BROOKHAVEN MANOR
2035 STONEBROOK PLACE, KINGSPORT, TN 37660
(423) 246-8934 PHONE • (423) 246-9280 FAX

acceptable POC #4

January 26, 2017

Tamra Turberville, RN
Regional Administrator
ETRO Health Care Facilities
7175 Strawberry Plains Pike
Suite 103
Knoxville, TN 37914

VIA EMAIL

Dear Tamra:

Enclosed, please find our credible Plan of Correction #4 for the survey November 1, 2016 through December 7, 2016, in which we allege compliance on January 20, 2017.

Sincerely,

Pete Prins, Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445174		R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN MANOR	2035 STONEBROOK PLACE KINGSPORT, TN 37660

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{F 000}	INITIAL COMMENTS A Revisit surveywas completed 12/19/16 through 12/21/16, following acceptance of an Allegation of Compliance recieved 12/16/16 to remove the Immediate Jeopardy for F-157 (J); F-223 (K), F-224 (J); F-225 (K); F-241 (J); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-353 (K); F-490 (K); F-493 (K); F-501 (K); and F-520 (K). The revisit revealed the corrective actions implemented with a compliance date of 12/16/16 removed the Immediate Jeopardy, but non-compliance continues at a "D" level Scope and Severity for F-157, F-224, F-241, F-280, F-309, F-312, and F-314, and non-compliance continues at a "E" level Scope and Severity for F-223, F-225, F-353, F-490, F-493, F-501, and F-520 for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the systemic processes instituted by the facility. An investigation for complaints #39760, #39844, #39993 #40046, #40047, #40048, #40050, and #40051 was initiated on 11/1/16. The Recertification and Licensure survey was conducted with the complaint investigation from 11/28 - 12/7/16, with an extended survey conducted on 12/7/16. During the complaint and annual survey, an Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to ensure physician notification of changes in condition, failure to prevent abuse	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/26/17

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 000}	Continued From page 1 and neglect, failure to thoroughly investigate allegations of abuse and immediately report allegations of abuse to administration and the State Agency, failure to protect residents from abuse by suspending alleged perpetrators, failure to revise care plans and implement care plans, failure to provide timely incontinence care, and failure to assess and implement interventions and treatments per physician's orders to prevent a decline in surgical wounds and for pressure ulcers. The facility's failure placed 11 residents (#106, #123, #75, #103, #65, #27, #68, #21, #45, #145, and #12) in Immediate Jeopardy. The Administrator and the Regional Nurse were notified of the IJ on 12/7/16 at 9:30 AM in the Administrator's office. The facility was cited an Immediate Jeopardy at F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-353 (K); F-490 (K); F-493 (K); F-501 (K); and F-520 (K). The facility was cited Substandard Quality of Care at F-223 (K); F-224 (J); F-225 (K); F-241 (J); F-309 (J); F-312 (J); and F-314 (J). The facility ws cited Harm at F-323 (G). The IJ was effective 2/6/16 and was removed 12/16/16 for F-223, F-225, F-353, F-490, F-493, F-501, and F-520. The IJ was effective 2/7/16 and was removed 12/16/16 for F-224, F-241, and F-312. The IJ was effective 7/20/16 and was removed 12/16/16 for F-280 and F-314.	{F 000}		

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{F 000}	Continued From page 2 The IJ was effective 7/25/16 and was removed 12/16/16 for F-157. The IJ was effective 10/27/16 and was removed 12/16/16 for F-309.	{F 000}	**F157 Notification of Changes**	1/20/17
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	{F 157}	1. **Resident #106** – Family attended Care Plan meeting on 8-11-16, skin condition was reviewed with family member in attendance. 11-11-16. Nurse practitioner examined resident knee on 12-7-16. Resident currently has no wounds. **Resident #123** – Nurse Practitioner was notified of Right Lower extremity posterior skin condition on 11/15/16. MD reviewed and co-signed (undated). Resident was aware and self-responsible. Resident #123 was discharged home on 12-10-16. 2. Residents experiencing change in skin condition have the potential to be affected and were identified by 100% audit of Skin integrity on December 13-16th by MDS Coordinator who insured appropriate notification to	

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{F 157}	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to promptly notify the Physician of the presence of a pressure ulcer for 2 residents (#106 and #123) of 8 residents reviewed for pressure ulcers, of 43 residents sampled. The facility's failure placed residents #106 and #123 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The Immediate Jeopardy was effective 7/25/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the immediacy of the Jeopardy. Noncompliance continues for F-157 at a "D" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Review of the facility policy, Pressure Ulcer Prevention of, dated 2006 revealed "...Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective..."	{F 157}	affirm MD awareness of skin alterations. 3. • Policy was reviewed by the facility nurse leadership team consisting of the DON, RM and MDS Coordinator along with the Corporate RN Consultants on-site on 12-12-16; no revisions were indicated. • Root cause analysis was conducted on 12/13/16 by Director of Operations and 3 Corporate Clinical Consultants who are RNs, by reviewing cited examples in accordance with the policy. Analysis indicated inconsistent implementation and supervision of the NOTIFICATION OF CHANGE IN CONDITION policy. • The Licensed Nurses, the intended audiencewere re-in-serviced on the "Notification of Change in Resident Condition or Status"	

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{F 157}	Continued From page 4 Medical record review revealed Resident #106 was re-admitted to the facility on 7/25/16 with diagnoses including Dementia, Sepsis, Osteoporosis, Osteoarthritis, Knee Pain, Anxiety, and Depression. Medical record review of the Re-Admission Resident Data Set dated 7/25/16 revealed Resident #106 had the sacral area circled on the body diagram with "...shearing [skin injury caused by opposite but parallel sliding motion]..." written out beside of the area. There were no measurements or description of the wound, and no treatment was initiated. Medical record review of the Nursing Weekly Summary dated 7/29/16 revealed "...open area in coccyx area. Bilateral buttocks reddened irritated, blood noted in brief from irritated areas on buttocks..." Medical record review of the physician's telephone orders dated 7/30/16 revealed "...clean coccyx [with] ns [normal saline], skin prep apply hydrocolloid to coccyx Q [every] three days and prn [as needed] till resolved..." Medical record review of the 5 Day Minimum Data Set (MDS) dated 7/31/16 revealed Resident #106 had one Stage 1 (defined by the MDS as intact skin with non-blanchable redness of a localized area usually over a bony prominence) and one Stage 2 pressure ulcer (defined by MDS as partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed without slough. May also present as an intact or open/ruptured serum filled blister) identified upon admission.	{F 157}	Policy, the by the Director of Nursing beginning on 12-12-16 and ending on 1/18/16to enhance awareness and importance of reporting of proper notification to physician, resident and representative with change in condition or treatment. In-service included, notification responsibilities, significant change definition, and medical emergency exceptions. This is 100% of the intended audience. • The DON and/or Risk Manager will ensure 100% training compliance by comparing the list of those already trained to the payroll list of all employed licensed nurses and CNA's. Those not currently trained will be in-serviced prior to acceptance of resident assignment. • All newly hired licensed Nurses will receive training on "Change in Resident	

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{F 157}	Continued From page 5 Medical record review of the wound assessment report dated 8/5/2016 revealed "...wound type pressure ulcer...location sacrum...present upon admission yes...stage 2...measurements length - 0.7 cm [centimeters] width - 0.4 cm....wound type pressure ulcer...wound location right buttock...present upon admission...yes...stage 1...measurements length - 0.7 cm width - 0.50 cm [centimeter]..." Interview with the treatment nurse on 11/8/16 at 4:45PM, in the small conference room, confirmed the physician was not notified of the stage 1 or stage 2 pressure ulcers on admission and there were no orders obtained for wound care. Interview with the Director of Nursing (DON) on 11/8/16 at 5:05 PM, in her office, revealed "...with stage 1 pressure ulcers we basically reposition and then notify the Doctor or Nurse Practitioner (NP) when they visit to do their assessment...if more than a stage one [stage 2 or above] they [nurses] would call the doctor for an order..." Interview with the Nurse Practitioner on 11/9/16 at 10:25 AM, in the small conference, room confirmed "...not notified of the shearing...I know they use turning and repositioning for stage 1 pressure ulcers...should have been treated with something..." Interview with the DON on 12/5/16 at 11:40 AM, in the conference room, confirmed the facility had failed to notify the resident's physician to obtain an order for treatment of the wound when it was identified on admission, 7/25/16. Continued interview confirmed Resident #106's wound declined after it had been identified and a	{F 157}	Condition or Status" policy as part of new employee orientation. • New orders and 24 hour report are being reviewed for new interventions, treatments and change of condition to ensure proper notification to MD in morning Clinical Meeting during which we discuss clinical considerations. Attendee's include Director of Nursing, Risk Manager, Social Services Director, Therapy Director, Medical records and Dietary Manager. • Notification Exception Tool was initiated on 12-15-16 by the Director of Nursing. Telephone orders and 24 hour report are reviewed 5x per week, x 8 weeks to achieve our goal of 100% compliance of notification to physician of change in condition, once achieved	

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{F 157}	Continued From page 6 treatment was not implemented. Medical record review revealed Resident #123 was admitted to the facility on 10/18/16 with diagnoses including Methcillin-resistant Staphylococcus Aureus (MRSA) Bacteremia, Right Quadriceps Tendon Rupture and Repair, and Chronic Obstructive Pulmonary Disease (COPD) with home oxygen. Medical record review of a Daily Skilled Nurses Note dated 11/13/16 at 12:00 AM, revealed "...brace on R [right] leg, Brace is off due to rubbing quarter size area (open) to calf [lower leg] area, to have tx [treatment] nurse address..." There was no documentation the physician was notified on 11/13/16. Medical record review of a Wound and Skin Status Report, completed by the Treatment Nurse, revealed the wound was documented as identified on 11/15/16 (the same wound identified in the nurses note dated 11/13/16). Continued review revealed the right calf wound was a Stage 1 (defined by the MDS as intact skin with nob-blanchable redness of a localized area usually over a bony prominence). Medical record review of a Nurse Practitioner's note dated 11/15/16, revealed "...Pt [patient] has eschar [dry patches of dead tissue] on posterior RLE [right lower extremity] that was caused by brace..." Medical record review of a Physician's Note dated 11/17/16 revealed "...There is a 2 cm ulceration on the posterior right calf..."	{F 157}	Notification Exception Tool audit will be completed weekly x 6 weeks then monthly x 3 months. The Director of Nursing has identified key staff members to complete this audit in her absence or at her direction. In addition to herself, these team members include the Medical Records Director who is an LPN; the Evening Supervisor and the Day Shift Supervisor. When notification is absent or in question, assigned staff member will document on tool created for this purpose and will speak directly with physician, resident and/or contact representative at the time of the audit finding. 4. • Finding noted on the Notification exception Tool or otherwise determined will be reported to the Quality Assurance Committee (Members include, at	

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{F 157}	Continued From page 7 Interview with the DON on 12/6/16 at 8:15 AM, in the conference room, confirmed the facility was not aware the pressure ulcer had been identified on 11/13/16 instead of 11/15/16. Further interview confirmed the new pressure ulcer had not been reported to the Nurse Practitioner until 11/15/16. Refer to F-314 Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records to ensure all Licensed staff and CNAs received education regarding proper notification to the physician, resident, and representative with any changes in condition and treatment by 12/12/16. 2. Verification through interviews was conducted with 9 Licensed caregivers on 12/19, 12/20, and 12/21/16, on all shifts, to confirm the staff received the required training regarding proper notification and were able to verbalize the training received. 3. Surveyors verified through observation and interview with staff on 12/19, 12/20, and 12/21/16, a Notification Tool was initiated on 12/15/16 and was being completed to include all telephone orders and a 24 hour reporting for any change of conditions. Interviews confirmed the supervisors had been educated to complete the log and document all notifications to the physician, resident, or representative.	{F 157}	minimum DON, Medical Director, Administrator, Social Services Director, Dietary Manager, Risk Manager) by the Director of Nursing monthly 6 months to evaluate need for amendment or continued need of ongoing intervention. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter. QA frequency will continue until substantial compliance is achieved or otherwise determined by the committee thereafter prior to the resumption of monthly.	

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{F 157}	Continued From page 8 3. Interview with the Medical Director on 12/21/16 at 10:05 AM, in the conference room, revealed the physician was available by phone for any resident issues. Further interview revealed the physician or Nurse Practitioner was, and had been, making freqent visits to the facility. The staff were calling the Medical Director with any issues related to resident care. 4. Interview on 12/21/16 with the Director of Nursing, in the conference room, confirmed the notification tool had been implemented. Further interview revealed any change in a resident's condition was documented in the medical record and on the notification tool to ensure proper follow-up. Further review revealed key staff had been chosen and educated regarding the log to assume responsibility in the absence of the DON. The facility remains out of compliance at a Scope and Severity level "D" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 157}		
{F 160} SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by:	{F 160}	**F160 Conveyance of Funds.** 1. Funds were conveyed to the estate of **Resident #171** on 11-17-16. 2. A 100% audit of resident trust fund conveyance was conducted by the Area Business office Manager on 12/14/2016.	1/20/17

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{F/60}		{F/60}3.	• Root cause analysis conducted by the Director of Operations and 3 Clinical Corporate Consultants who are RNs on the conveyance of funds x 1 resident; it was noted to primarily relate to a change in personnel and not fully following policy in the interim. Current Assistant office Manager was hired on 6/28/16 and trained by the Regional Accountant. • Policy related to Resident Trust Fund Conveyance was review by the Area Business office Manager and Corporate team on 12-9-16, no modifications were indicated • Members of the business office were in-serviced on 12-9-16 by the Area Business office Manager on the Resident Trust Fund Conveyance Policy.	

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{F160}		{F160}	• The Administrator will maintain a weekly compliance log, reviewing the list of discharged residents weekly, determining if any discharged residents had trust fund accounts and ascertaining that those accounts have been closed and any funds are issued prior to 30 days post discharge. On 12/30/16 • An audit is being conducted of discharged residents by the Assistant Business office Manager to assure timely conveyance of funds in accordance with policy and regulation times 8 weeks to achieve our goal of 100% compliance. Once achieved audit will be completed monthly thereafter. 4. Findings noted on the Audit conducted by the Assistant Business Office Manager will	

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{F/60}		{F/60}	be reported to the Quality Assurance Committee (Members include, at minimum DON, Medical Director, Administrator, Social Services Director, Dietary Manager, Risk Manager) x 8 weeks then monthly thereafter. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter. QA frequency will continue until substantial compliance is achieved or otherwise determined by the committee thereafter prior to the resumption of monthly.	

