>The annual MDS with an ARD of 11/15/14 documented Resident #65 had a BIMS score of 2 indicating the resident was severely cognitive impaired and there were no pressure ulcers present.</p> <p>The weekly skin integrity review form dated 12/25/14 documented, "Skin Condition... [checked] Redness... [checked] Other..." There were no identifying marks on the body figures on the feet or toes.</p> <p>The facility was unable to provide evidence that the weekly skin integrity review forms were completed after 12/25/14 until 2/21/15.</p> <p>The physician's orders dated 12/26/14 at 2:30 PM documented, "...Wound care to evaluate SDT1 [suspected deep tissue injury] on L [left] 2nd toe... Skin Prep 2nd Left Toe Q [every] shift & [and]</p>	F 314	<p>New hires will be in-serviced during orientation by SDC/designee.</p> <p>f. Daily audits of 100% CNAs skin care alert sheets by the ADON/designee began 5/4/15 & will continue indefinitely to ensure compliance with completion of the sheets by the CNAs.</p> <p>g. 100% audits of weekly skin integrity review sheets (completed by the licensed nurses) began 5/4/15 & will continue weekly by the ADON/designee for each unit weekly.</p> <p>h. 100% of admission/readmission records will be audited by the Director of Medical Records/designee within 2 business days for completion of skin assessments & orders for treatments indefinitely to ensure compliance. These audits will be brought to morning clinical meeting to ensure findings are addressed by the appropriate ADON/unit manager.</p>		

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F 314	<p>Continued From page 25 avoid placing strap over L 2nd toe..."</p> <p>The facility was unable to provide evidence that wound care evaluated the SDTI on Resident #65's left 2nd toe as ordered by the physician.</p> <p>Review of the Medication Administration Record (MAR) for 12/26/14 - 12/31/14 revealed Skin Prep Treatment to 2nd left left toe was not applied as ordered by the physician on the 7AM-7PM shift for 12/27, 12/28 and 12/30/14 or on the 7PM-7AM shift for 12/29 and 12/30/14.</p> <p>Review of the MAR for 1/1/15 - 1/31/15 revealed Skin Prep Treatment to the 2nd left toe was not applied as ordered by the physician on the 7AM - 7PM shift for 1/1, 1/2, 1/3, 1/10, 1/11, 1/12, 1/13, 1/16, 1/17, 1/18, 1/21, 1/23, 1/25, 1/26, 1/30 and 1/31/15 or on the 7PM-7AM shift for 1/5, 1/6/ 1/10, 1/11, 1/13, 1/14, 1/15, 1/16, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30 and 1/31/15.</p> <p>Review of the MAR for 2/1/15 - 2/28/15 revealed Skin Prep Treatment to the 2nd left toe was not applied as ordered by the physician on the 7AM - 7PM shift for 2/1, 2/3, 2/4, 2/6, 2/8, 2/9, 2/10, 2/11, 2/13, 2/14, 2/15, 2/16, 2/18, 2/19, 2/20, 2/21, 2/22, 2/23, 2/24, 2/27, 2/28 or on the 7PM-7AM shift for 2/1, 2/2, 2/4, 2/5, 2/6, 2/9, 2/10, 2/11, 2/17, 2/19, 2/20, 2/22, 2/23, 2/24, 2/25, 2/27 and 2/28/15.</p> <p>Review of the MAR for 3/1/15 - 3/16/15 revealed Skin Prep Treatment to the 2nd left toe was not applied as ordered by the physician on the 7AM-7PM shift for 3/1, 3/4, 3/6, 3/7, 3/9, 3/10, 3/11, 3/12, 3/13, 3/14 and 3/15/15 or on the 7PM-7AM shift for 3/1, 3/2, 3/3, 3/4, 3/9, 3/11,</p>	F 314	4. The ADON of each unit & the Medical Records Director will report audit findings to the QA & A committee at the monthly QAPI meeting monthly x 3 months & quarterly thereafter.		

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F 314	<p>Continued From page 26 3/12 and 3/16/15.</p> <p>Observations of Resident #65's lower extremities on 3/18/15 at 9:04 AM revealed an immobilizer on her left lower extremity and a heel protector on her right foot.</p> <p>Observations of Resident #65's left foot on 3/18/15 at 9:20 AM with RN #2/ADON revealed an open area on the knuckle of her left 2nd toe.</p> <p>Interview with LPN #2 (wound nurse) on 3/18/15 at 9:04 AM in Resident #65's room, LPN #2 was asked if wound care was provided for Resident #65's left 2nd toe. LPN #2 stated, "We don't do anything on her feet."</p> <p>Interview with the Corporate Nurse Consultant on 3/18/15 at 11:24 AM, in the conference room, the Corporate Nurse Consultant confirmed that the wound care consult by the wound care nurses to evaluate the SDTI on the left 2nd toe ordered by the physician on 12/26/14 had not been done.</p> <p>Interview with the DON on 3/18/15 at 6:26 PM in the conference room, the DON confirmed that the Skin Prep treatment ordered on 12/26/14 - 3/16/15 to Resident #65's left 2nd toe had not been applied as ordered by the physician.</p> <p>8. Medical record review revealed Resident #96 was admitted to the facility on 8/10/10 with diagnoses of Senile Delusions, Depression, Chronic Kidney Disease, Congestive Heart Failure, Muscle Disuse Atrophy and Hallucinations.</p> <p>A significant change MDS dated 2/13/15 documented Resident #96 was unable to</p>	F 314			

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- F 314	<p>Continued From page 27</p> <p>complete a BIMS assessment because she was rarely/never understood. Resident #96 was admitted to Hospice care and documented an unstageable pressure ulcer with slough and or eschar and one unstageable suspected deep tissue injury in evolution.</p> <p>A pressure ulcer record dated 1/19/15 documented site location: Rt. Ischium / admitted pressure ulcer. This record identified an admitted wound on the right ischium.</p> <p>A physician's order dated 1/19/15 documented, "0850 Nursing Order: Lt Ischium SDTI: Skin prep Q. [every] shift and cover c dry drsg. Notify wound care if worsens. Keep pressure off area Q shift..." This order identified the wound was on the left ischium.</p> <p>A physician's order dated 1/19/15 documented, "0855 Lt Ischium SDTI: Cleanse c wound cleanser dry, apply skin prep & cover with dry drsg 4x/wk. Assess & monitor daily..." This order identified the wound was on the left ischium.</p> <p>A physician's order dated 1/28/15 documented, "110 pm wound culture of ischial wound..." This order identified the wound on the ischium not specifying left or right.</p> <p>A physician's order dated 1/29/15 documented, "10:20 am Clarification for wound care to Rt Ischium clean c wound cleanser, gauze, apply silvasorb, dry dressing 4x wk, assess & monitor daily..." This order identified the wound on the right ischium.</p> <p>A pressure ulcer record dated 2/5/15 for Resident #96 documented site location: Rt. Ischium /</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>admitted with. The body diagram has the left ischium marked. This record identified the wound as admitted and was on the right ischium.</p> <p>Review of the facility's weekly pressure wound tracking forms dated 1/19/15 through 3/9/15 documented the Lt. Ischium was facility acquired. These weekly pressure ulcer tracking forms identified the wound as facility acquired on the left ischium.</p> <p>The weekly skin integrity sheets documented an open area on the right ischium on 1/23/15, 2/3/15, 2/7/15, (no date), 2/13/15, 2/20/15, 2/24/15, (no date), 3/3/15, 3/6/15, 3/9/15 and 3/10/15. These records identified the wound as an admitted pressure ulcer and was on the right ischium.</p> <p>The "Bedside Care Guide" (CNA care guide) documented: "off left side, turn no left side."</p> <p>Observations in Resident #96's room on 3/19/15 10:40 AM, revealed Resident #96 had a wound on the coccyx not on the ischial. Structures were visible in the wound bed. There was undermining in the wound. Brown, tan and yellowish slough was noted in the wound bed and in the undermined areas. The loose skin was moved by the wound nurse. There was a round white structure in the wound bed.</p> <p>Interview with LPN #2 (wound nurse) on 3/11/15 at 6:05 PM in the DON's office, LPN #2 was asked to verify if this wound was facility acquired or admitted with, and where this wound was on Resident #96's body. LPN #2 verified this was a facility acquired wound, and the wound was on the resident's right ischium. She also verified the weekly pressure wound tracking form incorrectly</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>documented the wound was on the left ischium.</p> <p>Interview with the DON on 3/18/15 at 3:36 PM, in the conference room, the DON was asked if a wound on the right side should have the intervention of turn no left side and off left side. The DON stated, "I see what you are talking about, keep pressure off area the right side, but this [bedside care guide] says off the left side. I see where she [LPN #1/wound nurse] taught the CNA that day, another teaching moment for [named LPN #1]."</p> <p>Interview with the Nurse Practitioner (NP) (during the observation of Resident #96's pressure ulcer) on 3/19/15 10:40 AM, in Resident #96's room with wound nurses (LPN #1 and LPN #2) at the bedside. There was a round white structure noted in the pressure ulcer. The surveyor asked what the round white structure was in the wound bed. The NP stated, "Let me touch it." As she touched the structure, she gently moved the white substance. The NP stated, "It moves, it is not bone, it may be slough"</p> <p>Interview with the NP on 3/19/15 at 11:00 AM at the R2 nurses desk, the NP was asked if the pressure ulcer was on the coccyx or on the ischium. The NP stated, "It does encompass the coccyx, the ischium is further down [on the body]. It is stageable now, to me it is a stage 4."</p> <p>Interview with the DON on 3/19/15 at 11:20 AM in the long hall, the DON confirmed the wound was on the coccyx."</p> <p>9. Medical record review revealed Resident #163 was admitted to the facility on 1/9/15 with a readmission date of 3/15/15 with diagnoses of</p>	F 314			