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{F 160}	Continued From page 9 Based on review of facility policy, review of facility financial records, and interview, the facility failed to convey a resident's funds within 30 days after death for 1 resident (#171) of 3 residents reviewed for resident funds. The findings included: Review of the facility policy Management of Resident Funds, revised 9/26/14, revealed "...All resident's accounts must be closed within 30 days of date of discharge..." Review of the facility's Trial Balance report dated 11/01/16, revealed "...[Resident #171]...1148.35 [resident's fund balance]...Expired 04/28/16..." Review of the Withdrawal Record Input Date for 11/11/2016, revealed "...[Resident #171]...1148.35...refund...Estate of...[Resident #171]..." Interview with the Business Office Manager on 12/1/16 at 3:25 PM, in the Business Office, confirmed Resident #171 had expired on 4/28/16 and the resident fund was not closed, with money conveyed to the estate, within 30 days.	{F 160}	**F223 Free from Abuse / Involuntary Seclusion** 1. **Resident #75 -** On February 6, 2016, CNA was suspended after allegation of verbal abuse by resident on February 6, 2016. CNA was subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #103 -** During the course of the Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that same CNA involved with the resident #75 event was verbally inappropriate to resident 103. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no	1/20/17
{F 223} SS=E	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	{F 223}		

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

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{F 223}	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of facility investigations, medical record review, review of facility staffing, review of personnel files, interview, and observation, the facility failed to prevent mental, physical, and verbal abuse for 9 residents (#75, #103, #65, #106, #27, #68, #47, #66, and #74) of 15 residents reviewed for abuse, of 43 sampled residents. The facility's systematic failure to immediately remove the accused, failure to report allegations to administration, and failure to investigate allegations of abuse, placed residents #75, #103, #65, #106, #27, and #68 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility was cited F 223 at a scope and severity of "K", which constitutes Substandard Quality of Care (SQC). The Immediate Jeopardy is effective 2/6/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-223 at a "E" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes	{F 223}	findings. Resident indicated she feels safe in facility. **Resident #65** - During the course of Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #106** - On July 8, 2016, Facility administrator was notified of unprofessional conduct by agency CNA. Facility contacted staffing agency on July 8, 2016 notifying agency the CNA was not to return. Resident was assessed on July 8, 2016 with no complaints at the time and no skin issues noted. Social Services Director interviewed resident on December 7, 2016 and	

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{F 223}	Continued From page 11 implemented by the facility. The findings included: Review of the facility's policy Abuse, undated, revealed "...3 Things to Remember 1. Stop it 2. Get Help 3. Report it...The facility will report and investigate all alleged incidents of resident abuse...Abuse - the willful infliction of injury...intimidation, or punishment with the resulting physical hurt or pain or mental anguish to the resident. Abuse is also the deprivation by an individual, including a caretaker, of goods or services that is necessary to attain or maintain, physical, mental, and psychosocial well being of a resident. This definition presumes that instances of abuse to any resident, even one in coma causes physical harm or pain or mental anguish. Verbal Abuse - Any use of oral...gestured language that will fully include disparaging and derogatory terms to a resident...or within their hearing distance, to describe residents, regardless of a resident's...ability to comprehend or mental and/or physical disability...Mental Abuse - Includes but is not limited to, humiliation, harassment, threats of punishment or deprivation of a resident..." Review of a facility investigation dated 2/6/16 at 5:00 AM revealed Resident #75 reported to Registered Nurse (RN) #2 that Certified Nursing Assistant (CNA) #14 had told Resident #75 she was wet and nasty and CNA #14 was going to change her. CNA #14 then grabbed her legs and made her move over. CNA #14 told her "...I wouldn't have to do this if your filthy lazy ass would get up and go to the bathroom instead of pissing on yourself..." RN #2 stated she heard Resident #75 screaming and crying, and because	{F 223}	noted no findings. Resident indicated she feels safe in facility. **Resident #27** - Discharged to home on October 24, 2016. BOM separated from employment 8/18/2016. C.N.A #4 was terminated on 12/11/16. **Resident #68** - Discharged to home on August 31, 2016.CNA # 15 provided by agency was barred from the facility effective 8/22/16. **Resident #47**- Resident was interviewed on 12-13-16 and identified that her needs were being met and call bell response time is "improving". **Resident #66** Resident has expired. **Resident #74**- Resident has expired. 2. All residents have the potential to be affected and were identified by interview of 100% of the patients to assure the safety and well being of all residents in our care on 12/7/16 by the Social Services Director. For	

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{F 223}	Continued From page 12 she had never heard the resident do that before, she immediately went to the resident's room. As RN #2 entered the room, CNA #14 was exiting. RN #2 assessed the resident for injury and administered Ativan to help settle the resident down. CNA #14 was told not to go back in the resident's room by RN #2, but was allowed to finish his shift unsupervised. Further review of the investigation revealed on 2/8/16 (2 days after the incident), the facility conducted interviews with all the residents that had a BIMS score greater than or equal to 9 (moderately impaired to cognitively intact score). Resident #65 and #103 reported CNA #14 had made inappropriate comments to them on 2/6/16. Review of the investigation revealed the facility substantiated the allegation for verbal abuse and terminated CNA #14. Resident #75 was admitted to the facility on 9/30/13 with diagnoses including Cerebral Palsy, Diabetes Mellitus Type II, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, and Morbid Obesity. Medical record review of the Quarterly Minimum Data Set (MDS) dated 12/29/15 revealed Resident #75 had a Brief Interview Mental Status (BIMS) score of 15 out of a possible 15, which indicated she was cognitively intact. Review of the Timecard Report for CNA #14 revealed the CNA clocked out on 2/6/16 at 6:39 AM at the end of his shift. Review of the personnel file revealed CNA #14 was suspended 2/6/16 through 2/10/16, after finishing his shift on 2/6/16, pending investigation of the abuse allegation.	{F 223}	those residents who did not respond to the interview, a head to toe body audit was conducted by the charge nurse on 12/6 and 12/7, 2016 to identify the presence of unreported bruising. Body audits revealing bruising were immediately advanced to nurse management for evaluation of prior reporting. All baseline skin assessments have been completed on 12/7/16 and continue on a weekly basis. 3. Staffing Agency personnel has not been utilized since August 19, 2016. • On November 18th, 2016, the Administrator and Director of Nursing Reviewed the "Resident Abuse Prohibition policy"..A policy revision was distributed company wide by the Director of Operations on 11/17/16 in accordance with the revised Conditions of	

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{F 223}	Continued From page 13 Telephone interview with RN #2 on 11/3/16 at 4:45 PM confirmed Resident #75 was so upset RN #2 had to administer Ativan, and did not suspend CNA #14, he was allowed to finish his shift. Telephone interview with CNA #14 on 11/14/16 at 11:45 AM, confirmed he had finished his dry rounds (check to see if incontinent residents need to be cleaned) before he exited the building. Interview with the Director of Nursing (DON) on 11/7/16 at 9:30 AM, in the small conference room, confirmed CNA #14 was terminated on 2/10/16 for verbal abuse. Interview with Resident #75 on 11/19/16 at 12:30 PM, in the resident's room, revealed "...I feel like it was abuse because of what he said and because he said no one would believe me [if she reported it to the facility administration or staff]..." Review of a facility investigation dated 2/6/16 revealed while the facility was investigating the allegation of abuse for Resident #75 Resident #103 reported to CNA #2 on 2/6/16 she did not want CNA #14 back in her room. Continued review revealed CNA #14 entered the room to provide incontinence care, grabbed the resident by her left arm and pulled her over. The resident told him not to do that because it hurt. CNA#14 told the Resident #103 "...could hurt her if he wanted to because it was his job to change her..." Resident #103 was admitted to the facility on 9/18/15 with diagnoses including Diabetes Mellitus Type II, Left sided Hemiplegia, Contracture of Left Elbow, and Depressive Disorder.	{F 223}	Participation. This policy was implemented on 11/18/16; no additional revisions were indicated. The root cause analysis was conducted by the Director of operations and 3 Corporate Clinical Consultants who are RNs on Dec 13, 2016. It was determined that facility was not adhering to policy in effect in its entirety to include removing accused expediently, reporting timely and thorough investigation. • Beginning on November 18, 2016, SSD and Risk Manager initiated revised resident abuse prohibition policy. From this date through December 7, 2016; intended audience: all facility staff with the exception of two (2) staff members (PRN CNA, CNA on medical leave) received the training. The two aforementioned staff members will be educated	

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{F 223}	Continued From page 14 Review of the 14 Day MDS dated 10/1/15 revealed Resident #103 scored a 15 out of a possible 15 on the BIMS. Interview with the DON on 11/14/16 at 11:35 AM, in her office, confirmed an investigation was not completed for Resident #103 "...because she [Resident #103] did not know if what he did was intentional or not..." Telephone interview with CNA #14 on 11/14/16 at 11:45 AM confirmed he was allowed to finish his shift on 2/6/16. Telephone interview with RN #2 on 11/3/16 at 4:45 PM confirmed CNA #14, was allowed to finish his shift after Resident #75 alleged abuse. Review of a facility investigation initiated for Resident #75 dated 2/6/16 revealed Resident #65 had reported on 2/7/16 she had told CNA #14 she was soaking wet and requested to be changed. CNA #14 told Resident #65 he was 2 hours behind and he could not get to her and did not return. RN #2 reported the incident to the DON on 2/8/16. On 2/8/16 the DON interviewed Resident #65 and the resident confirmed the allegation of abuse. Resident #65 was admitted to the facility on 12/11/09 with diagnoses including Diabetes Mellitus Type II, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, Spinal Stenosis, and Chronic Pain. Review of Annual MDS dated 11/18/15 revealed Resident #65 scored a 14 out of a possible 15 on the BIMS which indicated the resident was	{F 223}	prior to performing resident care. Risk Mgr. will ensure this will take place. A list of training attendees is compared to the entire active employee listing from payroll. • Post-testing on Abuse Inservice was conducted on 12-15-16 thru 1/20/17 to assureunderstanding of policy and expectation. A score of 100% was the acceptable benchmark. Staff have been in-serviced in the ABUSE PROHIBITION AND INVESTIGATION GUIDELINES to include: a. resident rights, b. dementia management and interventions to deal with aggressiveresidents, c. proper techniques for reporting to administration, definitions of possible activities of abuse, neglect, exploitation and misappropriation of resident	

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{F 223}	Continued From page 15 cognitively intact. Interview with Resident #65 on 11/9/16 at 11:40 AM, in resident room, revealed "...can't remember exactly what [CNA #14] said...didn't have time or something like that...had not changed me all night...it made me feel like I wasn't important..." Interview with the Administrator on 11/28/16 at 3:55 PM, in the conference room, revealed "...this allegation was not investigated separately because it was a part of... [Resident #75's]...investigation. It was the same perpetrator and he was suspended and then terminated..." Continued interview with the Administrator confirmed he would expect the facility to have followed the procedures outlined in the facility Abuse policy. Review of a facility investigation dated 7/8/16 revealed the facility initiated an investigation for 2 allegations of abuse for Resident #106 dated (6/24/16 and 7/1/16). Continued review revealed the first incident on 6/24/16 occurred when CNA #8 allegedly grabbed Resident #106 by the arm to roll her over. The second occurred on 7/1/16 when CNA #8 entered the residents' room and began slinging linens and things around and cursed the resident. Both allegations were witnessed by CNA #16 and reported to Licensed Practical Nurse (LPN) #3 on the date of each occurrence. Further review revealed CNA #8 was employed by the facility through a staffing agency and the facility contacted the agency on 7/8/16 by phone and reported the allegations and requested an interview with CNA #8. The facility again contacted the agency on 7/12/16 with no reported response.	{F 223}	property and prompt initiation of investigation. d. removal of any staff or contractor accused as soon as facility becomes aware of allegation of abuse, neglect misappropriation or exploitation. e. how to recognize staff burnout, frustration and stress, also included was the Reporting Suspected Crimes under the Federal Elder Justice Act. 108 staff members have been trained to date. • A resident council meeting was held on December 7, 2016, conducted by the Social Services Director to review the facilities initiatives related to abuse reporting and investigation to remind residents to report suspicious activity immediately and means to report anonymously. Eleven (11 residents attended. A letter to identify abuse prevention and awareness was provided to all families	

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{F 223}	Continued From page 16 Resident #106 was admitted to the facility on 6/7/16 with diagnoses including: Sepsis, Dementia without Behavioral Disturbances, Pain in Knees, Osteoporosis, Osteoarthritis, Anxiety, and Depression. Review of the 14 Day MDS dated 6/20/16 revealed Resident #106 had a BIMS score of 3 out of a possible 15 which indicated a severe cognitive impairment. Review of the daily staffing sheets revealed CNA #8 continued working his shift on 6/24/16 and was assigned to Resident #106 on 6/27/16, 7/1/16, 7/2/16, and 7/3/16 during 4 of 7 shifts. Telephone interview with LPN #3 on 11/7/16 at 5:45 PM confirmed she did not report the allegations to Administration and did not recall anyone asking her about either of the allegations. Continued interview revealed "...she [CNA #16] came and talked to me and she said something happened...I think something happened a few days before that too...I told him [CNA #8] not to go back in that room...she [Resident #106] had a habit of saying ouch, ouch, when she was moved...so I didn't think anything had happened..." Telephone interview with LPN #3 on 11/7/16 at 6:20PM revealed "...CNA #16 said she had talked to the DON about the 1st incident so I just thought they knew about it...it was almost time for the Risk Manager (RM) to come to work when she told me so I told her we would talk to her when she came in..." Interview with the RM on 11/9/16 at 12:00 PM, in her office, revealed she was notified by CNA #15	{F 223}	on December 8, 2016 and will be provided for all newly admitted residents and their families on admission. Meeting frequency will continue until substantial compliance is achieved, then resume monthly unless otherwise determined by the QA committee. Resident Council meetings will be held every 2 weeks by the Social Services Director to promote open dialogue regarding the facility's efforts to insure that all residents feel safe and identify any concerns related to abuse, neglect, misappropriation or care assistance. • A telephonic AdHoc QA meeting was held 12/07/2016 with the Medical Directorreviewing the IJ citations and requesting his approval regarding the elements required to submit	