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F 314	<p>Continued From page 30</p> <p>Acute and Chronic Respiratory Failure, Sepsis, Obstructive Chronic Bronchitis, Chronic Hepatitis C, Schizoaffective Disorder, Epilepsy, Hypothyroidism, Diabetes Mellitus, Acute Pancreatitis, Encephalopathy, Pneumonia, Muscle Weakness, Hypertension, Lack of Coordination, Difficulty in Walking, Severe Anemia, Hypokalemia, Anxiety, Hypermagnesemia, Urinary Tract Infection, Sacral Decubitus Ulcer, Gastrostomy Tube, Parkinsonism, Cerebral Palsy, Seizure Disorder and Constipation.</p> <p>A care plan dated 1/9/15 documented, "...PROBLEMS... Stage 2 Coccyx... INTREVENTION(S)... Prevent infection c treatment care... Tx: Calazime Cream Foam Drsg..."</p> <p>A physician's order dated 1/10/15 documented, "...Coccyx Stage 2 Pressure Ulcer: Cleanse with wound cleanser, apply Calazime Cream, Cover with foam drsg. 4xweek. assess and monitor daily. "</p> <p>A pressure ulcer record dated 2/2/15 documented, "...Coccyx... [X] STAGE II... Change to unst [unstageable]... MEASUREMENTS... Length (cm) 7.0 x Width (cm) 4.5... WOUND BED [marked with a slash mark] Slough - moist yellow or gray necrotic tissue 100%... PROGRESS NOTES... [Delta sign] [change] to unstageable. Treatment [Delta sign] [change] to Iodosorb..."</p> <p>A care plan updated on 2/9/15 documented, "...PROBLEMS... Unstageable... Coccyx... INTREVENTION... Iodosor..."</p> <p>A pressure ulcer record dated 2/9/15 documented, "...Coccyx... [X] Unstageable..."</p>	F 314			

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F 314	<p>Continued From page 31</p> <p>MEASUREMENTS... Length (cm) 7.5 x Width (cm) 4.0...WOUND BED [marked with a slash mark] Slough - moist yellow or gray necrotic tissue 100%... PROGRESS NOTES... Iodosorb Tx..."</p> <p>Review of the physician's orders dated 1/10/15 through 2/27/15 revealed no order written for Iodosorb to the coccyx wound.</p> <p>Resident #163's MAR dated 2/1/15 to 2/28/15 documented, "...APPLY CALAZIME CREAM... 4X/WK..." Review of this MAR documented Calazime was used on the coccyx wound 4x or more weekly from 2/1/15 through 2/10/15.</p> <p>The MAR dated 2/1/15 to 2/28/15 documented, "...APPLY IODOSORB... 4X/WK..." Review of this MAR documented Iodosorb was used on the coccyx wound 4x or more weekly from 2/11/15 through 2/28/15.</p> <p>Review of the physician's recertified orders for March, 2015 and dated 2/27/15 revealed the physician signed the recertification orders that documented, "...APPLY IODOSORB COVER WITH DRY DRSG..."</p> <p>Iodosorb was used as a treatment in the coccyx wound from 2/2/15 through 2/27/15 without a physician's order.</p> <p>Interview with the DON and LPN #2 (wound nurse) on 3/25/15 beginning at 1:02 PM in the conference room, the DON and LPN #2 were asked about Resident #163's wound treatment change from Calazime cream to Iodosorb. LPN #2 stated, "It was a stage 2, now it is unstageable. On 2/2/15 the order changed to</p>	F 314		

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F 314	<p>Continued From page 32</p> <p>Iodosorb. I don't see an order written for that." The DON stated, "Didn't write the order on 2/2 [15]. I don't see it." LPN #2 was asked if there was an order for the Iodosorb she had been putting on the wound. LPN #2 stated, "No."</p> <p>Interview in the DON's office on 3/18/15 at 6:37 PM, the DON was asked, do you expect your nurses to provide and document treatments as ordered. The DON stated, "Yes Ma'am."</p> <p>10. Medical record review revealed Resident #248 was admitted to the facility on 12/16/14 and re-admitted on 1/1/15, 1/14/15 and 2/11/15 with diagnoses of Aphonia, Colostomy, Chronic Obstructive Pulmonary Disease, Respiratory Failure, Ventilator Dependence, Obstructive Sleep Apnea, Morbid Obesity, Chronic Kidney Disease, Acinetobacter, Hypertension, Left Hemicolectomy, Osteomyelitis and Lung Mass.</p> <p>Review of admission MDS with an ARD of 12/22/14 revealed Resident #248 was admitted to the facility with 5 unstageable wounds with the largest being 8.0cm x 3.5cm x 1.0cm and 2cm unstageable - deep tissue injuries. Most severe tissue type present in any pressure ulcer bed was coded as "...Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous..."</p> <p>Review of weekly skin integrity review sheets revealed there were no weekly skin assessments performed during the weeks of 1/19/15 and 2/16/15.</p> <p>Interview with RN #5/ADON on 3/12/15 at 4:10 PM at the B2 nurses station, RN #5/ADON was asked about the gap in the skin assessment</p>	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE			STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218	
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F 314	Continued From page 33 dates. RN #5/ADON stated, "That is my fault. I made changes in the assignments and it just happened." Interview with the DON on 3/13/15 at 10:00 AM in the DON's office the DON was asked about the weekly skin assessment. The DON stated, "The weekly skin assessments for the weeks of 1/19/15 and 2/16/15 are not documented."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure the chair alarm intervention was always implemented as ordered for 1 of 5 (Resident #200) sampled residents with falls of the 58 residents included in the stage 2 review. The findings included: Review of the facility's "Resident Alarms" policy documented, "...Test alarm for... functioning. Clip must be snug... Check battery for strength or need of changing... Monitor alarm periodically to ensure that it is still attached to resident and alarm is still working..."	F 323	F 323 483.25 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES SS=D <u>Requirements:</u> The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Safety measures were put in place for resident #200 by a licensed nurse on 3/12/15. Care plan & bedside care guide were updated as needed.	

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F 323	Continued From page 34 Medical record review revealed Resident #200 was admitted to the facility on 11/1/14 with diagnoses of Diabetes Mellitus, Anxiety, Chronic Obstructive Pulmonary Disease, Osteoarthritis, Depression and Hypertension. Review of physician's order sheet for 2/26/15 to 3/31/15 documented, "...chair alarm when up in wheelchair..." Observations and interview in Resident #200's room on 3/11/15 at 4:10 PM, revealed Resident #200 lying in bed with bruising and swelling noted below both of the resident's eyes. Resident #200 stated, "I fell out of my wheelchair a week ago Sunday trying to go to the bathroom. I won't get up now without calling for help." Observations on 3/12/15 at 2:30 PM, revealed Resident #200 sitting up in her wheelchair, at a table in the B2 (Birmingham) activity room. A chair alarm was attached to resident's wheelchair, however, the cable was unplugged from the alarm and the clip was not attached to the resident and alarm was not going off. Observations of Resident #200 on 3/12/15 at 2:45 PM in the B2 activity room revealed the chair alarm was not attached to the resident nor was the device plugged in. The chair alarm was not alarming. Interview with Registered Nurse (RN) #5 / Assistant Director of Nursing (ADON) on 3/12/15 at 3:00 PM in the B2 activity room RN #5 confirmed the chair alarm was not in working condition. Interview with RN #5/ADON on 3/13/15 at 9:00	F 323	2. Observation rounds were conducted 5/4/15 by a member of nurse management to ensure safety devices were in place for other residents. 3. The SDC/designee conducted in-service with nursing staff regarding safety devices, proper functioning & placement during a skills fair 4/30, 5/1, 5/2 & 5/4/15. Process: When orders are received for safety devices, the order will be entered into the electronic MAR, they will be reviewed in the morning white board meeting & the care plan & bedside care guide will be revised by a member of the IDT to reflect the use of the safety device.	