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{F 223}	Continued From page 17 on 7/8/16 (13 days after the first allegation) of the allegations of abuse. Interview with LPN #3 on 11/29/16 at 7:00 AM, in the conference room, confirmed she did not send CNA #8 home "...placed him on a different hallway..." Continued interview revealed she had asked Resident #106 what had happened and the resident said "...nothing..." Interview with the DON on 11/30/16 at 1:00 PM, in the conference room, revealed "...I believe I talked to them, but I don't remember, I think I did and they didn't remember anything..." Continued interview revealed no other residents were interviewed to determine if any other residents were harmed. Review of a facility investigation dated 8/12/16 at 1:30 PM Resident #27 reported being "threatened" by the Business Office Manager (BOM) and requested CNA #7 hide in the bathroom and listen to the conversation during the meeting in her room. As CNA #7 exited the resident's room she saw the BOM and Assistant Business Office Manager (ABOM) coming down the hallway, so she entered the bathroom and closed the door. Continued review revealed the BOM asked the resident to sign a promissory note for $50.00 a month toward her past due balance. The BOM raised her hand during the conversation and told the resident "...Do not talk while I am talking..." Further review revealed "she was to sign the promissory note or she would be out of here..." The resident was described as being upset and tearful after the incident. CNA #7 and the ABOM immediately reported the incident to the DON and the Social Services Director (SSD). The DON notified the Administrator by	{F 223}	a credible AOC. He approved the initial draft. • Weekly body audit schedule was reviewed by the DON on 12-7-16 and body audits continue to be completed as assigned. • Audit of completion of assigned body audits began on 12-7-16 by the Medical Records Director (LPN) Audits are conducted weekly to assure goal of 100% compliance of body audits assigned. 100% Audits will remain ongoing x 8 weeks to achieve our goal of 100% compliance of completed skin audits; once goal is achieved audit will be reduced to 10 random per week x 6 weeks, then monthly x three months. • Corporate RN Staff has been assigned by the Director of Operations whoreports directly to the Board of	

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{F 223}	Continued From page 18 phone of the allegation. The BOM was allowed to finish her shift on 8/12/16 without being interviewed by the DON or SSD regarding the allegation. The BOM was terminated on 8/18/16 for unprofessional conduct. Interview with the ABOM on 11/2/16 at 2:30 PM, in the small conference room, confirmed she had witnessed the incident with the BOM and Resident #27, the BOM raised her hand during the conversation while telling the resident to stop talking and told the resident she was to "...sign the promissory note or she would be out of here..." Continued interview revealed "...I would never talk to someone like that...I felt it was hostile...I think the resident was just trying to plead her case..." Telephone interview with CNA #7 on 11/3/16 at 11:15 AM confirmed she overheard the conversation between the BOM and Resident #27. Continued interview revealed "...I really don't remember exactly what was said but I know [BOM] sounded aggressive...if she didn't pay [Resident #27] had to leave...the other girl [ABOM] kept trying to get [BOM] out of the room and she finally did...I don't know what would have happened if she didn't... [Resident #27]...was really upset when I came out of the bathroom...told her I was going to go tell someone..." CNA #7 immediately reported to the DON. Telephone interview with the BOM on 11/3/16 at 12:10 PM revealed "...that was the biggest joke of an investigation...did not ask me for my statement...I did hold up my hand trying to get her to stop talking..."	{F 223}	Directors for the managing entity. The Corporate staff began on 12/12/16 to provide surveillance, education, and administrative oversight 7 days per week and will remain assigned to the facility until substantial compliance is achieved and as long as the board continues to deem necessary thereafter. Substantial Compliance will be affirmed by review of supportive audit documentation and subsequent survey revisit. • Review of staffing schedule was conducted 12/16/15 in relation to incident trending and resident concerns. Schedule was amended to provide for RN supervision at night beginning 12/16/16. • Guardian Angel Rounds were established by the facility Administrator on 12/13/16 to provide means for residents openly discuss any	

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{F 223}	Continued From page 19 Telephone interview with Resident #27 on 11/21/16 at 9:30 AM confirmed she felt threatened by BOM during their conversation on 8/12/16. Continued interview with the resident confirmed no one from the facility followed up with her after the incident to see how she was feeling. Further interview revealed she "...was scared of her [BOM]..." Interview with the SSD on 11/28/16 at 4:00 PM in the conference room, confirmed Resident #27 had reported to her on 8/15/16 she was scared of the BOM. Continued interview confirmed the SSD had not interviewed any other residents in the facility. Further interview revealed "...it would be in the file if I did..." Interview with the Administrator on 11/28/16 at 4:00 PM in the conference room, confirmed he wrote the memorandum dated 8/18/16. Review of the memorandum revealed the BOM was separated from employment for "...unprofessional conduct stemming from an incident that took place Friday, August 12, 2016. The incident involved a verbal resident altercation in which the resident indicated she felt threatened with having to leave the facility if she did not immediately sign a promissory note to cover an outstanding debt..." Review of a facility investigation dated 9/3/16 revealed Resident #27 reported CNA #4 had told the resident she "... did not have to get her up that it was a privilege..." CNA #4 "...grabbed the draw sheet and slung the resident around causing the resident to fall backwards onto the bed. The CNA then grabbed the resident by the arms and manhandled her into the wheelchair..." Continued review revealed the Dietary Manager reported to LPN #7 on 9/3/16 the resident was	{F 223}	concerns they may have Rounding has been assigned 7 days per week ; residents will be visited several times per week, per schedule and additionally, as needed. Assigned Staff include Therapy Services, Social Services, Business Office, Maintenance, Dietary, Medical Records, Environmental, MDS, DON and Nursing Home Administrator. Assignments are conducted 7 days per week. • Any Guardian Angel Round resulting in patient concern is being reported immediately to administration, as trained. • As a result of the survey, the facility revalidated all current employees on 12-16-16 via Tennessee State Abuse Registry. Re-validation will occur annually.	

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{F 223}	Continued From page 20 upset and crying and told her LPN #7 and CNA #4 were being hateful and jerking her around. CNA #4 was allowed to finish her shift and continued to provide care for the resident. On 9/4/16 CNA #4 worked on the hall but was told by LPN #7 not to provide care for Resident #27 and was asked to provide a written statement of what had occurred between her and the resident. On 9/6/16 the RM interviewed Resident #27 and reported the incident to the DON and the Administrator. Resident #27 was admitted to the facility on 2/6/16 with diagnoses including Sepsis, Paraplegia, Sacral Pressure Ulcer Stage IV, and Acquired Absence of Left Leg below the Knee. Review of the Quarterly MDS dated 7/25/16 revealed Resident #27 had a BIMS score of 15 which indicated the resident was cognitively intact. Telephone interview with Resident #27 on 11/21/16 at 9:35 AM revealed CNA #4 entered room and stated "...I don't have to get you up; it's a privilege to get up...she grabbed the draw sheet jerked it and I fell backwards, then grabbed me by my wrists pulled me up, manhandled me and put me in my wheelchair. I got out of the room as fast as I could..." Continued interview revealed when the resident returned to the 100-200 hallway "...she [CNA #4] said if you want to go back to bed you get down here right now...other people heard it...she slammed the door...she said what was you doing outside talking about me? I told her [name of another resident] heard you [CNA #4] screaming outside of the door...she grabbed me up and put me back in bed...no one else transferred me like that...would use a lift or two	{F 223}	• Upon employment, the Human Resources Coordinator will responsible for obtaining professional licensure verification, certification and other required screening. Background checks are obtained according to state requirements. • Abuse Education training will be provided to all newly hired staff during their orientation process.ABUSE PROHIBITION AND INVESTIGATION GUIDELINES training to include: a. resident rights, b. dementia management and interventions to deal with aggressive residents, c. proper techniques for reporting to administration, definitions of possible activities of abuse, neglect, exploitation and misappropriation of resident property and prompt initiation of investigation.	

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{F 223}	Continued From page 21 people...she [CNA #4] said if I have to file a report I'll take you down with me...don't know what she meant...I kept asking her what was wrong...saw her in the hall on Sunday [9/4/16]...I was scared of her after that...that was abuse...I was a little sore...no one assessed me for bruising or injury...no, the SSD never came and followed up with me...one time she [CNA#4] come to do [supervise] smoke break and I was out there and she [CNA #4] went back in and a guy came out and said she [CNA #4] couldn't smoke us because she was out there, I took it as meaning me...made me feel like I had done something wrong..." Review of the staffing sheets for 9/3/16 and 9/4/16 confirmed CNA #4 worked the 100-200 hall way (where the resident was located). Review of the monthly schedule for 9/2016 revealed CNA #4 was scheduled off on 9/5/16 and 9/6/16. CNA #4 was scheduled to work 9/7/16 and 9/8/16. Review of the Individual Timecard for CNA #4 confirmed on 9/3/16 the CNA completed her shift on 9/3/16 and worked a full shift again on 9/4/16. Continued review revealed CNA #4 worked 9/8/16. Review of the personnel file for CNA #4 revealed a 3 day suspension dated 9/7/16 (unsigned by CNA #4 and did not indicate suspension dates). Continued review revealed a written warning on 9/12/16 for inconsiderate treatment of a resident. Interview with the Certified Dietary Manager (CDM) on 11/28/16 at 11:00 AM, at the 100-200 nurses station confirmed she had reported	{F 223}	d. removal of any staff or contractor accused as soon as facility becomes aware of allegation of abuse, neglect misappropriation or exploitation. e. how to recognize staff burnout, frustration and stress, also included was the Reporting Suspected Crimes under the Federal Elder Justice Act. Employees not completing this training will not be assigned. • All newly hired licensed nurses and CNA's will receive training on "Abuse Prohibition and investigation" policy as part of new employee orientation. 4. To assure continued compliance with facility policy related freedom fro abuse, findings noted on the following audits/tools will be	

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{F 223}	Continued From page 22 Resident #27 had stated CNA #4 had been hateful an jerked her around. Continued interview revealed "...I took her [Resident #27] back to her room then went and reported to her nurse that she might want to go check on her because she [Resident #27] was upset and crying..." Interview with the Administrator on 11/28/16 at 11:30 AM, in the front hallway revealed "...both the resident and the CNA stated it happened during transfer...so it came down to being just harsh words...so the CNA received a disciplinary action for unprofessional conduct..." Interview with the Director of Nursing on 11/30/16 at 1:00 PM, in the conference room, confirmed the investigation consisted of 4 residents being interviewed by the SSD. Continued interview revealed "...upon reviewing we felt it was more unprofessional conduct..." Review of a facility investigation dated 8/17/16 the revealed SSD and DON were made aware Resident #68 reported she had her call light on for a while and when no one answered she began yelling. There was no documentation to whom or when the resident reported the incident to and the SSD and DON could not recall. Certified Nursing Assistant (CNA) #15 had entered her room and screamed at Resident #68 "...For no reason should you shout...You don't talk to me that way. You can tell everyone here I screamed and no one will tell..." CNA #15 was allowed to complete her scheduled shift on 8/16/16 and clocked out at 6:30 AM. Continued review revealed the staffing agency was notified of the investigation and the CNA #15 would not be allowed to return. Resident #68 was admitted to the facility on	{F 223}	reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Grievance Log reported by Social Services Director o Incident Log reported by Risk Manager o New Hire Abuse Educationreported by Risk Manager	

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{F 223}	Continued From page 23 8/13/16 with diagnoses including Spinal Abscess Granuloma, Sepsis, Bipolar Disorder, and Psychoactive Substance Abuse. Review of the Admission MDS dated 8/20/16 revealed Resident #68 had a Brief Interview Mental Status score of 14 out of a possible 15 indicating was cognitively intact. Continued review revealed the resident was totally dependent for dressing and bathing, required extensive assistance for transfers, and personal hygiene with 1 person assist. Telephone interview with CNA #15 on 11/23/16 at 9:10 AM revealed she was contacted by the facility by phone on 8/18/16. She spoke with the Administrator and was told of the allegation of abuse. Continued interview revealed the Administrator placed her on speaker phone and asked her a few questions. Further interview revealed she was told by the Administrator he would have to finish the investigation and she could not return to the facility to work. Interview with the Social Services Director on 11/28/16 at 4:00 PM, in the conference, room revealed "... there were no investigations initiated and no additional information was available... had taken what [Resident #27, #47, #66, #74, and #75] had stated and summarized it in the written statement..." Interview with the DON on 11/30/16 at 2:00 PM, in the conference room confirmed there was no additional documentation for the investigation. Continued interview revealed the facility was unable to determine when they became aware of the allegation of abuse.	{F 223}	The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 223}	Continued From page 24 Review of a facility investigation dated 8/17/16 revealed Resident #47 thought CNA #15 was a smart aleck, pushy, and a know it all. Resident #47 was admitted to the facility on 1/19/15 with diagnoses including Diabetes Mellitus Type II, Morbid Obesity, Bipolar Disorder, and Paroxysmal Atrial Fibrillation. Review of the Quarterly MDS dated 6/6/16 revealed Resident #47 had a BIMS score of 15 out of a possible 15 indicating she was cognitively intact. Continued review revealed the resident was totally dependent for transfers and personal hygiene with the assist of 1 person. Further review revealed the resident was always incontinent of bowel and bladder. Interview with Resident #47 on 11/8/16 at 2:15 PM, in her room, revealed "...seems like she was always rushing and I don't like to be rushed..." Review of a facility investigation dated 8/17/16 revealed Resident #66 thought CNA #15 was hateful. Resident #66 was admitted to the facility on 4/13/16 with diagnoses including Malnutrition, Generalized Anxiety Disorder, Major Depressive Disorder and Congestive Heart Failure. Review of the 60 Day MDS dated 6/10/16 revealed Resident #66 scored a 15 out of 15 on the BIMS indicating she was cognitively intact. Continued review revealed the resident required extensive assist with transfers and was totally dependent for dressing and personal hygiene with the assist of 1 person.	{F 223}		