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F 323	<p>Continued From page 34</p> <p>Medical record review revealed Resident #200 was admitted to the facility on 11/1/14 with diagnoses of Diabetes Mellitus, Anxiety, Chronic Obstructive Pulmonary Disease, Osteoarthritis, Depression and Hypertension. Review of physician's order sheet for 2/26/15 to 3/31/15 documented, "...chair alarm when up in wheelchair..."</p> <p>Observations and interview in Resident #200's room on 3/11/15 at 4:10 PM, revealed Resident #200 lying in bed with bruising and swelling noted below both of the resident's eyes. Resident #200 stated, "I fell out of my wheelchair a week ago Sunday trying to go to the bathroom. I won't get up now without calling for help."</p> <p>Observations on 3/12/15 at 2:30 PM, revealed Resident #200 sitting up in her wheelchair, at a table in the B2 (Birmingham) activity room. A chair alarm was attached to resident's wheelchair, however, the cable was unplugged from the alarm and the clip was not attached to the resident and alarm was not going off.</p> <p>Observations of Resident #200 on 3/12/15 at 2:45 PM in the B2 activity room revealed the chair alarm was not attached to the resident nor was the device plugged in. The chair alarm was not alarming.</p> <p>Interview with Registered Nurse (RN) #5 / Assistant Director of Nursing (ADON) on 3/12/15 at 3:00 PM in the B2 activity room RN #5 confirmed the chair alarm was not in working condition.</p> <p>Interview with RN #5/ADON on 3/13/15 at 9:00</p>	F 323	<p>4. Nurse management will conduct observation rounds beginning 5/4/15, 5 x a week for 2 weeks to ensure safety measures are in place. If safety measures are found to be in place & compliance is maintained, 2 observation rounds for 2 weeks will be conducted, if compliance is maintained, the safety observation rounds will be conducted at least monthly. The DON will review the findings at the monthly QAPI meeting x 3 months, then quarterly thereafter.</p> <p>Compliance Date: 05/10/15</p>	

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F 323	Continued From page 35 AM.at the B (Birmingham) 2 nurse's station the ADON stated, "We have no log or method of making sure chair alarm batteries are functioning."	F 323		
F 362 SS=D	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the there was sufficient staff present to ensure meal trays were passed in a timely manner for 2 of 46 (Residents #64 and 202) residents served a lunch meal on Ribeiro 2 (R2). The findings included: 1. Observations on R2 on 3/9/15 at 11:58 AM, revealed cart #1 was delivered to the floor and serving was started at 11:59 AM. At 12:08 PM, 5 trays remained on cart #1 including the lunch trays for Resident #64 and #202. Observations on R2 on 3/9/15 at 12:20 PM revealed cart #2 was delivered to the floor. Residents on the R2 hall were not served until 12:43 PM. There were 4 trays left on cart #2 when it was returned to the dining room. The five trays from cart #1 were then placed on cart #2, including the trays for Residents #64 and #202.	F 362	F362 483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL SS=D Requirements: The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. 1. On 4/29/15 the ADON/dietary supervisor revised the cart delivery schedule for Ribeiro 2 unit to ensure enough staff are available for tray pass in a timely manner for residents #64 & #202. 2. a. On 5/4/15 the ADONs/charge nurses observed tray pass on the remaining units to ensure enough staff are available for tray pass in a timely manner.	

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F 362	<p>Continued From page 36</p> <p>Observations on R2 on 3/9/15 at 1:10 PM revealed the last 2 trays were served to Resident #64 and #202. That was 1 hour and 12 minutes after the trays were delivered to R2.</p> <p>2. Interview with Certified Nursing Assistant (CNA) #3 on 3/10/15 at 5:18 PM in the R2 dining room CNA #3 was asked when residents should be served their meal tray. CNA #3 stated, "As soon as possible." CNA #3 was asked to explain about meal service on R2. CNA #3 stated, "It depends on how many techs [technicians] and what you have to do for each resident. If we do not have enough staff it takes longer. It also depends on what is served and how much you have to open up for each resident. It takes about 2 hours for everything from passing the trays to feeding everyone." CNA #3 was asked if it was acceptable to have a tray come up on the first cart and not be served until after the last cart was sent to the floor. CNA #3 stated, "It is not acceptable."</p> <p>Interview with Registered Nurse (RN) #1 / Assistant Director of Nursing (ADON) on 3/10/15 at 5:30 PM, in the ADON's office, the ADON was asked to explain the meal service on R2. The ADON stated, "Trays should be passed in 30 minutes to an hour. Trays for residents in the dining room should be passed immediately then trays are passed on the halls." RN #1/ADON was asked if it was acceptable for trays to come up on the first cart and not be served until the last cart was delivered. RN #1/ADON stated, "No."</p> <p>Interview with the Director of Nursing (DON) on 3/13/15 at 3:25 PM in the DON's office, the DON was asked when meal trays should be passed. The DON stated, "Trays should be passed</p>	F 362	<p>b. On 5/4/15 the DON/Dietary Supervisor reviewed/revised the cart delivery schedule for the remaining units to ensure enough staff are available for tray pass in a timely manner.</p> <p>3. a. The SDC/designee conducted in-service during a skills fair 4/30, 5/1, 5/2 & 5/4/15 regarding the timeliness of tray delivery to ensure tray pass in a timely manner.</p> <p>b. Beginning 5/4/15, tray pass audits will be conducted</p> <p>at each meal daily x 1 week by ADONs /designee to ensure timely delivery of meal trays on each unit, if compliance is achieved, the audits will decrease to 3 x weekly, if compliance is achieved the audits will decrease to 1 x weekly. If compliance is not achieved the audits will resume daily until compliance is achieved.</p>	

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F 362 F 369 SS=D	Continued From page 37 immediately up to and not more than 45 minutes." 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide a sippy cup assistive device for dining as ordered by the physician for 1 of 36 (Resident #78) sampled residents of the 58 residents included in the stage 2 review. The findings included: Medical record review revealed Resident #78 was admitted to the facility on 1/17/14 with diagnoses of Chronic Respiratory Failure, Tracheostomy, Morbid Obesity, Dysphagia and Pickwickian Syndrome. The physician's orders dated 3/1/15 with an original order date of 6/26/14 documented, "...DIET ORDER: RESIDENT TO USE SIPPY CUP, NO STRAWS EACH SHIFT..." The orange meal tray card documented, "...Instructions: no straws..." The orange meal tray card did not include the physician's order to use sippy cups. Observations in Resident #78's room on 3/17/15 at 8:52 AM, revealed Resident #78 sitting up in bed eating breakfast. Certified Nursing Assistant (CNA) #5 was seated in a chair by Resident #78's bed. Resident #78 had 3 cups of thin liquids in regular cups on the breakfast tray with no sippy	F 362 F 369	4. The ADON for each unit will report findings of the tray pass audits at the QAPI committee meeting monthly x 3 months & quarterly thereafter. Compliance Date: 5/10/2015 F369 483.35(g) ASSISTIVE DEVICES-EATING EQUIPMENT / UTENSILS SS=D <u>Requirements:</u> The facility must provide special eating equipment and utensils for residents who need them. 1. On 3/27/15 the dietary department provided a sippy cup assistive device for dining to resident #78 & the orange tray card was updated with the order for the device by the RD. Care plan & bedside care guide were updated as needed.	

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F 362 F 369 SS=D	Continued From page 37 immediately up to and not more than 45 minutes." 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide a sippy cup assistive device for dining as ordered by the physician for 1 of 36 (Resident #78) sampled residents of the 58 residents included in the stage 2 review. The findings included: Medical record review revealed Resident #78 was admitted to the facility on 1/17/14 with diagnoses of Chronic Respiratory Failure, Tracheostomy, Morbid Obesity, Dysphagia and Pickwickian Syndrome. The physician's orders dated 3/1/15 with an original order date of 6/26/14 documented, "...DIET ORDER: RESIDENT TO USE SIPPY CUP, NO STRAWS EACH SHIFT..." The orange meal tray card documented, "...Instructions: no straws..." The orange meal tray card did not include the physician's order to use sippy cups. Observations in Resident #78's room on 3/17/15 at 8:52 AM, revealed Resident #78 sitting up in bed eating breakfast. Certified Nursing Assistant (CNA) #5 was seated in a chair by Resident #78's bed. Resident #78 had 3 cups of thin liquids in regular cups on the breakfast tray with no sippy	F 362 F 369	2. a. Observation during meal service by the ADON/designee was conducted on 5/4/15 to ensure that assistive dining devices were present as ordered. b. On 5/4/15 a member of nurse management/Dietary Supervisor audited the tray cards to ensure any orders for assistive dining devices were listed on the cards & a member of nurse management reviewed the care plans & bedside care guides to ensure any orders for assistive dining devices were documented. 3. a. The SDC / designee conducted in-service with nursing/dietary/therapy staff during a skills fair 4/30, 5/1,		

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F 362 F 369 SS=D	Continued From page 37 immediately up to and not more than 45 minutes." 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide a sippy cup assistive device for dining as ordered by the physician for 1 of 36 (Resident #78) sampled residents of the 58 residents included in the stage 2 review. The findings included: Medical record review revealed Resident #78 was admitted to the facility on 1/17/14 with diagnoses of Chronic Respiratory Failure, Tracheostomy, Morbid Obesity, Dysphagia and Pickwickian Syndrome. The physician's orders dated 3/1/15 with an original order date of 6/26/14 documented, "...DIET ORDER: RESIDENT TO USE SIPPY CUP, NO STRAWS EACH SHIFT..." The orange meal tray card documented, "...Instructions: no straws..." The orange meal tray card did not include the physician's order to use sippy cups. Observations in Resident #78's room on 3/17/15 at 8:52 AM, revealed Resident #78 sitting up in bed eating breakfast. Certified Nursing Assistant (CNA) #5 was seated in a chair by Resident #78's bed. Resident #78 had 3 cups of thin liquids in regular cups on the breakfast tray with no sippy	F 362 F 369	5/2 & 5/4/15 regarding the processing of physician's orders for assistive dining devices to include listing on the residents' tray card, care plan & bedside care guide. b. Beginning 5/4/15, tray pass audits will be conducted at each meal daily x 1 week by ADONs /designee to ensure assistive dining devices are implemented, if compliance is achieved, the audits will decrease to 3 x weekly, if compliance is achieved the audits will decrease to 1 x weekly. If compliance is not achieved the audits will resume daily until compliance is achieved. c. On 5/4/15 a licensed nurse audited physicians' orders to ensure that any orders for assistive dining devices were reflected on the residents' tray card, in their care plan & on the bedside care guide.		

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F 369	Continued From page 38 cup present. Interview with the Chef on 3/17/15 at 10:10 AM in the conference room, the Chef was asked how information on the orange tray card was communicated to the kitchen. The Chef stated, "We receive instructions from Dietitian and we type it." Interview with the Registered Dietitian (RD) on 3/17/15 at 10:34 AM in the conference room, the RD was asked why the physician's order for Resident #78 to use sippy cups was not on the orange meal tray card. The RD stated, "I don't know why."	F 369	4. The ADON for each unit will report findings of the assistive dining device audits at the QAPI committee meeting monthly x 3 months & quarterly thereafter. Compliance Date: 5/10/2015	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431 483.60(b),(d),(e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS SS=D Requirements: The facility must ensure medications/biologicals are stored securely. 1. A licensed nurse removed the medications/biologicals from Resident #215-room on (3-11-15); room #B305 on (3/10/15) & #B308 on (3/9/15); #B404 on (3/12/15) & #B433 on (3/10/15).	

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F 431	Continued From page 39 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to ensure medications were stored securely as evidenced by medications and biologicals found in 1 of 34 (Resident #215's room) resident rooms on Riberio (R) 2; in 2 of 35 (Room B305 and B308) resident rooms on Birmingham 3 (B); and in 2 of 35 (Room B404 and B433) residents rooms on B4. The findings included: 1. The facility's "Medication Storage" policy documented, "...The medication supply is accessible only to licensed nursing personnel..." The facility's "Bedside Medication Storage" policy documented, "...Bedside medication storage is	F 431	2. All other rooms were observed for unsecured medications / biologicals during observation rounds by the ADONs/unit managers on 3/13/15. 3. a. The SDC/designee conducted in-service with nursing staff during a skills fair 3/23-3/26/15 & will be repeated with facility staff during a skills fair 4/30, 5/1, 5/2, & 5/4/15 regarding proper storage of medications/biologicals & that these should not be left unsecured at bedside. b. The ADONs / unit managers will conduct daily observation rounds of resident rooms to ensure that medications/biologicals are properly stored x 30 days if compliance is achieved, then observation rounds will	

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F 431	<p>Continued From page 40</p> <p>permitted for residents who are able to self-administer medication... upon the written order of the prescriber and when it is deemed appropriate in the judgement of the nursing care center's interdisciplinary resident assessment team. Procedures... 2 a written order for the bedside storage of medication is present in the resident's medical record..."</p> <p>2. Observations in Resident #215's room on 3/11/15 at 9:07 AM revealed a box of 50 extra strength headache powders (Acetaminophen / Aspirin / Caffeine) lying on the bedside table.</p> <p>Interview with Resident #215 on 3/11/15 at 9:08 AM, in Resident #215's room, Resident #215 was asked if he takes the headache powders. Resident #215 stated, "Yes, I do for bad headaches."</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 3/11/15 at 9:09 AM, in Resident #215's room LPN #3 revealed Resident #215 was not supposed to have the headache powders at his bedside and he does not self administer medications.</p> <p>3. Observations in room B305 on 3/10/15 at 3:31 PM, revealed a 4 ounce bottle of Hydrogen Peroxide 3 percent (%) on the overbed table.</p> <p>4. Observations in room B308 on 3/9/15 at 4:30 PM, revealed a 4 ounce bottle of Hydrogen Peroxide 3% on the bedside table and on the window sill.</p> <p>Observations in room B308 on 3/10/15 at 7:55 AM and at 2:09 PM, on 3/11/15 at 7:52 AM, and on 3/12/15 at 8:23 AM revealed a 4 ounce bottle</p>	F 431	<p>decrease to resident rooms on 2 halls daily x 2 weeks, if compliance is achieved, observation rounds will decrease to resident rooms on one hall 3 x / week. If compliance is achieved, the effectiveness of the observation rounds will be evaluated. If noncompliance occurs at any time, then daily observation rounds will resume until compliance is achieved.</p> <p>4. The ADONs will report audit findings at the QAPI committee meeting monthly & quarterly thereafter.</p> <p>Compliance Date: 05/10/15</p>	

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F 431	Continued From page 41 of Hydrogen Peroxide 3% on the bedside table. 5. Observations in room B404 on 3/9/15 at 3:36 PM, revealed a bottle of 91% Isopropyl Alcohol on the bedside table. Interview with Registered Nurse (RN) #2 / Assistant Director of Nursing (ADON) on 3/12/15 at 3:31 PM in room B404, the ADON asked if it was appropriate to have alcohol out on bedside table. RN #2/ADON stated, "No." and removed the bottle from the resident's room. 6. Observations in room B433 on 3/10/15 at 3:31 PM, revealed a bottle of Chlorhexidine Gluconate on the window sill. 7. Interview with the Director of Nursing (DON) on 3/13/15 at 3:30 PM, in the conference room, the DON confirmed that medications and biologicals should not be left at the bedside unless there is a physician's order to self administer medications.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS SS=D Requirements: The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	

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F 441	<p>Continued From page 42</p> <p>should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when 1 of 2 nurses (Licensed Practical Nurse (LPN) #5) failed to disinfect the glucometer after use and failed to change wall suction canisters timely for 1 of 36 (Resident #80) sampled residents of the 58 residents included in the the stage 2 review.</p> <p>The findings included:</p>	F 441	<ol style="list-style-type: none"> 1. a. The ADON observed licensed nurse #5 appropriately clean the glucometer on 3/10/15. b. The ADON observed licensed nurse #5 change the suction canister for resident #80 on 3/10/15. 2. a. Other licensed nurses were observed during med pass 3/30-4/3/15 for glucometer cleaning to ensure proper infection control procedures were followed. b. All other rooms were observed for suction canisters that needed changing by ADONs/unit managers on 3/30-4/3/15 to ensure they were changed daily & pm. 3. a. The SDC/designee conducted in-service with licensed nurses during a skills fair 4/30, 5/1, 5/2, & 5/4 regarding infection control practices to include 	

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F 441	<p>Continued From page 43</p> <p>1. The facility's "Cleaning and Disinfecting Non-Critical Resident-Care Items" policy documented, "...3. d. Reusable items are cleaned and disinfected between residents..."</p> <p>Observations in Resident #244's room on 3/10/15 beginning at 5:12 PM, revealed LPN #5 performed an accucheck on Resident #244. LPN #5 did not disinfect the glucometer before or after performing the accucheck on Resident #244. LPN #5 placed the glucometer in a drawer in the medication cart without disinfecting it.</p> <p>Interview with LPN #5 on 3/10/15 at 5:23 PM in the B2 (Birmingham) hall, LPN #5 was asked when the glucometer should be cleaned. LPN #5 stated, "I normally clean the machine afterwards." LPN #5 was then asked when she was going to clean the glucometer. LPN #5 stated, "I don't have anymore accuchecks so was gonna clean it later."</p> <p>2. Medical record review revealed Resident #80 was admitted to the facility on 11/4/04 and readmitted on 8/19/14 with diagnoses of Chronic Obstructive Asthma, Congestive Heart Failure, Subdural Hemorrhage, Hypertension and Dysphagia.</p> <p>Observations in Resident #80's room on 3/25/15 at 5:21 PM and on 3/26/15 at 8:17 AM, revealed a sign on the wall "WALL SUCTION CANISTER AND TUBING ARE TO BE CHANGED EVERY 3 - DAYS CANISTER MUST BE LABELED WITH DATE CHANGED."</p> <p>Observations in Resident #80's room on 3/25/15 at 5:22 PM and on 3/26/15 at 8:18 AM, revealed a yankauer (helps clear secretions from the mouth)</p>	F 441	<p>glucometer cleaning before and after use & changing of suction canisters daily & pm.</p> <p>b. ADONs/designee will observe licensed nurses during med pass (1 nurse per shift x 1 week) then (1 nurse per day x 1 week) for proper cleaning of glucometers before & after use. If compliance is achieved then observation of nurses during glucometer cleaning will occur with quarterly pharmacy med pass audit. If at any time noncompliance occurs ADON/designee audits will resume until compliance is achieved. New hires will be educated on this process in orientation.</p>	

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F 441	<p>Continued From page 43</p> <p>1. The facility's "Cleaning and Disinfecting Non-Critical Resident-Care Items" policy documented, "...3. d. Reusable items are cleaned and disinfected between residents..."</p> <p>Observations in Resident #244's room on 3/10/15 beginning at 5:12 PM, revealed LPN #5 performed an accucheck on Resident #244. LPN #5 did not disinfect the glucometer before or after performing the accucheck on Resident #244. LPN #5 placed the glucometer in a drawer in the medication cart without disinfecting it.</p> <p>Interview with LPN #5 on 3/10/15 at 5:23 PM in the B2 (Birmingham) hall, LPN #5 was asked when the glucometer should be cleaned. LPN #5 stated, "I normally clean the machine afterwards." LPN #5 was then asked when she was going to clean the glucometer. LPN #5 stated, "I don't have anymore accuchecks so was gonna clean it later."</p> <p>2. Medical record review revealed Resident #80 was admitted to the facility on 11/4/04 and readmitted on 8/19/14 with diagnoses of Chronic Obstructive Asthma, Congestive Heart Failure, Subdural Hemorrhage, Hypertension and Dysphagia.</p> <p>Observations in Resident #80's room on 3/25/15 at 5:21 PM and on 3/26/15 at 8:17 AM, revealed a sign on the wall "WALL SUCTION CANISTER AND TUBING ARE TO BE CHANGED EVERY 3 - DAYS CANISTER MUST BE LABELED WITH DATE CHANGED."</p> <p>Observations in Resident #80's room on 3/25/15 at 5:22 PM and on 3/26/15 at 8:18 AM, revealed a yankauer (helps clear secretions from the mouth)</p>	F 441	<p>c. Rounding audits will be conducted by the ADONs/designee consisting of going from room to room and ensuring that suction canisters are changed appropriately beginning 5/4/15 daily x 1 week, then 3 x per week x 1 week, then 1 x per week. If compliance is achieved then ADON will evaluate the effectiveness of the audits. If noncompliance occurs at any time, then ADON rounding audit will resume until compliance is achieved. New hires will be educated on this process in orientation.</p> <p>4. The ADONs will report audit findings at the QAPI committee meeting monthly x 3 months, then quarterly thereafter.</p> <p>Compliance Date: 05/10/15</p>	