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{F 223}	Continued From page 25 Interview with Resident #66 on 12/1/16 at 8:15 AM in her room revealed "can't recall the CNA's names, only their faces..." Review of a facility investigation dated 8/17/16 revealed Resident #74 thought CNA #15 was a smart aleck, being pushy, and being a know it all. Resident #74 was admitted to the facility on 5/11/12 with diagnoses including Diabetes Mellitus Type II, Parkinson Disease, Heart Failure, Acute Kidney Failure and Failure to Thrive. Review of the Quarterly MDS dated 6/26/16 revealed the Resident #74 had a BIMS score of 15 out of a possible 15 indicating she was cognitively intact. Interview with the SSD on 11/28/16 at 4:00 PM, in the conference room, revealed there was no additional information available and there were no investigations initiated for residents #47, #66, and #74 allegations regarding CNA #15, who was allowed to fininsh her shift on 8/16/16. Interview with the SSD on 11/1/16 at 1:00 PM, in the small conference room confirmed all staff received education on abuse upon hire, quarterly, and as needed. Interview with the Administrator on 11/28/16 at 4:00 PM in the conference room confirmed he would expect the facility policy to be followed for an allegation of abuse. Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation,	{F 223}		

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{F 223}	Continued From page 26 review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records ensuring that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's new Abuse Prohibition Policy, initiated 11/18/16. Education occurred on 11/18/16 and 12/9/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 11/18/16 and 12/9/16 and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 100% of the active staff had been educated on facility policies by 12/9/16. 2. Verification by interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted during the revisit survey on 12/19, 12/20, and 12/21/16, on all shifts, to verify the staff's understanding of the facility's policies for abuse prohibition. 3. Interviews were conducted with 11 residents during the revisit survey on 12/19, 12/20, and 12/21/16, and revealed no residents complained about being abused or seeing any other resident being abused. The facility remains out of compliance at a Scope and Severity level "E" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 223}		
{F 224} SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	{F 224}		

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{F 224}	Continued From page 27 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, observation and interview the facility failed to provide services to prevent neglect for 3 residents (#65, #21 and #45) of 43 residents reviewed. The facility's failure to provide services to prevent neglect is likely to place all residents requiring assistance with incontinence care in Immediate Jeopardy (a situation which the provider's noncompliance has caused,or is likely to cause, serious harm, impairment or death). The facility was cited F224 at a scope and severity of "J" which constitutes Substandard Quality of Care (SQC). The Immediate Jeopardy is effective 2/7/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-224 at a "D" level for the facility's monitoring of the effectiveness of	{F 224}	**F224 Prohibit Mistreatment / Neglect and Misappropriation** 1. **Resident #65** - During the course of Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #21** Resident #21was interviewed by the Social Services Director on 12/13-16 and voiced no current concerns.	1/20/17

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{F 224}	Continued From page 28 corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Review of facility policy Abuse undated revealed "Abuse...deprivation by an individual...of goods or services that is necessary to attain or maintain, physical, mental and psychosocial well being of a resident...Residents most at risk: of neglect...residents who are bedfast and totally dependent on care..." Resident #65 was admitted to the facility on 12/11/09 with diagnoses including Diabetes Mellitus Type II, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, Spinal Stenosis, and Chronic Pain. Review of Annual MDS dated 11/18/15 revealed Resident #65 scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Continued review revealed the resident required extensive assist with transfers and dressing and total assist for person hygiene and bathing with 1-2 person assist and was always incontinent of bowel and bladder. Review of a facility investigation dated 2/7/16 revealed Resident #65 reported to RN #2 she told CNA #14 she was soaking wet and requested incontinence care. Continued review revealed CNA #14 told the resident he was "... 2 hours behind and he could not get to her..." Further review revealed RN #2 reported the incident to the DON on 2/8/16. Continued review revealed the DON interviewed Resident #65 and the	{F 224}	**Resident #45** Resident #45 was interviewed by the social Services Director on 12/13/16 and voiced no current concerns. 2. All residents have the potential to be affected and were identified by interview of 100% of the patients to assure care needs being met. Interviews were conducted on 12/7/16 by the Social Services Director. For those residents who did not respond to the interview, a head to toe body audit was conducted by the charge nurse on 12/6 and 12/7, 2016 to identify the presence skin alteration. Body audits revealing alteration were immediately advanced to nurse management for evaluation of prior reporting. All baseline skin assessments have been completed on 12/7/16 and continue on a weekly basis.	

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{F 224}	Continued From page 29 resident reported the same incident. Interview with Resident #65 on 11/9/16 revealed "...can't remember exactly what he said...didn't have time or something like that...it made me feel like I wasn't important..." Interview with Resident #65 on 11/19/16 at 11:25 AM confirmed CNA #14 did not return to the resident's room to provide incontinence care. Interview with the DON on 12/5/16 at 2:17 PM, in the conference room, confirmed she expected residents to be checked and changed every 2 hours and as needed. Medical record review revealed Resident #21 was admitted to the facility on 12/9/15 with diagnoses including Paraplegia, Dysphagia, Contracture Right Ankle, Contracture Left Ankle, and Osteoporosis. Medical record review of the Interdisciplinary Progress Notes dated 12/12/15 revealed "...Resident is paraplegic and requires total care for ADL's...Incont [incontinent] of B&B [bowel and bladder] c [with] peri care q2 [every 2 hours] + [and] PRN [as needed]..." Medical record review of the Annual Minimum Data Set (MDS) dated 10/17/16 revealed Resident #21 had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. Continued review revealed Resident #21 was totally dependent on staff with assistance of one person for with mobility, transferring and toileting. Further review of the MDS revealed the resident was always incontinent.	{F 224}	3. • Root cause analysis was conducted on 12/13/16 by Director of Operations and 3 Corporate Clinical Consultants who are RNs, by reviewing cited examples in accordance with the policy. Analysis indicated inconsistent implementation and supervision of the ABUSE PREVENTION POLICY and timing of personal care provision. • On November 18th, 2016, the Administrator and Director of Nursing Reviewed the "Resident Abuse Prohibition " policy which was previously revised by the Director of Operations on 11/17/16 in accordance with the revised Conditions of Participation. No further revisions were indicated. It was determined that facility was not adhering to policy in its entirety to include the provision of care	

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{F 224}	Continued From page 30 Medical record review of the Care Plan dated 10/18/16 revealed "...Self Care Deficit r/t [related] paraplegia...Potential for skin breakdown d/t [due to] decrease mobility...Provide Peri care with each incontinent episode...Potential for urinary tract infection r/t incontinence of B&B [bowel and bladder]...Self Care Deficit r/t paraplegia...Assist with ADLs as needed..." Medical record review of the Nurse Aide's Information Sheet undated, revealed Resident #21 was incontinent and required total care assistance. Continued review revealed the resident required a mechanical lift for transfers. Interview with Certified Nursing Assistant (CNA) #19 on 11/30/16 at 8:04 PM, in the 400 hall, revealed "...I have done my first dry rounds...Starting 8's [8:00 PM rounds] now...Last rounds at 4 [4:00 PM] before I got here..." Observation on 11/30/16 at 8:08 PM, on the 400 hall, revealed Resident #21 had a strong urine odor. Continued observation revealed the resident had a wet stain from the groin to her knee. Interview with Resident #21 on 11/30/16 at 8:08 PM, on the 400 hall, confirmed "...They haven't changed or clean me yet...not since last state person [state surveyor] was here..." Interview with CNA #19 on 11/30/16 at 8:09 PM, on the 400 hall, revealed "...I haven't changed her yet tonight [shift begin at 6:00 PM]..." Further interview confirmed CNA #19 failed to provide services for incontinence care for Resident #21. Continued interview confirmed the resident had to	{F 224}	and services in timely manner. • On November 18, 2016, SSD and Risk Mgr initiated revised "Resident Abuse prohibition policy" to include emphasis on education related to failure to provide care services. From this date through December 7, 2016 all facility staff with the exception of two (2) staff members (PRN CNA and CNA on medical leave) received the training. The two aforementioned staff members will be education prior to performing resident care. Risk Manager will assure this will take place. A list of attendees was compared to entire active payroll listing from payroll. Staff members not trained will not be assigned until training received. • On12/12/16 through 12-15-16 the DON conducted	

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{F 224}	Continued From page 31 wait 3 hours to be provided incontinence care. Observation with Licensed Practical Nurse (LPN) #13 on 11/30/16 at 8:12 PM, in the 400 hallway, revealed Resident #21 was in the wheelchair with a wet saturation on the resident's pants from the groin, to inner thigh, to knee. Interview with LPN #14 on 11/30/16 at 8:12 PM, on the 400 hall, confirmed "...She is soiled...She is a lift transfer...I expect her to be changed every 2 hours..." In Summary Resident #21 had a BIMS of 15. Observation and interview on 11/30/16 confirmed the resident was visibly soiled with urine in the wheelchair while in the 400 hallway. Interview with LPNs and CNAs confirmed the resident was incontinent and required incontinence care. Resident #21 had to wait 3 hours to be cleaned and changed. Medical record review revealed Resident #45 was admitted to the facility on 6/27/16 with diagnoses including Age-Related Osteoporosis, Muscle Spasm, Morbid Obesity, Chronic Obstructive Pulmonary Disease, and Contracture of Muscle. Medical record review of the Care Plan dated 3/25/16 and updated 9/15/16 revealed "...Self Care Deficit...Assist with ADL's as needed...Has incontinence bowel & bladder...Incontinence to be provided by staff as needed..." Medical record review of the Quarterly MDS dated 9/14/16 revealed Resident #45 had a Brief Interview for Mental Status Score of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed the resident was total	{F 224}	training on incontinence care with focus on dignity, resident need and prevention of skin impairment to CNA's. Education remains ongoing. • Guardian Angel Rounds were established by the facility Administrator on 12/13/16 to provide means for residents openly discuss any concerns they may have Rounding has been assigned 7 days per week ; residents will be visited several times per week, per schedule and additionally, as needed. Assigned Staff include Therapy Services, Social Services, Business Office, Maintenance, Dietary, Medical Records, Environmental, MDS, DON and Nursing Home Administrator. Assignments are conducted 7 days per week .	

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{F 224}	Continued From page 32 dependence with toileting. Further review of the MDS revealed the resident was always incontinent. Medical record review of the Nurses Note dated 11/6/16 revealed "...we do not want any skin breakdown or skin issues that can arise d/t [due to] poor hygiene..." Medical record review of the Nursing Weekly Summary dated 11/19/16 revealed "...ass [assist] x [times] 2 c [with] ADL's + [and] t/f's [transfers]...Incont of B+B [bowel and bladder] peri care PRN + q2 [every 2 hours]...non amb [ambulatory] is in the bed most of the time..." Medical record review of the Bladder Evaluation dated 11/26/15 revealed "...Functional Status/Assist...Total dependence...multiple daily episodes [incontinence]..." Medical record review of Nurse Aide's Information Sheet (Kardex), undated, revealed "...Incontinent...Total care...Geri chair...Lift to chair...[mechanical lift]..." Interview with Resident #45 on 11/30/16 at 8:18 PM, in the resident's room, confirmed "...I haven't been changed since before supper before 5 [5:00 PM]..." Interview with Registered Nurse #2 on 11/30/16 at 8:25 PM, on the 300 hall, confirmed the CNAs were to check and change the residents every 2 hours. Continued interview confirmed the CNAs started their rounds at 6:00 PM. Telephone interview with CNA #18 on 12/1/16 at 8:38 PM, confirmed she was assigned to	{F 224}	• Weekly body audit was conducted by the charge nurse on 12/6 and 12/7, 2016. Weekly body audit schedule was reviewed and body audits continue to be completed as assigned to identify care concerns. • Schedule was revised on 12-16-16 by the Corporate Team to assign Nurse Manager to 11-7 shift, 7 days per week to provide supervision and abuse surveillance. • Beginning on 12-12-16, Corporate RN Staff has been assigned by the Director of Operations who reports directly to the Board of Directors for the managing entity. The Corporate staff will provide surveillance, education, and administrative oversight 7 days per week and will remain assigned to the facility until substantial compliance is achieved and	

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{F 224}	Continued From page 33 Resident #45 on the night of 11/30/16. Continued interview confirmed she finished her first dry rounds (rounds to check residents for incontinence and hygiene needs) after 10:00 PM (took 4 hours to complete 6:00 PM dry rounds). Further interview confirmed CNA #18 failed to provide services for incontinence care for Resident #45. Interview with RN #5 on 12/2/16 at 2:37 PM, in the conference room, confirmed Resident #45 was incontinent and required a mechanical lift for mobility. Interview with the Director of Nursing on 12/5/16 at 2:17 PM, in the conference room, confirmed she expected the residents to be checked and changed every 2 hours and as needed. Interview with CNA #13 on 12/7/16 at 8:01 AM, on the 300 hall, confirmed she was assigned to Resident #45 on the dayshift on 11/30/16 and finished her dry rounds at 5:00 PM. Interview with Resident #45 on 12/7/16 at 9:39 AM in the resident's room, confirmed "...It is what it is. What can you do about it..." In Summary Resident #45 had a BIMS of 15. During the interview on 11/30/16 the resident stated she had not been changed since before dinner time at 5:00 PM. Interview with CNA assigned to resident on the night shift on 11/30/16 confirmed she had not finished her first set of dry rounds till 10:00 PM and had not cleaned and changed Resident #45 till 8:30 PM. Resident #45 had to wait 3 hours to be provided incontinent care.	{F 224}	as long as the board continues to deem necessary thereafter. • All grievances and incidents are logged for tracking of investigation and resolution by the Social Services Director and Risk Management Nurse, RN. The Social Services Director, the Risk Manager and the Administrator review each entry weekly to assure timely and complete investigation, reporting, if applicable, and resolution. • The Human Resources Designee revalidated all current employees on 12-16-16 via Tennessee State Abuse Registry. • Upon employment, the Human Resources Coordinator will be responsible for obtaining professional licensure verification, certification and other required screening.	