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F 441	Continued From page 44 attached to suction tubing laying on the bed and the other end was attached to a wall suction canister containing a tan colored substance. The wall suction canister was labeled, "3/15/15..." Interview with Registered Nurse (RN) #2 / Assistant Director of Nursing (ADON) on 3/26/15 at 8:30 AM, in the conference room, the ADON confirmed the nurses are responsible for changing the suction canister. The ADON stated, "The canisters should be changed when they are full or become stinky. Not more than several days." The ADON was asked to go to Resident #80's room and check the canister. When the ADON saw the sign on the wall and the date on the canister she stated, "We will get that [canister] changed."	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure the chair alarm was in an operating condition for 1 of 5 (Resident #200) sampled residents with falls of the 58 residents included in	F 456	F 456 483.70©(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION SS=D <u>Requirements:</u> The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	

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F 456	<p>Continued From page 45 the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's "Resident Alarms" policy documented, "...Test alarm for... functioning. Clip must be snug... Check battery for strength or need of changing... Monitor alarm periodically to ensure that it is still attached to resident and alarm is still working..."</p> <p>Medical record review revealed Resident #200 was admitted to the facility on 11/1/14 with diagnoses of Diabetes Mellitus, Anxiety, Chronic Obstructive Pulmonary Disease, Osteoarthritis, Depression and Hypertension. Review of physician's order sheet for 2/26/15 to 3/31/15 documented, "...chair alarm when up in wheelchair..."</p> <p>Observations on 3/12/15 at 2:30 PM, revealed Resident #200 sitting up in her wheelchair, at a table in the B2 (Birmingham) activity room. A chair alarm was attached to resident's wheelchair, however, the cable was unplugged from the alarm and the clip was not attached to the resident and alarm was not going off.</p> <p>Observations of Resident #200 on 3/12/15 at 2:45 PM in the B2 activity room revealed the chair alarm was not attached to the resident nor was the device plugged in. The chair alarm was not alarming.</p> <p>Interview with Registered Nurse (RN) #5 / Assistant Director of Nursing (ADON) on 3/12/15 at 3:00 PM in the B2 activity room RN #5 confirmed the chair alarm was not in working condition.</p>	F 456	<ol style="list-style-type: none"> 1. Safety measures were put in place for resident #200 by a licensed nurse on 3/12/15. Care plan & bedside care guide were updated as needed. 2. Observation rounds were conducted 5/4/15 by a member of nurse management to ensure safety devices were in place for other residents. 3. The SDC/designee conducted in-service with nursing staff regarding safety devices, proper functioning & placement during a skills fair 4/30, 5/1, 5/2 & 5/4/15. <p>Process: When orders are received for safety devices, the order will be entered into the electronic MAR, they will be reviewed in the morning white board meeting & the care plan & bedside care guide will be revised by a member of the IDT to reflect the use of the safety device.</p>	

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F 456	Continued From page 46	F 456	<p>4. Nurse management will conduct observation rounds beginning 5/4/15, 5 x a week for 2 weeks to ensure safety measures are in place. If safety measures are found to be in place & compliance is maintained, 2 observation rounds for 2 weeks will be conducted, if compliance is maintained, the safety observation rounds will be conducted at least monthly. The DON will review the findings at the monthly QAPI meeting x 3 months, then quarterly thereafter.</p> <p>Compliance Date: 05/10/15</p>	
F 514 SS=H	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, review of facility weekly pressure ulcer tracking forms, observation and interview, the facility failed to ensure documentation was correct and/or complete for weekly skin assessments, correctly identifying the origin of a pressure ulcer and correctly identifying the anatomical location of a pressure ulcer for 7 of 58 (Residents #14, 115, 196, 277, 96, 232 and 248) sampled residents included in the stage 2 review. The failure of the facility staff to complete weekly skin assessments on residents who were at risk for developing</p>	F 514		

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F 514 SS=H	<p>Interview with RN #5/ADON on 3/13/15 at 9:00 AM at the B (Birmingham) 2 nurse's station the ADON stated, "We have no log or method of making sure chair alarm batteries are functioning."</p> <p>483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, review of facility weekly pressure ulcer tracking forms, observation and interview, the facility failed to ensure documentation was correct and/or complete for weekly skin assessments, correctly identifying the origin of a pressure ulcer and correctly identifying the anatomical location of a pressure ulcer for 7 of 58 (Residents #14, 115, 196, 277, 96, 232 and 248) sampled residents included in the stage 2 review. The failure of the facility staff to complete weekly skin assessments on residents who were at risk for developing</p>	F 514	<p>F 514 483.75 (I)(1) RES RECORDS-COMplete/ ACCURATE/ACCESSIBLE</p> <p>SS=H</p> <p><u>Requirements:</u></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible, and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>	

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F 514	<p>Continued From page 47</p> <p>pressure ulcers and identify pressure ulcers before residents developed an unstageable pressure ulcer resulted in actual harm for 4 of 9 (Residents #4, 115, 196 and 277) sampled residents with pressure ulcers.</p> <p>The findings included:</p> <p>1. Review of the facility's "Skin Management and Prevention" policy revealed, "...weekly skin..." will be utilized to determine if any new skin alterations have developed... Any new skin condition(s) found during the weekly skin rounds will be documented..."</p> <p>2. Medical record review revealed Resident #14 was admitted to the facility on 2/10/15 with diagnoses of Acute Respiratory Failure, Status Post Tracheostomy, Methicillin-Resistant Staphylococcus Aureus (MRSA) Pneumonia, Urinary Tract Infection with Vancomycin-Resistant Enterococcus (VRE), Iron Deficiency Anemia, Paraplegia, Dysphagia, and Depression.</p> <p>Review of the Braden scale dated 2/10/15 revealed a score of 11 indicating Resident #14 was at a high risk for pressure ulcer.</p> <p>Review of the interim plan of care (developed on admission) dated 2/10/15 documented, "...Skin assessment weekly..."</p> <p>Review of the nursing admission information documented, "...2/11/15 11:00... Pt. [patient] assessed head to toe by wound care. No skin breakdown or alteration in skin integrity at this time..."</p> <p>Review of the admission Minimum Data Set</p>	F 514	<p>1. a. A skin integrity review was completed by a licensed nurse on resident #14 on 3/11/15 & repeated on 4/30/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p> <p>b. A skin integrity review was completed by a licensed nurse on resident #115 on 3/12/15 & repeated 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p>		

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F 514	<p>Continued From page 48 (MDS) with an Assessment Reference Date (ARD) of 2/17/15 revealed Resident #14 did not have any unhealed pressure ulcers.</p> <p>Review of the weekly skin integrity form dated 2/24/15 documented, "[checked] Rash... [checked] Redness... Open Area... [checked] Old... 2/24/15... [checked] Open Area (black) area... [checked] Old... 12.5x [by] 5.0... black eschar... soft..."</p> <p>Review of a physician's order dated 2/24/15 at 10:15 AM documented, "Wound Care to Rt [right] Buttocks Unstageable Pressure Ulcer: Cleanse [symbol for with] wound cleanser apply skin prep and MediHoney cover with dry dressing 4 x [times] / wk [week]... Assess and monitor Daily..."</p> <p>Review of the pressure ulcer report dated 2/24/15 documented, "...Date of Origin 2/24/15... Site Location: Buttocks... [checked] Facility acquired... [checked] Unstageable... MEASUREMENTS Length (cm) [centimeters] 12.5 x Width (cm). 5.0 Depth (cm) 0.1..."</p> <p>The facility was unable to provide documentation of the weekly skin integrity reviews were completed from the date of admission (2/10/15) until 2/24/15.</p> <p>Observations in Resident #14's room on 3/13/15 at 2:43 PM, revealed Resident #14 coccyx pressure ulcer was the size of a small toy football with brown loose slough covering the wound bed.</p> <p>Interview with the Medical Director on 3/17/15 at 3:50 PM at the B2 (Birmingham) nurses station, the Medical Director was asked about the</p>	F 514	<p>c. A skin integrity review was completed by a licensed nurse on resident #196 on 3/12/15 & repeated on 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p> <p>d. A skin integrity review was completed by a licensed nurse on resident #277 on 3/12/15 by a member of nurse management to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15. Pt was discharged on 4/18/15.</p>	

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F 514	<p>Continued From page 49</p> <p>unstageable pressure ulcer on Resident #14. The Medical Director stated, "he wound could have come on suddenly but with the size and the black eschar you would think someone would have noticed it when they were cleaning him up. Black eschar takes some time to develop."</p> <p>Failure of the facility to complete weekly skin assessments and to identify a pressure ulcer before it was unstageable resulted in actual harm to Resident #14.</p> <p>3. Medical record review revealed Resident #115 was admitted to the facility on 12/22/14 with diagnoses of Paraplegia, Spinal Cord Injury, Anxiety, Anemia, Hypertension, Insomnia, Chronic Rhinitis and Muscle Atrophy.</p> <p>The comprehensive care plan dated 1/12/15 documented, "...Problem... Increased potential for impaired skin integrity R/T [related to] Dx [diagnosis] paraplegia and related weakness with presence of incontinence and impaired ROM/Mobility... Goal... Skin will remain intact... Approach... assess for prompt intervention s/s [signs and symptoms] of further impaired skin integrity and report prn [as needed] to MD [medical doctor] as per facility practice and consult with wound care nsg [nursing] prn..."</p> <p>A care plan dated 3/9/15 documented, "...Resident is with pressure ulcer(s) Classified as: Unstageable Location: Lt [left] posterior L.E. [lower extremity] below base of buttocks... Goals... Will address all needed treatment to specific ulcer(s) / wound(s) to facilitate healing thru [through] next review date... Interventions... assess and monitor daily... Use clean technique for wound care... Tx [treatment] 3/9/15 calcium</p>	F 514	<p>e. A skin integrity review was completed by a licensed nurse on resident #65 on 3/12/15 & repeated on 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p> <p>f. A skin integrity review was completed by a license nurse on resident # 96 on 3/12/15 & repeated on 4/29/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p>		

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F 514	<p>Continued From page 50 alginate hydrocolloid..."</p> <p>A physician's order dated 3/9/15 documented, "...Wound care to Lt posterior L.E. below base of buttocks as follows. Clean c [with] wound cleanser gauze, apply Calcium alginate, hydrocolloid 4 x wk assess and monitor daily..."</p> <p>Review of the weekly skin integrity review sheet dated 12/1/14 through 3/9/15 revealed skin assessments were not done on 12/8/14, 12/15/14, 12/22/14, 12/19/14, 2/9/15, 2/16/15, 2/23/15, and 3/2/15.</p> <p>The weekly skin integrity review form dated 3/9/15 documented, "...skin intact..." completed by Licensed Practical Nurse (LPN) #3.</p> <p>The pressure ulcer record dated 3/9/15 documented, "...Lt Posterior L.E. @ [at] base of buttocks... Facility acquired... Unstageable... Length (cm)... 2 x Width (cm)... 2.5... Depth (cm)... 0.5... Wound Bed... Slough... 80% [percent]... Eschar... 20%... Consult received noted new wound treatment orders..."</p> <p>Review of the nurse's notes dated 3/9/15 documented, "...Observed open area on Lt posterior L.E. Under base of buttocks new orders to treat wound..."</p> <p>LPN #1 and LPN #2 (wound nurses) entered Resident #15's room, on 3/14/15 at 10:45 AM to allow the surveyor to observe Resident #115's pressure ulcer. While observing the pressure ulcer LPN #2 stated to LPN #1, "This left buttock wound actually looks like a stage III. I think you [LPN #1] miss-staged this."</p>	F 514	<p>g. A skin integrity review was completed by a license nurse on resident #163 on 3/12/15 & repeated on 4/30/15 by a licensed nurse to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. The care plan was reviewed/revised to reflect the resident's current status during weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16/15 & 4/17/15.</p> <p>h. A skin integrity review was completed by a licensed nurse on resident #248 on 3/12/15 by a member of nurse management to confirm the stage, anatomical location & treatment orders for the identified pressure ulcers. Pt expired 4/16/15.</p> <p>2. a. 100% skin integrity review was conducted of other residents by a licensed nurse on 4/29/15 through 4/30/15 to ensure that a skin integrity review was performed to accomplish early identification of pressure</p>		

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F 514	<p>Continued From page 51</p> <p>Interview with the Assistant Director of Nursing (ADON) / Registered Nurse (RN) #1 on 3/13/15 at 9:55 AM, at R2 (Riberio 2nd floor) nurses station, the ADON was asked what she expected from her nursing staff when performing skin assessments. The ADON stated, "I expect them to do the weekly skin assessments and notify the MD [medical doctor], treatment nurse and family if something is discovered." The ADON/RN #1 was asked whose responsibility was it to make sure the skin assessments were being done weekly. The ADON/RN #1 stated, Mine." The ADON/RN #1 was shown the weekly skin integrity review sheets for the months 12/1/14 through 3/9/15 and was asked if weekly skin assessments had been completed. The ADON/RN #1 stated, "No."</p> <p>Interview with LPN #3 on 3/13/15 at 10:08 AM, at R2 nurses station, LPN #3 was shown the weekly skin integrity review form dated 3/9/15 and was asked if she completed the skin assessment on 3/9/15 for Resident #115. LPN #3 stated, "Yes." LPN #3 was shown the pressure ulcer record dated 3/9/15 and asked if her assessment was accurate. LPN #3 stated, "Other than I didn't see it [the pressure ulcer]. I just didn't see it, that's all I can say."</p> <p>Failure of the facility to complete weekly skin assessments and to identify a pressure ulcer before it was unstageable resulted in actual harm to Resident #115.</p> <p>4. Medical record review revealed Resident #196 was admitted to the facility on 1/6/15 with diagnoses of Open Surgical Wound; Kidney Malignant Neoplasm, Diabetes Mellitus, History of Pulmonary Embolism, Peripheral Vascular</p>	F 514	<p>ulcers, that any identified pressure ulcers were staged appropriately, anatomical location was accurate & treatment orders were obtained & followed as ordered. Care plans were implemented / revised as needed.</p> <p>b. The schedule for weekly skin integrity review was revised for the licensed nurses by a member of nurse management on 3/12/15 & placed in the front of the weekly skin integrity review binder on the nursing units.</p> <p>c. A new Braden Scale was completed on 100% of residents on 3/19-3/20/15 & on 5/5/15. Residents with a Braden score of 14 or less that utilize a chair were provided a preventative cushion. Residents with a special chair that would not accommodate the cushion were evaluated for alternatives or risk versus benefit. Fifty-five cushions were implemented. Any new residents identified with a</p>	

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F 514	<p>Continued From page 52</p> <p>Disease, Depression, Hypertension, Morbid Obesity, Esophageal Reflux, Peripheral Neuropathy and History of Rectal and Anal Malignancy.</p> <p>The Braden scale dated 1/6/15 documented a score of 14 indicating the resident was a moderate risk for developing a pressure ulcer.</p> <p>The pressure ulcer record dated 2/4/15 documented, "...Lt. Buttocks... Facility acquired... Unstageable... 3.0cm x 7.5cm x 0.1cm... Exudate... Serous... Scant... 100% slough..."</p> <p>A wound care note dated 2/5/15 documented, "...Unstageable wound on L [circled] buttox [buttock]... Drainage... Large amount... Foul..."</p> <p>A physician's order dated 2/6/15 documented, "...Lt buttocks unstageable pressure ulcer: cleanse c [with] wound cleanser Apply Dakin's moistened gauze. cover c dry drsg. [dressing] 4x/wk..."</p> <p>The facility was unable to provide weekly skin integrity review sheets from 2/23/15 to 3/12/15.</p> <p>Observations in Resident #196's room on 3/12/15 at 8:50 AM revealed a large unstageable left buttock wound. There was 20% eschar and 80% slough with slight bright red bleeding from around the edges.</p> <p>Interview with LPN #2 (wound nurse) on 3/12/15 at 1:59 PM, in the conference room, LPN #2 was asked who discovered the unstageable buttocks wound. LPN #2 stated, "When you are doing treatments in the area [of the body where the wound is] sometimes we will start treating [a</p>	F 514	<p>Braden Score of 14 or less will be evaluated for a preventative cushion & the cushion will be implemented as appropriate. Care plans & bedside care guides were updated to reflect current interventions during the weekly Skin Nutrition At Risk (SNAR) meeting beginning 4/16 & 4/17/15.</p> <p>d. The Corporate WOCN nurse, SCC, DON & Medical Director (WCC) collaborated in the development of a new skin integrity care plan to be utilized by the IDT & kept in the medical record for use by the entire team. The Medical Director approved a Physician Based Wound Order for implementation by the licensed nurses upon identification of wounds until a wound consult can be performed by the wound team within 24 hours.</p>		

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F 514	<p>Continued From page 53</p> <p>second wound]." LPN #2 was asked how often do you treat Resident #196. LPN #2 stated, "Four times a week. I'm pretty sure it [left buttock wound] started out red. He [Resident #196] wouldn't stay off his left side. The nursing staff probably wouldn't notice anything wrong as it was probably covered with a dressing. It could have been I just missed it or forgot to start documentation. Yep, I think I missed that."</p> <p>Interview with RN #2/ADON on 3/12/15 at 4:00 PM, at the B4 nurses desk, RN #2/ADON was asked what she expected from her nursing staff regarding skin assessments. RN #2/ADON stated, "I expect my staff to complete skin assessments per policy which is weekly or normally in the shower since the residents are in their birthday suits."</p> <p>Interview with the Medical Director on 3/24/15 at 4:00 PM, in the conference room, the Medical Director was asked about Resident #196's pressure ulcer. The Medical Director stated, "Based on what the wound nurse told me, she [wound nurse] was treating the new area that was close to the surgical coccyx wound, but she did not document on the new area until it was open. She [wound nurse] knows it was started as a DTI [deep tissue injury] and used skin prep until it opened, but I have no supporting documentation. I did not sign it [determination that development of pressure sore is unavoidable form] because I had no verification of documentation. She [wound nurse] said right in front of me that she forgot to document it."</p> <p>Failure of the facility to identify a pressure ulcer before it was unstageable resulted in actual harm to Resident #196.</p>	F 514	<p>e. CNA skin care alert sheets were implemented on 3/12/15 by nurse management for documentation of any skin issues identified during residents' showers & or daily care by the CNAs. The licensed nurses' weekly skin integrity review schedule was revised to coincide with the residents' shower schedule on 3/12/15.</p> <p>f. A process was developed for completion of skin integrity review from admission / readmission, weekly & upon identification of skin issues by CNAs or licensed nurses & consultation to the wound nurse to ensure early identification of pressure ulcers and implementation of treatment orders.</p> <p>3. a. The SDC/designee conducted in-service with licensed nurses during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15</p>	