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{F 224}	Continued From page 34 Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records ensuring that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's new Abuse Prevention Policy initiated 11/18/16. Education was completed on 11/18/16 and 12/9/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 11/18/16 and 12/9/16 and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 100% of the active staff were educated on facility policies by 12/9/16. 2. Verification through interviews with 13 licensed nurses and Certified Nurse Assistants (CNA's) was conducted during the revisit survey on 12/19, 12/20, and 12/21/16, on all shifts, to confirm the staff's understanding of the facility's policies for abuse prevention. 3. Interviews with 11 residents during the revisit survey on 12/19, 12/20, and 12/21/16, revealed no residents complained about being abused or seeing any other resident being abused. The facility remains out of compliance at a Scope and Severity level "D" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 224}	Background checks are obtained according to state requirements. • All newly hired licensed nurses and CNA's will receive training on "Abuse Prevention and Investigation Policy" policy as part of new employee orientation. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to prevention of abuse and neglect. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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{F224}		{F224}	Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Grievance Log reported by Social Services Director o Incident Log reported by Risk Manager o New Hire Abuse Education reported by Risk Manager The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3	

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{F224}		{F224}	months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 225} {F 225} SS=E	Continued From page 35 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	{F 225} {F 225}	**F225 Investigations / Allegations / Individual** 1. **Resident #75** - On February 6, 2016, CNA was suspended after allegation of verbal abuse by resident on February 6, 2016. CNA was subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #103** - During the course of the investigation of Resident #75, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that same CNA involved with Resident #75 case was verbally inappropriate, CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services	1/20/17

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{F 225}	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, interview, review of the facility's investigations and observation, the facility failed to immediately report allegations of abuse and complete thorough investigations for allegations of abuse for 7 residents (#75, #103, #65, #106, #27, #68, and #12) of 15 residents reviewed for abuse. The facility's failure placed residents ((#75, #103, #65, #106, #27, #68, and #12) in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The Immediate Jeopardy was effective 2/6/16 and was removed 12/16/16. The facility was cited F 225 at a scope and severity of "K", which constitutes Substandard Quality of Care (SQC). The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-225 at a "E" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility.	{F 225}	Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #65** - During the course of the investigation of resident #75, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #106** - On July 8, 2016, Facility administrator was notified of unprofessional conduct by agency CNA. Facility	

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{F 225}	Continued From page 37 The findings included: Review of the facility policy Accidents and Incidents, dated May 2001, revealed "...An incident is any occurrence, which is not consistent with the routine operation of the institution or the routine care of a particular patient. It may involve an injury...charge nurse shall: Examine all...victims...Notify the...physician and inform of the accident /incident...Regardless of how minor...it must be reported to the department supervisor, and a report form is to be completed on the shift...must be reported to the Director of Nursing and the Director of Risk Management...All details are to be recorded in the nurses' notes, including disposition and follow up care for a period of 72 hours...The Risk Manager will review...investigation as needed..." Review of the facility policy Abuse, undated, revealed "...The facility will report and investigate all alleged incidents of resident abuse, mistreatment, neglect...and misappropriation of property. The facility will complete a thorough investigation of an alleged incident by the appropriate staff...Procedures...The charge nurse notifies the shift supervisor of the allegation. The supervisor initiates notification to the Social Services Department (SSD) and begins an investigation immediately...Immediately notify the Director of Nursing (DNS) and the Administrator by phone, if necessary. Investigate the alleged incident during the shift on which the allegation of abuse occurred...Interview the resident or other witnesses. The interview is to be dated, documented and signed by the supervisor. Interview the staff implicated. Have the employee document, in writing if able, their knowledge/version of the incident. Ensure the	{F 225}	contacted staffing agency on July 8, 2016 notifying agency the CNA was not to return. Resident was assessed on July 8, 2016 with no complaints at the time and no skin issues noted. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #27** - Discharged to home on October 24, 2016. Employee #4 terminated 8/18/16. **Resident #68** - Discharged to home on August 31, 2016.Employee . CNA #15 was banned from returning to the facility from the agency 8/22/16 **Resident #12** – Left leg wound was resolved prior to annual survey. Nurse Practitioner examined resident on December 7,	

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{F 225}	Continued From page 38 employee's written narrative is signed and dated. Interview any staff witnesses or other available witnesses. Have the witnesses document their knowledge/version of the incident. If the witnesses are unable to write their knowledge/version, have an administrative staff member write it for them. Ensure the witnesses sign and date their written narrative. Interview all staff on the unit to make sure all the information is gathered promptly. When a staff member is implicated in potential resident abuse situation, the employee is to be removed from all patient care areas and sent home after the narrative is obtained from the employee. The employee is instructed to contact the DNS [Director of Nursing Services] or Administrator the next day...Reporting and Documentation Requirements Facility investigation continues as needed over the next 24-48 hours...Place documentation in the resident's Medical record to reflect any direct observable facts...Social Services should document resident's psychosocial status and assessment of feelings, re: [regarding] safety, any counseling efforts. Documentation should continue over the next few days..." Medical record review revealed Resident #75 was admitted to the facility on 9/30/13 with diagnoses including Cerebral Palsy, Diabetes Mellitus Type II, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, and Morbid Obesity. Review of a facility investigation for Resident #75 revealed on 2/6/16 at approximately 5:00 AM Resident #75 reported to Registered Nurse (RN) #2 Certified Nursing Assistant (CNA) #14 told her she was wet and nasty and he was going to change her, he then grabbed her legs and made	{F 225}	2016 and no areas of concern noted. 2. All residents have the potential to be affected and were identified by interview of 100% of the patients to assure the safety and well being of all residents in our care on 12/7/16 by the Social Services Director. For those residents who did not respond to the interview, a head to toe weekly body audit was conducted by the charge nurse on 12/6 and 12/7, 2016Weekly body audit schedule was reviewed and body audits continue to be completed as assigned. 3. • Root cause analysis was conducted on 12/13/16 by Director of Operations and 3 Corporate Clinical Consultants who are RNs, by reviewing cited examples in	

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{F 225}	Continued From page 39 her move over. The resident reported the CNA told her I wouldn't have to do this if your filthy lazy ass would get up and go to the bathroom instead of pissing on yourself. The resident began screaming and crying. RN #2 stated she had never heard the resident do that before, she immediately went to the resident's room and as she entered the room CNA #14 was exiting. RN #2 assessed the resident for injury and administered Ativan to help calm the resident. The CNA was told not to go back in the residents' room and was allowed to finish his shift unsupervised. Further review revealed on 2/8/16 the facility conducted interviews with all the residents that had a BIMS score greater than or equal to 9 (moderately impaired to cognitively intact score 0-15). Resident #65 and #103 reported CNA #14 had made inappropriate comments to them on 2/6/16. The facility substantiated the allegation for verbal abuse and terminated CNA #14. Review of the Quarterly Minimum Data Set dated 12/29/15 revealed Resident #75 had a Brief Interview Mental Status (BIMS) score of 15 out of a possible 15 which indicated she was cognitively intact. Review of the Timecard Report for CNA #14 clocked out on 2/6/16 at 6:39 AM. Review of the personnel file revealed CNA #14 was suspended on 2/6/16 through 2/10/16 pending investigation. Investigation substantiates verbal abuse, terminated. Telephone interview with RN #2 on 11/3/16 at 4:45 PM revealed she did not know if CNA #14 had entered Resident #65 and #103's room	{F 225}	accordance with the policy. Analysis indicated inconsistent implementation of Abuse Policy as it relates to and reporting of suspected occurrence . • On November 18th, 2016, the Administrator and Director of Nursing reviewed the "Resident Abuse Prohibition "policy which was previously revised by the Director of Operations on 11/17/16 accordance with the revised Conditions of Participation. No further revisions were indicated. • The Administrator and Director of Nursing were in-serviced on Abuse Prevention, Identification, thorough investigation and reporting requirements by the Corporate Clinical Consultant on 11/29/16 In-service included procedure for	

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{F 225}	Continued From page 40 before or after Resident #75's room. Telephone interview with RN #2 on 11/3/16 at 4:45PM, revealed she did not know if CNA#14 had entered Resident #65 and #103's room before or after Resident #75's room. Telephone interview with CNA #14 on 11/14/16 at 11:45 AM, confirmed he had finished his dry round and wrote a statement before he exited the building. Interview with the Director of Nursing (DON) on 11/7/16 confirmed CNA #14 was terminated for verbal abuse. Continued interview revealed the DON stated "...called abuse registry and reported CNA #14...do not have documentation of report..." Interview with Resident #75 on 11/19/16 at 12:30 PM, in the resident's room, revealed "...I feel like it was abuse because of what he said and because he said no one would believe me..." Review of the facility Reportable Event Form revealed the incident occurred on 2/6/16 at 5:30 AM and was reported to the state agency on 2/10/16 at 6:26 PM (This is 3 days past the deadline of 24 hours). Review a facility investigation dated 2/6/16 revealed Resident #103 had reported to CNA #2 on 2/6/16 she did not want CNA #14 back in her room. The CNA had entered the room to provide incontinence care, grabbed the resident by her left arm and pulled her over. Resident #103 told him not to do that because it hurt. CNA #2 stated "... could hurt her if he wanted to because it was his job to change her..."	{F 225}	a. completion of incident/accident investigation b. reporting requirements to include reporting to state agency. • The Administrator will assure compliance with state and Federal guidelines related to investigation and reporting utilizing tool established for this purpose on 12/15/16. (Administrator's Incident/Occurrence Worksheet) The worksheet includes but is not limited to guide as an algorithm for completion of defining event, gathering statements for investigation, evaluating information gathered, assessing reporting criteria and reaching conclusion. • To assure prompt reporting, Staff on-duty have been re-in-serviced in the ABUSE PROHIBITION AND INVESTIGATION GUIDELINES	

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{F 225}	Continued From page 41 Resident #103 was admitted to the facility on 9/18/15 with diagnoses including Diabetes Mellitus Type II, Left sided Hemiplegia, Contracture of Left Elbow, and Depressive Disorder. Review of the 14 Day MDS dated 10/1/15 revealed Resident #103 scored a 15 out of a possible 15 on the BIMS which indicated she was cognitively intact. Interview with the DON on 11/14/16 at 11:35 AM in her office confirmed an investigation was not completed for Resident # 103 "...because she [Resident #103] did not know if what he did was intentional or not..." In summary, the facility investigation consisted of interviews with residents that had a BIMS score greater than or equal to 9, statements from CNA #5, RN #2, and Resident #75. The facility failed to: suspend CNA #5 immediately (continued to work at least 1 ½ hours) , interview all staff working during the shift, complete skin assessments for all residents with a BIMS score of less than 9, and failed to investigate Resident's #65 and #103 allegation of abuse. The facility failed to report an allegation of abuse to the state agency. Review of a facility investigation revealed Resident #65 had reported on 2/7/16 she had told CNA #14 she was soaking wet and requested to be changed. CNA #14 told the resident he was 2 hours behind and he could not get to her and did not return. RN #2 reported this to the DON on 2/8/16. The DON interviewed Resident #65 and the resident repeated the same incident.	{F 225}	to include Reporting Suspected Crimes under the Federal Elder Justice Act In-service will remain ongoing until employees, scheduled contract staff and volunteers have been trained. 107 staff members were trained between November 18, 2016 and December 7, 2016 by the SSD and Risk Mgr. • Post-testing on Abuse Inservice was conducted on 12-15-16 thru 1/20/17 to assure understanding of policy and expectation. A score of 100% was the acceptable benchmark. Staff have been in-serviced in the ABUSE PROHIBITION AND INVESTIGATION GUIDELINES to include: a. resident rights, b. dementia management and interventions to deal with aggressive residents, c. proper techniques for	

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{F 225}	Continued From page 42 Resident #65 was admitted to the facility on 12/11/09 with diagnoses including Diabetes Mellitus Type II, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, Spinal Stenosis, and Chronic Pain. Review of Annual MDS dated 11/18/15 revealed Resident #65 scored a 14 out of a possible 15 on the BIMS which indicated the resident was cognitively intact. Interview with the DON on 11/14/16 at 11:35 AM in her office revealed the allegation of abuse for Resident #65 was "...not investigated because the resident did not know if CNA #14 was joking or not..." Interview with Resident #65 on 11/9/16 revealed "...can't remember exactly what he said...didn't have time or something like that...it made me feel like I wasn't important..." Interview with the Administrator on 11/28/16 at 3:55 PM, in the conference room revealed "...this allegation was not investigated separately because it was a part of... [Resident #75's]...investigation. It was the same perpetrator and he was suspended and then terminated..." Continued interview with the Administrator confirmed he would expect the facility to have followed the procedures outlined in the facility Abuse policy. Review of a facility investigation revealed on 7/8/16 the facility initiated an investigation for 2 reported allegations of abuse for Resident #106. The first occurred on 6/24/16 when Certified Nursing Assistant (CNA) #8 allegedly grabbed Resident #106 by the arm to roll her over. The	{F 225}	reporting to administration, definitions of possible activities of abuse, neglect, exploitation and misappropriation of resident property and prompt initiation of investigation. d. removal of any staff or contractor accused as soon as facility becomes aware of allegation of abuse, neglect misappropriation or exploitation. e. how to recognize staff burnout, frustration and stress, also included was the **Reporting Suspected Crimes** under the Federal Elder Justice Act. 108 staff members have been trained to date. • To assure timely identification, Guardian Angel Rounds were established by the facility Administrator on 12/13/16 to openly discuss any concerns residents may have regarding their care.	