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F 514	Continued From page 54 5. Medical record review revealed Resident #277 was admitted to the facility on 2/27/15 with diagnoses of Chronic Respiratory Failure, Gastroesophageal Reflux Disease, Dysphagia, Tracheotomy, Diabetes Mellitus, Generalized Pain, Congestive Heart Failure, Depression, and Deep Vein Thrombosis. The admission nurses' notes documented the following: a. 2/27/15 - "...Multiple bruises noted on abdomen and BUE [bilateral upper extremities]... Skin warm and dry no lesions or rash noted..." b. 3/1/15 at 9:00 AM - "Wound care full skin assessment done at admission... pressure ulcer on buttocks/coccyx noted wound care orders wrote for treatment..." There is no evidence in the medical record that Resident #277 was admitted to the facility with a pressure ulcer on 2/27/15. Review of the pressure ulcer record dated 3/1/15 revealed, "...Date of Origin 3/1/15... Site Location: Coccyx... [checked] Admitted with... Date 3/1/15... STAGE... [checked] Unstageable... Length (cm) 9 x Width (cm) 7.5 Depth (cm) 0.5... [checked] Slough... 80%... [checked] Eschar... 20%... SPECIALTY INTERVENTIONS... [checked] Mattress... PROGRESS NOTES... Upon assessment on admission noted pt has unstageable coccyx wound new orders... gave over phone..." A physician's order dated 3/1/15 documented, "Wound care to coccyx unstageable wound as follows clean with wound cleanser, gauze, apply skin prep, calcium alginate cover with dry	F 514	regarding the processes for completion of weekly skin integrity review, admission / readmission skin integrity review, wound team consult within 24 hours of admission / readmission & with new skin issues identified by licensed nurses/CNAs during showers/ADLs. In-service education will be completed with licensed nurses by 5/4/15. Any licensed nurse not attending the scheduled in-services will not be scheduled to work until in-service education is completed prior to working the next scheduled shift. New hires will be in-serviced during orientation by SDC/designee. b. The SDC/designee conducted in-service with CNAs during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15	

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F 514	<p>Continued From page 55</p> <p>dressing 3x week assess and monitor daily." A Nutritional Progress Note dated 3/2/15 at 2:58 documented, "...skin intact ..."</p> <p>Interview with the Director of Nursing (DON) on 3/23/15 at 4:45 PM in the DON's office, the DON was asked what she expected of her nurses regarding skin assessments on admission. The DON stated, "To fill out the skin assessment sheet within 24 hours." The DON was asked what she expected of her wound nurses as far as completed a skin assessments. The DON stated, "The policy says 24 [hours] but sometimes they don't get around to it until 48 hours." The DON was asked why the coccyx wound was documented as being admitted with when it was discovered on 3/1/15 and the resident was admitted 2/27/15. The DON stated, "I can't answer that question."</p> <p>Interview with the Medical Director on 3/24/15 at 4:05 PM in the conference room, the Medical Director was asked about the unstageable pressure ulcer on Resident #277. The Medical Director stated, "If it [the pressure ulcer] was from [named hospital] they would have written wound orders. Have to open up the folds during the assessment."</p> <p>The failure of the facility to identify a pressure wound before it became unstageable resulted in actual harm to Resident #277.</p> <p>6. Medical record review revealed Resident #96 was admitted to the facility on 8/10/10 with diagnoses of Senile Delusions, Depression, Chronic Kidney Disease, Congestive Heart Failure, Hallucinations and Muscle Disuse Atrophy.</p>	F 514	<p>regarding the process for completing CNA skin alert sheets during showers & daily care In-service education will be completed with CNA by 5/4/15. Any CNA not attending the scheduled in-services will not be scheduled to work until in-service education is completed prior to working the next scheduled shift. New hires will be in-serviced during orientation by SDC/designee.</p> <p>c. The SDC/designee conducted in-service during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15 with licensed nurses & CNAs regarding pressure ulcer prevention, early identification of pressure ulcers, immediate intervention when pressure ulcers develop, and utilization of appropriate support surfaces (mattresses & cushions). In-service education will be completed</p>		

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F 514	Continued From page 56 A pressure ulcer record dated 1/19/15 documented Resident #96 was admitted with a pressure ulcer on the right ischium. A physician's order dated 1/19/15 documented, "0850 Nursing Order: Lt (Left) Ischium SDTI [suspected deep tissue injury]: Skin prep Q. [every] shift and cover c [symbol for with] dry drsg. Notify wound care if worsens. Keep pressure off area Q shift..." This order identified the wound was on the left ischium. A physician's order dated 1/19/15 documented, "0855 Lt Ischium SDTI: Cleanse c wound cleanser dry, apply skin prep & [and] cover with dry drsg 4x/wk. Assess & monitor daily..." This order identified the wound was on the left ischium. A physician's order dated 1/29/15 documented, "10:20 am Clarification for wound care to Rt Ischium clean c wound cleanser, gauze, apply silvasorb, dry dressing 4x wk, assess & monitor daily..." This order identified the wound on the right ischium. A pressure ulcer record dated 2/5/15 documented Resident #96 was admitted with a pressure ulcer on the right ischium, yet the body diagram had the left ischium marked. Review of the facility's weekly pressure wound tracking forms dated 1/19/15 to 3/9/15 documented a left ischium pressure ulcer, facility acquired and date of occurrence 1/19/15. These weekly pressure ulcer tracking forms identified the wound as facility acquired on the left ischium.	F 514	with licensed nurses & CNAs by 5/4/15. Any licensed nurse/CNA not attending the scheduled in-services will not be scheduled to work until in-service education is completed prior to working the next scheduled shift. New hires will be in-serviced during orientation by SDC/designee. d. The Corporate WOCN/SCC conducted in-service with the wound nurses, MDS director, SDC director & admission nurse regarding implementation of the new skin integrity care plan on 4/13/15. e. The SDC/designee conducted in-service during a skills fair held between 3/23/15-3/26/15 & a second skills fair is scheduled for 4/30/15, 5/1/15, 5/2/15 & 5/4/15 with licensed nurses regarding implementation of the new skin integrity care plan. In-service education will be completed with licensed nurses by 5/4/15.		

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F 514	<p>Continued From page 57</p> <p>The weekly skin integrity sheets documented an open area on the right ischium on 1/23/15, 2/3/15, 2/7/15, (no date), 2/13/15, 2/20/15, 2/24/15, (no date), 3/3/15, 3/6/15, 3/9/15 and 3/10/15. These records identified the wound as an admitted pressure ulcer and was on the right ischium.</p> <p>The bedside care guide (certified nursing assistant care guide) documented keep off left side, turn no left side, this inaccurate for a pressure ulcer on the right ischium.</p> <p>Observation in Resident #96's room on 3/19/15 10:40 AM, revealed Resident #96's pressure ulcer was on the coccyx.</p> <p>Interview with the DON on 3/18/15 at 3:36 PM, in the conference room, the DON was asked if a wound on the right side should have the intervention of turn no left side and off left side. The DON stated, "I see what you are talking about. Keep pressure off area the right side, but this [bedside care guide] says off the left side. I see where she [LPN #1] taught the CNA that day, another teaching moment for [named LPN #1]."</p> <p>Interview with LPN #2/wound nurse on 3/11/15 at 6:05 PM, in the DON's office, LPN #2/wound nurse was asked to verify if this wound was facility acquired or admitted with, and where this wound was on Resident #96's body. LPN #2/wound nurse verified this was a facility acquired wound, and the wound was on the resident's right ischium. LPN #2/wound nurse verified the weekly pressure wound tracking form incorrectly documented the wound was on the left ischium.</p> <p>Interview with the Nurse Practitioner (NP) on</p>	F 514	<p>Any licensed nurse not attending the scheduled in-services will not be scheduled to work until in-service education is completed prior to working the next shift. New hires will be in-serviced during orientation by SDC/designee.</p> <p>f. Daily audits of 100% CNAs skin care alert sheets by the ADON/designee began 5/4/15 & will continue indefinitely to ensure compliance with completion of the sheets by the CNAs.</p> <p>g. 100% audits of weekly skin integrity review sheets (completed by the licensed nurses) began 5/4/15 & will continue weekly by the ADON/designee for each unit weekly.</p>	