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{F 225}	Continued From page 43 second occurred on 7/1/16 when CNA #8 entered the residents' room and began slinging linens and things around and cursed the resident. Both allegations were witnessed by CNA #16 and reported to Licensed Practical Nurse (LPN) #3 on the date of the occurrence. Further review revealed CNA #8 was employed by the facility through a staffing agency and the facility contacted the agency on 7/8/16 by phone and reported the allegations and requested an interview with CNA #8. The facility again contacted the agency on 7/12/16 with no reported response. Resident #106 was admitted to the facility on 6/7/16 with diagnoses including: Sepsis, Dementia without Behavioral Disturbances, Pain in Knees, Osteoporosis, Osteoarthritis, Anxiety, and Depression. Review of the 14 Day Minimum Data Set dated 6/20/16 revealed Resident #106 had a Brief Interview Mental Status score of 3 out of a possible 15 which indicated a severe cognitive impairment. Review of the daily staffing sheets revealed CNA #8 continued working his shift on 6/24/16 and was assigned to Resident #106 on 6/27, 7/1, 7/2, and 7/3 during 4 of 7 shifts. Telephone interview with LPN #3 on 11/7/16 at 5:45 PM confirmed she did not report the allegations to Administration and did not recall anyone asking her about either of the allegations. Continued interview revealed "...she [CNA #16] came and talked to me and she said something happened...I think something happened a few days before that too... I told him not to go back in	{F 225}	Rounding has been assigned 7 days per week; residents will be visited several times per week, per schedule and additionally, as needed. Assigned Staff include Therapy Services, Social Services, Business Office, Maintenance, Dietary, Medical Records, Environmental, MDS, DON and Nursing Home Administrator. Assignments are conducted 7 days per week with residents specifically visited a minimum of 5 x per week. • Schedule was revised on 12-15-16 by the Corporate Team to assign Nurse Manager to 11-7 shift beginning on 12-16-16, 7 days per week to provide supervision and abuse surveillance. • On 12-12-16 Corporate RN Staff has been assigned by the Director of Operations who reports directly to the Board of Directors for the	

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{F 225}	Continued From page 44 that room...she [Resident #106] had a habit of saying ouch, ouch, when she was moved...so I didn't think anything had happened..." Telephone interview with LPN # 3 on 11/7/16 at 6:20PM revealed "...CNA #16 said she had talked to the DON about the 1st incident so I just thought they knew about it...it was almost time for the Risk Manager (RM) to come to work when she told me so I told her we would talk to her when she came in..." Interview with the RM on 11/9/16 at 12:00 PM in her office revealed she was notified by CNA #15 on 7/8/16 of the allegations of abuse and reported to Administration immediately. Interview with the DON on 11/9/16 at 12:30 PM, in her office, "...chose who [residents] to interview because of the physical layout of the facility..." Interview with LPN #3 on 11/29/16 at 7:00 AM in the conference room confirmed she did not send CNA #8 home "...placed him on a different hallway..." Continued interview revealed she had asked Resident #106 what had happened and the resident said nothing..." Interview with the Social Services Director on 11/29/16 at 4:00 PM, in the conference room, confirmed she felt it was a complete investigation. Interview with the DON on 11/30/16 at 1:00 PM, in the conference room, revealed "...I believe I talked to them, but I don't remember, I think I did and they didn't remember anything..." Continued interview revealed no other residents were interviewed to determine if any other residents were harmed.	{F 225}	managing entity. The Corporate staff will provide surveillance, education, and administrative oversight 7 days per week and will remain assigned to the facility until substantial compliance is achieved and as long as the board continues to deem necessary thereafter. • All newly hired licensed nurses and CNA's will receive training on "Change in Resident Condition or Status" policy as part of new employee orientation. a. resident rights, b. dementia management and interventions to deal with aggressive residents, c. proper techniques for reporting to administration, definitions of possible activities of abuse, neglect, exploitation and	

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{F 225}	Continued From page 45 In summary, the facility investigation for Resident #106 consisted of 2 statements that were written by CNA #16, notification of the residents' family and the staffing agency, 2 resident interviews, and the resident was assessed by the physician. The facility failed to: suspend the CNA #8 immediately, notify the Administrator or DON timely (13 days after the 1st allegation), interview all residents with a BIMS score of 9 or greater, conduct skin assessments for those residents with a BIMS score less than 9. Review of a facility investigation dated 8/12/16 at approximately 1:30 PM Resident #27 reported to Certified Nursing Assistant (CNA) #7 she was being threatened by the Business Office Manager (BOM). The BOM asked the resident to sign a promissory note for $50.00 a month toward her past due balance. The BOM raised her hand during the conversation and told the resident "...Do not talk while I am talking..." The BOM was quoted as having said to the resident "she was to sign the promissory note or she would be out of here". CNA #7 and the ABOM immediately reported the incident to the Director of Nursing (DON) and the Social Services Director (SSD). The DON then notified the Administrator by phone and made him aware of the allegation. The BOM was notified by the Administrator per a phone call on evening of 8/12/16 (Friday). The BOM was terminated on 8/18/16 (Thursday) for unprofessional conduct. Interview with the ABOM on 11/2/16 at 2:30PM in the small conference room confirmed she had witnessed the incident with the BOM and Resident #27, the BOM had raised her hand during the conversation while telling the resident	{F 225}	misappropriation of resident property and prompt initiation of investigation. d. removal of any staff or contractor accused as soon as facility becomes aware of allegation of abuse, neglect misappropriation or exploitation. e. how to recognize staff burnout, frustration and stress, also included was the **Reporting Suspected Crimes** under the Federal Elder Justice Act. Employees not completing this training will not be assigned. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure investigation are conducted	

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{F 225}	Continued From page 46 to stop talking and had told the resident she was to sign the promissory note or she would be out of here. Continued interview revealed "...I would never talk to someone like that...I felt it was hostile...I think the resident was just trying to plead her case... Telephone interview with CNA # 7 on 11/3/16 at 11:15 AM confirmed she had overheard the conversation between the BOM and Resident #27. Continued interview revealed "...I really don't remember exactly what was said but I know [BOM name] sounded aggressive...if she didn't pay she had to leave...the other girl [ABOM] kept trying to get [BOM name] out of the room and she finally did...I don't know what would have happened if she didn't..." Resident #27 "...was really upset when I came out of the bathroom...told her I was going to go tell someone..." CNA #7 immediately reported to the DON. Telephone interview with the BOM on 11/3/16 at 12:10 PM revealed "...that was the biggest joke of an investigation...did not ask me for my statement...I did hold up my hand trying to get her to stop talking..." Telephone interview with Resident #27 on 11/21/16 at 9:30 AM confirmed she had felt threatened by BOM during their conversation on 8/12/16. Continued interview with the resident confirmed no one from the facility had followed up with her after the incident to see how she was feeling. Further interview revealed she "was scared of her [BOM]..." Interview with the Administrator on 11/28/16 at 4:00 PM, in the conference room confirmed he	{F 225}	per facility policy. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Grievance Log reported by Social Services Director o Incident Log reported by Risk Manager o New Hire Abuse Education reported by Risk Manager The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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{F 225}	Continued From page 47 had written the memorandum dated 8/18/16. Continued interview and review of the memorandum revealed the BOM was separated from employment for "...unprofessional conduct stemming from an incident that took place Friday, August 12, 2016. The incident involved a verbal resident altercation in which the resident indicated she felt threatened with having to leave the facility if she did not immediately sign a promissory note to cover an outstanding debt..." Interview with the SSD on 11/28/16 at 4:00 PM, in the conference room, confirmed Resident #27 had reported to her on 8/15/16 she was scared of the BOM. Continued interview confirmed the SSD had not interviewed any other residents in the facility. Further interview revealed "...it would be in the file if I did..." Review of the State Reportable Incident form revealed date of occurrence as 8/12/16 at 3:00 PM with a report date of 8/18/16 (5 days past the required 24 hours). Interview with the Administrator on 11/28/16 at 4:00 PM, in the conference room, confirmed he wrote the memorandum dated 8/18/16. Review of the memorandum revealed the BOM was separated from employment for "...unprofessional conduct stemming from an incident that took place Friday, August 12, 2016. The incident involved a verbal resident altercation in which the resident indicated she felt threatened with having to leave the facility if she did not immediately sign a promissory note to cover an outstanding debt..." In summary, the facility investigation consisted of interview and statements from the BOM, ABOM, CNA #7, and Resident #27. The facility failed to:	{F 225}	QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 225}	Continued From page 48 immediately interview and remove the BOM, interview other residents and family members the BOM may have spoken with, and assess, document and provide psychosocial support for Resident #27 following the incident. Review of a facility investigation revealed dated 9/3/16 Resident #27 reported Certified Nursing Assistant (CNA) #4 told Resident #27 she "...did not have to get her up that was a privilege..." CNA #4 grabbed the draw sheet and slung the resident around causing the resident to fall backwards onto the bed. The CNA then grabbed the resident by the arms and manhandled her into the wheelchair. The Dietary Manager reported to Licensed Practical Nurse (LPN) #7 on 9/3/16 the resident was upset and crying and had told her the nurse and CNA were being hateful and jerking her around. CNA #4 was allowed to finish her shift and continued to provide care for the resident. Continued review revealed on 9/6/16 the Risk Manager (RM) interviewed Resident #27 and reported the incident to the Director of Nursing (DON) and the Administrator. Resident #27 was admitted to the facility on 2/6/16 with diagnoses including Sepsis, Paraplegia, Sacral Pressure Ulcer Stage IV, and Acquired Absence of Left Leg below the Knee. Review of the Quarterly Minimum Data Set dated 7/25/16 revealed Resident #27 had a BIMS score of 15. Interview with Social Services Director (SSD) on 11/7/16 at 9:30 AM, in the small conference room, confirmed she interviewed those residents with a BIMS score of 9 or greater (indication of moderate impairment to cognitively intact).	{F 225}		

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{F 225}	Continued From page 49 Continued interview confirmed "...they all voiced CNA#4 was a good CNA and has never talked harsh or handled them roughly..." Interview with the DON on 11/7/16 at 9:30 AM, in the small conference room, revealed "...that was the only hall she was working at that time...didn't have a reason to do skin assessments on residents since the residents that were interviewed were saying positive things about her..." Telephone interview with Resident #27 on 11/21/16 at 9:35 AM revealed CNA #4 entered room and stated "...I don't have to get you up; it's a privilege to get up...she grabbed the draw sheet jerked it and I fell backwards, then grabbed me by my wrists pulled me up, manhandled me and put me in my wheelchair. I got out of the room as fast as I could..." When the resident returned to the hallway "...she [CNA] said if want to go back to bed you get down here right now...other people heard it...she slammed the door...she said what was you doing outside talking about me? I told her [name of another resident] heard you [CNA] screaming outside of the door...she grabbed me up and put me back in bed...no one else transferred me like that...would use a lift or two people..." Interview with the Certified Dietary Manager (CDM) on 11/28/16 at 11:00 AM, at the 100-200 nurses station confirmed she had reported Resident #27 had stated CNA #4 and the nurse had been hateful an jerked her around. Continued interview revealed "...I took her [Resident #27] back to her room then went and reported to her nurse that she might want to go check on her because she [resident] was upset and crying..."	{F 225}		

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{F 225}	Continued From page 50 This allegation was not reported to the state agency and was not reported to Administration until 2 days after the incident. Review of the facility investigation revealed on 10/17/16 the SSD and DON were made aware Resident #68 reported she had her call light on for a while and when no one answered she began yelling. Certified Nursing Assistant (CNA) #15 had entered her room and screamed at her saying "...For no reason should you shout...You don't talk to me that way. You can tell everyone here I screamed and no one will tell..." There was no documentation to whom or when the resident reported the incident to and the SSD and DON could not recall. CNA #15 was allowed to complete her scheduled shift on 10/16/16. Resident #68 was admitted to the facility on 8/13/16 with diagnoses including Spinal Abscess Granuloma, Sepsis, Bipolar Disorder, and Psychoactive Substance Abuse. Review of the Admission MDS dated 8/20/16 revealed Resident #68 had a Brief Interview Mental Status score of 14 out of a possible 15 indicating she was cognitively Intact. Interview with the Social Services Director on 11/28/16 at 4:00 PM in the conference room revealed "... there were no investigations initiated and no additional information was available... Medical record review revealed Resident #12 was admitted to the facility on 6/15/12 with diagnoses including Atrial Fibrillation, Aphasia, Chronic Obstructive Pulmonary Disease, Dysphagia, Dementia, Osteoporosis, Hypertension, Impulse	{F 225}		

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{F 225}	Continued From page 51 Control Disorder, Anemia, Anxiety, Major Depressive Disorder, Generalized Osteoarthritis, Gastroesophageal Reflux Disease, and Insomnia. Medical record review of the Quarterly Minimum Data Set (MDS) dated 6/6/16 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating the resident had severe cognitive impairment. Continued review revealed the resident was totally dependent for bed mobility and transfers with 2 or more person physical assist. Review of a Physician's Progress Note dated 7/13/16, authored by Nurse Practitioner (NP) #2, revealed "...nursing report pt [patient] w/ [with] LLE [left lower extremity] bruising, edema...LLE w/ large bruised/reddened area, warm to touch...painful (grimacing w/palp [palpation])..." Continued review revealed "assessment/plan...venous Doppler R/O [rule out] blood clot..." Review of Nurse's Notes revealed no documentation of the bruising by the nurses on 7/13/16. Review of a Physician's Progress Note dated 7/19/16, authored by the Physician, revealed "...new bruising and swelling of the left leg...no injuries that have been reported by staff...xray to rule out underlying fracture...Ultrasound negative for DVT [deep vein thrombosis]..." Review of an imaging report dated 7/19/16 revealed "...proximal [nearer to center] tibial and fibular [bones of lower leg] mildly displaced fractures..."	{F 225}		

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{F 225}	Continued From page 52 Review of a Resident Incident Report dated 7/20/16 revealed "...Resident C/O [complained of] pain when turned, order received for xray...Green bruising noted to shin and calf area..." Continued review revealed 4 witness statements by staff stated they had no knowledge of the cause of the fractured leg. Further review of a typed summary of the investigation, unsigned, revealed "...noted protrusion in wall and bruise consistent with rolling toward wall and coming in contact with the protrusion...resident unable to recall direct force incident...According to research a side ways bend at ankle or knee could have caused practure [fracture]..." Review of the Physician's Progress Note dated 7/20/16 revealed "...Tib/fib [tibia/fibula bones of lower leg] fx [fracture]..." Interview with the Director of Nursing (DON) on12/1/16 at 8:51 AM, in the conference room, confirmed bruises were to be documented by the assigned nurse upon discovery. Further interview confirmed no investigation had been started until the fracture was discovered on 7/20/16. Interview with the DON on12/2/16 at 9:57AM, in the resident's room, confirmed the resident's left leg was "probably bent when the resident was turned on her left side. The resident's left leg probably went between the bed and the mattress and hit the protrusion on the wall." Interview and observation with the Maintenance Director on 12/1/16 at 4:10 PM, in resident's room, confirmed there was a buffer (wood panel to prevent bed from scraping wall) on the bed side of the wall 18" from the floor, below the top	{F 225}		