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F 514	<p>Continued From page 58</p> <p>3/19/15 at 11:00 AM at the R2 (Riberio) nurses desk, the NP was asked if the pressure ulcer was a coccyx wound or an ischial wound. The NP stated, "It does encompass the coccyx, the ischium is further down [on the body]..."</p> <p>Interview with the DON on 3/19/15 at 11:20 AM, on the long hall, the DON confirmed Resident 96's pressure ulcer was on the coccyx.</p> <p>7. Medical record review revealed Resident #232 was admitted to the facility on 5/28/14 and readmitted on 11/5/14 with diagnosis of Subarachnoid Hemorrhage, Chronic Respiratory Failure, Diabetes Mellitus, Flaccid Hemiplegia, General Nonconvulsive Epilepsy, Tracheostomy, Hypertension and Joint Contractures.</p> <p>The facility was unable to provide weekly skin integrity reviews completed between 2/3/15 through 3/8/15.</p> <p>Interview with the Assistant Director of Nursing (ADON) / Registered Nurse (RN) #2 on 3/12/15 at 10:12 AM, at the B2 (Birmingham) nurses station confirmed the weekly skin integrity reviews between 2/3/15 and 3/8/15 had not been completed.</p> <p>8. Medical record review revealed Resident #248 was admitted to the facility on 12/16/14 and re-admitted on 1/1/15, 1/14/15 and 2/11/15 with diagnosis of Aphonia, Colostomy, Chronic Obstructive Pulmonary Disease, Respiratory Failure, Ventilator Dependence, Obstructive Sleep Apnea, Morbid Obesity, Chronic Kidney Disease, Acinetobacter, Hypertension, Lung Mass, Osteomyelitis and Left Hemicolectomy.</p>	F 514	<p>h. 100% of admission/readmission records will be audited by the Director of Medical Records/designee within 2 business days for completion of skin assessments & orders for treatments indefinitely to ensure compliance. These audits will be brought to morning clinical meeting to ensure findings are addressed by the appropriate ADON/unit manager.</p> <p>4. The ADON of each unit & the Medical Records Director will report audit findings to the QA & A committee at the monthly QAPI meeting monthly x 3 months & quarterly thereafter.</p> <p>Compliance Date 05/10/15</p>	

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F 514	Continued From page 59 Review of admission MDS with an Assessment Reference Date (ARD) of 12/22/14 revealed Resident #248 was admitted to the facility with 5 unstageable wounds with the largest being 8.0cm x 3.5cm x 1.0cm and 2 Unstageable - Deep tissue injuries. Most severe tissue type present in any pressure ulcer bed was coded as "...Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous..." Review of weekly skin integrity review sheets revealed there were no weekly skin assessments performed during the weeks of 1/19/15 and 2/16/15. Interview with Registered Nurse (RN) #5/ADON on 3/12/15 at 4:10 PM at the B2 nurse's station revealed, RN #5/ADON was asked about the gap in the skin assessment dates. The ADON stated, "That is my fault. I made changes in the assignments and it just happened." Interview with the DON on 3/13/15 at 10:00 AM in the DON's office the DON stated, "The weekly skin assessments for the weeks of 1/19/15 and 2/16/15 are not documented."	F 514		
F 520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520	F 520 483.75 (o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS SS=H	

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F 520	<p>Continued From page 60</p> <p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Prevention quick reference guide, policy review, medical record review, review of the facility's weekly pressure ulcer tracking forms, observation and interview, the facility's quality assessment and assurance committee failed to identify and address quality assurance issues to identify and implement plans of actions to correct concerns when nurses failed to complete weekly skin assessments and identify pressure ulcers timely, identify the correct anatomical location of a pressure ulcer, obtain a physician's order prior to treatment and/or provide treatments as ordered for 8 of 9 (Residents #14, 115, 196, 277, 65, 96, 163 and 248) sampled residents reviewed of the 17 residents with pressure ulcers. The failure of the facility staff to complete weekly skin assessments on residents who were at risk for developing pressure ulcers and identify pressure</p>	F 520	<p>Requirements:</p> <p>The facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>For Clarification Purposes: The facility Interdisciplinary Team (IDT) consists of the Chief Executive Officer (CEO, Director of Nursing (DON), Assistant Directors of Nursing (ADONs), QA nurse, Unit Managers, MDS Coordinator(s), Food Service Supervisor or Registered Dietitian, Social Services Director, Admission Coordinator, Staff Development Coordinator(s) (SDC), Maintenance Director and /or Maintenance Assistant, Quality of Life Director, Chaplin, and Environmental Services. Stand-Up</p>	

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F 520	<p>Continued From page 61</p> <p>ulcers before residents developed an unstageable pressure ulcer resulted in actual harm for Residents #14, 115, 196 and 277.</p> <p>The findings included:</p> <p>The failure of the Quality Assessment and Assurance (QAA) committee to identify and address concerns when nurses failed to complete weekly skin assessments and identify pressure ulcers timely, identify the correct anatomical location of a pressure ulcer, obtain a physician's order prior to treatment and/or provide treatments as ordered for 8 of 9 (Residents #14, 115, 196, 277, 65, 96, 163 and 248) sampled residents reviewed of the 17 residents with pressure ulcers. The failure of the facility staff to complete weekly skin assessments on residents who were at risk for developing pressure ulcers and identify pressure ulcers before residents developed an unstageable pressure ulcer resulted in actual harm for Residents #14, 115, 196 and 277.</p> <p>Refer to F314.</p> <p>Interview with the Quality Assurance (QA) Coordinator on 3/26/15 at 4:28 PM in the QA Coordinator's office, the QA Coordinator was asked what where the concerns discussed in the January, 2015 QA meeting, what did you do, and was it effective. The QA Coordinator stated, "We did the in-service for the handwashing from the December [2014] meeting and that was effective, and we had no other issues." The QA Coordinator was asked what issues were identified in the February, 2015 QA meeting, what did you do and was it effective, the QA Coordinator stated, "... [Named Staff], the PAE [Preadmission Screening Evaluation] nurse went back to school to get her</p>	F 520	<p>meeting is conducted daily (Monday-Friday).</p> <ol style="list-style-type: none"> 1. The information reviewed during the morning Stand-Up meeting is provided by verbal report from department leaders in attendance and review of daily documentation (list not all inclusive: but not limited to 24 hour reports, facility staffing reports, grievances, pharmacy, admission referrals, audits, MDS Assessments and care plans). 2. The role and purpose of the morning Stand-Up meeting is to review clinical and operational information to identify potential areas that need process/performance improvement plans. 		

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F 520	<p>Continued From page 61</p> <p>ulcers before residents developed an unstageable pressure ulcer resulted in actual harm for Residents #14, 115, 196 and 277.</p> <p>The findings included:</p> <p>The failure of the Quality Assessment and Assurance (QAA) committee to identify and address concerns when nurses failed to complete weekly skin assessments and identify pressure ulcers timely, identify the correct anatomical location of a pressure ulcer, obtain a physician's order prior to treatment and/or provide treatments as ordered for 8 of 9 (Residents #14, 115, 196, 277, 65, 96, 163 and 248) sampled residents reviewed of the 17 residents with pressure ulcers. The failure of the facility staff to complete weekly skin assessments on residents who were at risk for developing pressure ulcers and identify pressure ulcers before residents developed an unstageable pressure ulcer resulted in actual harm for Residents #14, 115, 196 and 277.</p> <p>Refer to F314.</p> <p>Interview with the Quality Assurance (QA) Coordinator on 3/26/15 at 4:28 PM in the QA Coordinator's office, the QA Coordinator was asked what where the concerns discussed in the January, 2015 QA meeting, what did you do, and was it effective. The QA Coordinator stated, "We did the in-service for the handwashing from the December [2014] meeting and that was effective, and we had no other issues." The QA Coordinator was asked what issues were identified in the February, 2015 QA meeting, what did you do and was it effective, the QA Coordinator stated, "... [Named Staff], the PAE [Preadmission Screening Evaluation] nurse went back to school to get her</p>	F 520	<p>3. Corrective actions, interventions and plans developed during the morning Stand-Up process are evaluated and monitored during the monthly Quality Assurance Performance Improvement meeting. These committee meetings consist of collaboration with the IDT on resident issues (list not all inclusive: wounds, falls, nutrition, medications, pharmacy, other discipline recommendations, ADL / toileting needs, and grievances); audit trends, in-service needs, evaluation of systems, and development of Performance Improvement Plans. A Quality Assurance Meeting was conducted by</p>		

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F 520	Continued From page 62 RN [Registered Nurse] and we have been losing leads and money, so we have hired someone in her place. We did an event manager update and did nurse training, now all the falls go in event manager and they do not give me any paper. [Named CNA computer program] was out of compliance so we educated staff and put announcements in place." Interview with the Director of Nursing (DON) on 3/26/15 at 3/26/15 at 5:48 PM in the conference room, the DON was asked if QA committee had identified a trend in pressure ulcers. The DON stated, "No."	F 520	the QA nurse with the Medical Director and the facility department heads on 4-22-15. The CEO reviewed the recent complaint survey findings and the corrective action plan to be implemented. The Medical Director shared ideas to assist in improving processes moving forward. The IDT reviewed and discussed the PIPs for Wound Processes/Prevention Interventions & Grievances. The DON reviewed the number of pressure ulcers for the month of February & March of 2015 & any identified trends. 4. The IDT will conduct a weekly Adhoc QA meeting with the Medical Director x 4 weeks starting 4/28/15, then will resume the QAPI meeting monthly. The DON or designee will review findings from all audits conducted and will consult with the Medical Director for policy revision, as needed.	

Compliance Date: 05/10/15