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{F 225}	Continued From page 53 of the mattress, and extended the entire length of the left wall. Continued observation and interview revealed the protrusion had a curved, smooth surface on the top edge and protruded outward 9/16 of an inch from wall. Interview with Licensed Practical Nurse (LPN) #12 on 12/2/16 at 12:45 PM, at the 300/400 nurses station, confirmed a CNA (couldn't remember which one) reported bruising and swelling to Resident #12's leg on 7/13/16. Continued interview revealed LPN #12 notified the NP on the same day (7/13/16), but did not document in the nurse's notes or fill out an incident report. Further interview confirmed LPN #12 should have documented the bruising and swelling and initiated an incident report. Continued interview confirmed Resident #12 was unable to roll over in the bed independently. Interview with the resident's Physician on 12/2/16 at 3:55 PM, in the conference room, confirmed Resident #12 was seen by Nurse Practitioner (NP) #2 on 7/13/16 for edema and discoloration of the left lower leg. Continued interview revealed the Physician was "...surprised when the xray report revealed a fracture because the resident was so cooperative with care..." Further interview with the Physician revealed the fracture most likely occurred around 7/13/16 (when the bruising and edema was first noticed). In summary, review of the facility investigative documentation for Resident #12 revealed the facility did not initiate an investigation into the injury of unknown origin on the date the injury was discovered, 7/13/16. Further review of the facility's investigative documentation revealed the facility failed to obtain interviews from staff who	{F 225}		

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{F 225}	Continued From page 54	{F 225}		

had worked prior to and on 7/13/16. Further review revealed no skin assessments were completed for resident's unable to be interviewed to identify additional potential injuries.

Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by:

1. Review of the facility's in-service records ensuring that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's new Abuse Prohibition and Investigation Policy initiated 11/18/16. Education was comducted on 11/18/16 and 12/9/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 11/18/16 and 12/9/16 and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 107 staff members, contract staff, and volunteers were educated on facility policies between 11/18/16 and 12/9/16.

2. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs), the Director of Nursing, the Administrator, and the Medical Director was conducted on 12/19, 12/20, and 12/21/16, on all shifts, and verified the staff's understanding of the facility's policies for reporting and investigating abuse and the timeframe the allegations and investigation were to be reported in.

3. Interviews with 11 residents on 12/19, 12/20, and 12/21/16, revealed there were no complaints of being abused or seeing any other resident being abused.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 225}	Continued From page 55	{F 225}		
	The facility remains out of compliance at a Scope and Severity level "E" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.			
{F 241} SS=D	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 medical record review, review of facility investigation, interview, and observation, the facility failed to provide timely incontinence care to maintain dignity for 3 dependent residents (#65, #21, and #45) of 43 residents reviewed. The facility's failure placed residents #65, #21, and #45 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death) and was likely to place any resident requiring assistance with incontinence care in Immediate Jeopardy. The facility was cited F-241 at a scope and severity of "J" which constitues Substandard Quality of Care. The Immediate Jeopardy was effective 2/7/16 and was removed 12/16/16.	{F 241}	**F241 Dignity and Respect of Individuality** **1. Resident #65** During the course of the #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility.	1/20/17

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{F 241}	Continued From page 56 The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-241 at a "D" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Resident #65 was admitted to the facility on 12/11/09 with diagnoses including Diabetes Mellitus Type II, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, Spinal Stenosis, and Chronic Pain. Review of the Annual Minimum Data Set (MDS) dated 11/18/15 revealed Resident #65 scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Continued review revealed the resident required extensive assist with transfers and dressing, total assist for hygiene and bathing, and was always incontinent of bowel and bladder. Review of a facility investigation revealed Resident #65 reported on 2/7/16 she told Certified Nursing Aide (CNA) #14 she was soaking wet and requested to be changed. Continued review revealed CNA #14 told the resident he was 2 hours behind, and he could not get to her, and the CNA did not return. Registered	{F 241}	**Resident #21** Resident was interviewed by the Social Services Director on 12/13-16 and voiced no current concerns. **Resident #45** Resident was interviewed by the social Services Director on 12/13/16 and voiced no current concerns. 2. All residents have the potential to be affected and were identified by interview of 100% of the patients to assure care needs being met. Interviews were conducted on 12/7/16 by the Social Services Director. For those residents who did not respond to the interview, a head to toe body audit was conducted by the charge nurse on 12/6 and 12/7, 2016 to identify the presence skin alteration. Body audits revealing alteration were immediately advanced to	

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{F 241}	Continued From page 57 Nurse (RN) #2 reported the incident to the Director of Nursing (DON) on 2/8/16. The DON interviewed Resident #65 and the resident confirmed the incident. Interview with Resident #65 on 11/9/16 at 11:40 AM, in the resident's room, revealed "...can't remember exactly what he [CNA #14] said...didn't have time or something like that...it made me feel like I wasn't important..." Interview with the DON on 12/5/16 at 2:17 PM, in the conference room, confirmed care was not provided to maintain the resident's dignity. Medical record review revealed Resident #21 was admitted to the facility on 12/9/15 with diagnoses including Paraplegia, Dysphagia, Contracture Right Ankle, Contracture Left Ankle, and Osteoporosis. Medical record review of the Annual MDS dated 10/17/16 revealed Resident #21 had a BIMS Score of 15, indicating the resident was cognitively intact. Continued review revealed Resident #21 was total dependence of one person for mobility, transferring and toileting, and the resident was always incontinent. Medical record review of the Resident's Care Plan dated 10/18/16 revealed "...Self Care Deficit r/t [related to] paraplegia...Provide Peri care with each incontinent episode...Assist with ADLs [activities of daily living] as needed..." Medical record review of the Interdisplinary Progress Notes dated 12/12/15 revealed "...Resident is paraplegic and requires total care for ADL's...Incont [incontinent] of B&B [bowel and	{F 241}	nurse management for evaluation of prior reporting. All baseline skin assessments have been completed on 12/7/16 and continue on a weekly basis. 3. • Root cause analysis was conducted on 12/13/16 by Director of Operations and 3 Corporate Clinical Consultants who are RNs, by reviewing cited examples in accordance with the policy. Analysis indicated inconsistent implementation and supervision of the Facility's incontinence policy. • A resident council meeting was held on December 7, 2016, conducted by the Social Services Director to review the facilities initiatives related to personal care assistance. Eleven (11) residents attended..	

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{F 241}	Continued From page 58 bladder] c [with] peri care q2 [every 2 hours] + [and] PRN [as needed]..." Observation on 11/30/16 at 8:08 PM, on the 400 hall, revealed Resident #21 had a strong urine odor. Continued observation revealed the resident's pants had a wet stain from her groin to the knee. Observation with Licensed Practical Nurse (LPN) #14 on 11/30/16 at 8:12 PM, in the 400 hallway, revealed Resident #21 was in a wheelchair, with a wet saturation on the resident's pants, from the groin to, down the inner thigh, to her knees. Interview with Resident #21 on 11/30/16 at 8:08 PM, on the 400 hall, confirmed "...They haven't changed or clean me yet..." Interview with CNA #19 on 11/30/16 at 8:09 PM, on the 400 hall, revealed "...I haven't changed her yet tonight [shift began at 6:00 PM]..." Continued interview confirmed the resident had to wait 3 hours to be provided incontinence care. Interview with LPN #14 on 11/30/16 at 8:12 PM, on the 400 hall, confirmed "...She is soiled..." Further interview confirmed the resident's dignity was not maintained. Medical record review revealed Resident #45 was admitted to the facility on 6/27/13, and readmitted on 6/19/14, with diagnoses including Age-Related Osteoporosis, Muscle Spasm, Morbid Obesity, Chronic Obstructive Pulmonary Disease, and Contracture of Muscle. Medical record review of the Care Plan dated 3/25/16 and updated 9/15/16 revealed "...Self	{F 241}	Meeting frequency will continue until substantial compliance is achieved then resume monthly unless otherwise determined by the QA committee. • On 12/12/16-12/15/16 the DON conducted training in incontinence care with focus on dignity, resident need and prevention of skin impairment. Education remains ongoing. • Guardian Angel Rounds were established by the facility Administrator on 12/13/16 to provide means for residents openly discuss any concerns they may have Rounding has been assigned 7 days per week ; residents will be visited several times per week, per schedule and additionally, as needed. Assigned Staff include Therapy Services, Social Services, Business Office, Maintenance, Dietary,	

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{F 241}	Continued From page 59 Care Deficit...Assist with ADL's as needed...Has incontinence bowel & [and] bladder...Incontinence [care] to be provided by staff as needed..." Medical record review of the Quarterly MDS dated 9/14/16 revealed Resident #45 had a BIMS Score of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed the resident was total dependence with toileting. Further review revealed the resident was always incontinent. Medical record review of the Nursing Weekly Summary dated 11/19/16 revealed "...ass [assist] x [times] 2 c [with] ADL's + t/f's [transfers]...Incont of B+B peri care PRN + q2 [every 2]...non amb [ambulatory] is in the bed most of the time..." Medical record review of a Nurse Aide's Information Sheet undated, revealed "...Incontinent...Total care...Geri chair...Lift to chair...[mechanical lift]..." Interview with Resident #45 on 11/30/16 at 8:18 PM, in the resident's room, confirmed "... I haven't been changed since before supper before 5 [5:00 PM]..." Telephone interview with CNA #18 on 12/1/16 at 8:38 PM, confirmed she was assigned to Resident #45 on the night of 11/30/16. Continued interview confirmed she finished her first dry rounds (checking for bowel and urinary incontience needs) after 10:00 PM. Further interview confirmed the resident had to wait more than 3 hours to be changed. Continued interview confirmed Resident #45's dignity was not maintained.	{F 241}	~~Medical Records,~~ Environmental, MDS, DON and Nursing Home Administrator. Assignments are conducted 7 days per week. • Weekly body audit was conducted by the charge nurse on 12/6 and 12/7, 2016Weekly body audit schedule was reviewed and body audits continue to be completed as assigned to identify care concerns for dependent residents unable to verbalize concerns. • Schedule was revised on 12-15-16 by the Corporate Team to assign Nurse Manager to 11-7 shift beginning 12/16/16, 7 days per week to provide supervision and care delivery surveillance. • Corporate RN Staff has been assigned by the Director of Operations who reports directly to the Board of	

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{F 241}	Continued From page 60 Interview with the Director of Nursing on 12/5/16 at 2:17 PM, in the conference room, confirmed she expected the residents to be checked and changed at least every 2 hours. Interview with Resident #45 on 12/7/16 at 9:39 AM in the resident's room, revealed "...It is what it is. What can you do about it..." Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records dated 12/9/16 and 12/13/16 to ensure 100% of the nursing staff were educated regading Patient Rights, Incontinence Care and Dignity. Review of the facility's plan of action revealed all nurses were educated on the policies before being allowed to return to work. Interviews with Administrative staff conducted on 12/19, 12/20, and 12/21/16, confirmed all employees received the education. 2. Verification through interviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN]) was conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and with 9 Certified Nurse Assistants (CNA) beween the same time frames and dates, and verified the staff's understanding of Patient Rights, Dignity and Incontience Care. 3. Review of 19 resident records on 12/19/16-12/21/16 revealed no evidence of incontience care not being provided timely.	{F 241}	Directors for the managing entity. The Corporate staff began on 12/12/16 to provide surveillance, education, and administrative oversight 7 days per week and will remain assigned to the facility until substantial compliance is achieved and as long as the board continues to deem necessary thereafter. Substantial Compliance will be affirmed by review of supportive audit documentation and subsequent survey revisit. • All grievances and incidents are logged for tracking for investigation and resolution by the Social Services Director and Risk Management Nurse, RN. (Concerns identified during guardian angel rounds will be recorded on grievance form to assure follow up per facility policy) The Social Services Director, the Risk Manager and the	

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{F 241}	Continued From page 61 4. Interviews were conducted on 12/19/16 through 12/21/16 with 11 interviewable residents and revealed there were no complaints regarding any issues with dignity or Patient Rights. 5. Verification of implementation of the Guardian Angel Rounds was done through observations and interviews and revealed the administrative staff had made rounds on the residents on a daily basis to ensure the resident's dignity. Further review revealed documentation in 19 medical records of the Social Service Director speaking with the residents regarding their care and questions regarding any complaints the residents may have. 6. Review of the Cooporate Staff schedule revealed an administrative staff member was assigned to be present in the facility 7 days a week to provide supervision and abuse surveillance. Further review revealed an Administrative schedule for Manager on duty was implemented and in place. Observation on 12/19/16 at 8:30 PM revealed administrative staff were in the building when the survey team arrived in the facility to begin the Revisit survey. 7. Coorporate RN staff was assigned by the Regional Director to be present in the facility to ensure 7 days per week survillance would occur and they will remain in the building until substantial compliance is achieved. Observations during the survey revealed the coorporate nurses were present and active in the building. 8. Verification through interviews with the Cooporate nurses on 12/21/16 at 10:30 AM confirmed the nurses were assigned to the	{F 241}	Administrator review each entry weekly to assure timely provision of personal care assistance, and resolution to concerns voiced. • All newly hired licensed nurses and CNA's will receive training on incontinence management and personal care assistance as part of new employee orientation. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to the provision of timely incontinent care delivery. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services	

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{F241}		{F241}	Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Grievance Log reported by Social Services Director(The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued	

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{F241}		{F241}	need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 241}	Continued From page 62 building. The facility remains out of compliance at a Scope and Severity level "D" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 241}	**F258 Maintenance of Comfortable Sound Levels** 1. Resident #18 had review of medications to identify possible interactions on 12/21/16 and 12/29/16 by the Pharmacy Consultant. No interactions were identified by the Pharmacy Consultant. Medication adjustments were initiated on 12/3/16 and remain ongoing to facilitate effectiveness in accordance with physician/practitioner oversight, pharmacy consultant review and change in condition to facilitate optimal comfort for the patient and those in his proximity. Plan of Care was reviewed by the interdisciplinary team on 12/29/16 to establish an intervention plan in	1/20/17
{F 258} SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain comfortable noise levels in the facility for 2 of 4 hallways. The findings included: Medical record review revealed Resident #18 was admitted to the facility on 6/30/03 and readmitted on 12/2/15 with diagnoses including Athetoid Cerebral Palsy (a movement disorder caused by damage to the developing brain), Epilepsy, Profound Severe Intellectual Disabilities, Visual Loss Both Eyes, Psychotic Disorder with Hallucinations and Agitation, Schizoaffective Disorders, Major Depressive Disorder, Anxiety Disorders, Skull Deformity, Down's Syndrome, Neurocognitive Impairment, and Severe Mental Retardation with Self Harming Behaviors.	{F 258}		

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{F 258}	Continued From page 63 Medical record review of a physician progress note dated 9/7/16 revealed "...seeing patient today to follow up on staff concerns that patient has increased agitation and screaming out. He continues to come out into the hallway and roll around in the floor...his irritability has increased...still screams out intermittently...patient is lying on the floor in his room...he is continually yelling out and grunting loudly..." Medical record review of a psychiatric progress note dated 9/7/16 revealed "...pt screams continuous (grunts) often..." Medical record review of a preadmission screening form dated 9/26/16 revealed Resident #18 had "...severe agitation...yells & [and] screams loudly for a long period of time...screaming continuous for hours..." Observation on 11/28/16 at 12:30 PM, on the 400 hallway, revealed Resident #18 was in the hallway scooting self around, making a lot of very loud noises, and yelling. Observation on 11/28/16 at 12:42 PM, on the 400 hallway, revealed Resident #18 was still yelling loudly. Observation on 11/28/16 at 12:45 PM, on the 400 hallway, revealed one resident in a wheelchair, speaking with another resident regarding the loud noise Resident #18 was making. This resident yelled at Resident #18 to be quite. Continued observation at 12:46 PM revealed the resident still scooting himself down the hall and making loud noises.	{F 258}	response to resident vocalizations. 2. All residents on the 2 identified halls have the potential to be affected by increased noise levels and are interviewed, at minimum, 4 x per week by way of Guardian Angel Rounds. 3. • A patterning worksheet was implemented on 12-22-16 x 72 hours to evaluate the behavioral trends of identified resident. • On 12/14/16 an interdisciplinary team meeting was held for the identified resident to reestablish a plan of care to facilitate behavioral interventions and activities to promote optimal quality of life while respecting the audible impact to others.	

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{F 258}	Continued From page 64 Observation on 11/28/16 at 12:53 PM revealed Resident #18 had scooted down the hall away from his room and was against a wall. A staff member knelt down and talked with Resident #18, and he quieted down while they were speaking with him. Continued observation at 1:00 PM revealed the staff member had left his side and Resident #18 was yelling again. Interview with Licensed Practical Nurse (LPN) #15 on 11/28/16 at 1:10 PM, at the 300/400 nursing station, confirmed Resident #18 yells like that "...all the time..." Observation on 11/29/16 at 7:30 AM, revealed Resident #18's yelling could be heard up the hallway at the activity room, approximately 50 feet from the 300/400 nursing station. Interview with LPN #1 on 11/29/16 at 8:27 AM, on the 300 hall, confirmed "...the rooms towards the front of the 300 hall complain of the noise he [Resident #18] makes..." Observation on 11/30/16 at 8:00 PM, in the 400 hallway, revealed Resident #18 was sitting in the hallway, holding a blanket, scooting around, and making loud noises. Observation on 12/1/16 at 2:00 PM, in the 400 hallway, revealed Resident #18 scooting around, making loud noises. Interview with the Risk Manager on 12/5/16 at 11:45 AM, in the Risk Manager office, confirmed some residents had complained about the noise. Observation from 11/28/16 through 12/7/16,	{F 258}	• A Staff member is being temporarily assigned to visit identified resident to observe and provide sensory input 5 days per week...this intervention began on 12/14/16. Successes are reported to the interdisciplinary team during regularly scheduled morning meetings with a goal of establishing optimal plan of care. Frequency of visits will decrease in accordance with increase in successful interventions and established plan of care. • Interdisciplinary team meeting was held on 12/29/16 and are held monthly at minimum to review effectiveness of interventions for identified resident. • The Activity Director revised resident plan of care for identified resident on	

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{F258}		{F258}	12/29/16 to address periods of increased vocalizations by identified resident. • The Licensed Nurses, the intended audience were re-in-serviced on the "Notification of Change in Resident Condition or Status" Policy, the by the Director of Nursing beginning on 12-12-16 and ending on 1/18/16 to enhance awareness and importance of reporting of proper notification to physician, resident and representative with change in condition or treatment. In-service included, notification responsibilities, significant change definition, and medical emergency exceptions. This is 100% of the intended audience. • Sound levels will be monitored during Guardian Angel Rounds which occur daily. Results of assigned rounds will be reviewed in	

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{F258}		{F258}	regularly scheduled interdisciplinary team meetings. The Guardian Angel Rounding tool will be used to document concerns related to sound levels with the goal of comfortable sound levels for all guests. This goal is evidenced by trending of concerns voiced in this regard. • All newly hired licensed nurses will receive training on "Notification of Change in Resident Condition or Status" (to include behavioral changes resulting in increased audible expressions) policy as part of new employee orientation. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the	

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{F258}		{F258}	daily audits noted to assure adherence to facility policy related to Comfortable Sound Levels. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Grievance Log reported by Social Services Director o Incident Log reported by Risk Manager The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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{F258}		{F258}	QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 258}	Continued From page 65	{F 258}	~~F280 Right to Participate in Care~~ Planning	1/20/17
{F 280} SS=D	revealed Resident #18 made loud noises every day for large parts of the day, except when a staff member was talking with him, or he was asleep. 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, 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to revise the care plan to include interventions for an immobilizer for 2 residents (#12 and #123) and failed to revise the care plan for pressure ulcers for 3 residents (#12, #123, and #54) of 43 residents reviewed. The facility's failure placed residents #12 and #123 in Immediate Jeopardy (a situation in which the	{F 280}	1. **Resident #12** — Immoblizer, Pressure Ulcers: care plan reviewed and revised by the nurse assessment coordinator 12/13/16. **Resident #123** -- Immoblizer, Pressure Ulcers: care plan reviewed and revised by the RN Assessment coordinator on 12/13/16. **Resident #54** — Pressure Ulcers; care plan revised by the RN Assessment coordinator on 12/13/16. 2. Other residents who may be affected were identified by reconciliation of the Weekly Wound and Pressure Ulcer Report and Splint Listing on 12-13-16 by the MDS Coordinators (RNs) to assure care planning in accordance with treatment. This report is provided weekly and will	

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{F 280}	Continued From page 66 facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The Immediate Jeopardy was effective 7/20/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-280 at a "D" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Medical record review revealed Resident #12 was admitted to the facility on 6/15/12 with diagnoses including Aphasia, Chronic Obstructive Pulmonary Disease, Dysphagia, Dementia, Osteoporosis, Hypertension, Impulse Control Disorder, Anxiety, Major Depressive Disorder, and Generalized Osteoarthritis. Medical record review of the Quarterly Minimum Data Set (MDS) dated 6/6/16 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating the resident had a severe cognitive impairment. Continued review revealed the resident was totally dependent for bed mobility and personal hygiene with one person physical assist. Further	{F 280}	continue to serve as basis for care plan audit. 3. • Root cause was identified on 12/13/16 by the Director of Operations and 3 Corporate Clinical Consultants who are RNs, to be the result of care planning related to splint/orthotic application, removal, and care. • Inservice with DON and MDS Coordinators on coding of Section M of MDS and revisions to care plans conducted by Corporate Resident Assessment Specialist on 12-12-16.. • Residents who have splints or related devices were reviewed by the care planning team on 12-13-16 to assure applicable care directives to assure application, removal and care.	

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{F 280}	Continued From page 67 review revealed Resident #12 was totally dependent for transfers and bathing with 2+ person physical assist. Review of a Physician's Progress Note dated 7/20/16 revealed "...Tib/fib [tibia/fibula bones of lower leg] fx [fracture]...Brace noted to LLE [left lower extremity]..." Review of a Physician's Telephone Orders dated 7/21/16 at 11:30 AM revealed "...knee immobilizer to LLE q [every] shift..." Review of the care plan implemented 3/9/16 revealed a care plan revision dated 7/21/16, "...Knee immobilizer to LLE [left lower extremity] as ordered. Check as ordered..." Continued review revealed no other documentation for specific interventions, goals, and outcomes that were time sensitive, including what was to be checked and how often. Review of the LAB (Laboratory) Record (record utilized by the facility to document immobilizer assessments) dated July 2016, revealed "...Leg imobilizer [immobilizer] to LLE check q shift..." Further review revealed no documentation the immobilizer had been checked until 7/26/16 on the 6A-6P shift. Review of the Nursing Supplemental Record dated August 2016 revealed "...Knee immobilizer to LLE, check skin integrity q shift...Order date 7/21/16..." Continued review revealed, "...8/1/16 May continue to wear brace with activity and transfers but can remove @ [at] rest..." Further review revealed no documentation skin integrity was checked on the 8/11/16 6P-6A shift.	{F 280}	• On 1/9/17, the DON began auditing 5 newly processed physician's orders each week to insure care plan is updated when indicated. • All newly hired MDS Nurses and interdisciplinary team members will receive training on "Change in Resident Condition or Status" policy as it relates to care plan update as part of new employee orientation. Interdisciplinary team members include Director of Nursing, Risk Manager, Therapy Director, MDS Nurse, Dietary Manager, Activity Director) 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure	

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{F 280}	Continued From page 68 Review of the resident's care plan revealed no revision to the care plan the leg brace was to be removed at rest. Medical record review of the Quarterly Minimum Data Set (MDS) dated 8/30/16 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 3 of possible 15, indicating the resident had severe cognitive impairment. Continued review revealed the resident was totally dependent for bed mobility, bathing, and personal hygiene with one person assistance. Further review revealed Resident #12 was totally dependent for transfers with 2 plus persons physical assistance and was at risk for developing pressure ulcers. Review of the Nursing Supplemental Record dated September 2016 revealed "...Knee immobilizer to LLE with activity & [and] transfers but can remove @ rest; check skin integrity q shift Order Date: 8/01/16..." Continued review revealed no documentation the skin integrity had been checked on any days in September except the 9/1/16 6A-6P shift. Review of the resident's care plan revealed the care plan was not revised to indicate the immobilizer could be removed at rest or to check the skin integrity every shift. Review of a Progress Note, authored by Nurse Practitioner (NP) #1 and dated 9/23/16, revealed "...pt [patient] with 2 open areas on LLE. Ankle measures 3 x 3 L [left] lateral leg area measures 1 [centimeter] x 4.8 [centimeters]..." Review of the September 2016 Treatment Administration Record revealed "...9-23-16 Clean	{F 280}	adherence to facility policy related to Care Planning and Revisions of Care plan. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: • Right to Participate and Care Plan Revision tool The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued	

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{F 280}	Continued From page 69 area on (L) ankle with NS [normal saline], pat dry apply...[treatment for wounds] et [and] cover with ABD [abdominal] pad et secure with tape... [change] QD [every day]..." Continued review revealed no documentation treatments had been done on 9/25/16, 9/29/16, and 9/30/16. Medical record review of the September 2016 Treatment Administration Record revealed "...9-23-16 Clean area on (L) lower leg with NS pat dry apply...cover with ABD pad et wrap..." Continued review revealed no documentation the treatment had been completed on 9/24/16, 9/29/16 and 9/30/16. Review of the resident's care plan revealed a handwritten revision to the care plan, with no date, "...Staged area to LLE..." Further review of the care plan revealed no specific interventions or treatments for the "staged area," and no time-sensitive goals. Further review revealed no documentation of the stage, character, or size of the "staged area." Medical record review of the Nursing Supplemental Record dated October 2016 revealed "...Remove LLE knee immobilizer brace while in bed, but place it with transfers, check skin integrity Q shift...Order Date: 9/22/16..." Medical record review of the resident's care plan revealed the care plan was not revised to indicate the need to remove the LLE immobilizer while the resident was in bed or to check the skin integrity every shift. Review of a Nurse's Note dated 10/1/16 at 5:00 PM, revealed "...leg and ankle small amount of drainage and blood noted..." Further review	{F 280}	need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 280}	Continued From page 70 revealed a note on 10/2/16 at 8:00 AM, "...leg and ankle small amount of drainage and blood noted. Foul odor...NP made aware and N.O. [New Order] Doxycycline [antibiotic]...for wound infection..." Review of the Physician's Progress Note dated 11/22/16 revealed "...out of immobilizer which was causing wounds." Interview with Resident #12's Physician on 12/2/16 at 3:55 PM, in the conference room, confirmed the pressure ulcers should have been discovered at a Stage 1 and Stage 3 pressure ulcers would take 2-5 days to develop. Further interview confirmed the pressure ulcers could have been avoided if the skin had been checked every shift. Interview with the Treatment Nurse on 12/5/16 at 9:15 AM, at the 100/200 nurses station, confirmed on 9/23/16 a CNA discovered 2 pressure ulcers to Resident #12's left shin and ankle during a shower and reported those to the treatment nurse. Continued interview revealed it was the nurses responsibility to check the skin when "check skin integrity" was ordered. Telephone interview with Licensed Practical Nurse (LPN) #15 on 12/5/16 at 8:38 PM, confirmed she did not remove the brace every shift and look at the skin. Telephone interview with LPN #11 on 12/5/16 at 8:52 PM, confirmed the LPN did not check the skin integrity every shift. Interview with RN #5 on 12/7/16 at 12:53 PM in the conference room confirmed the MDS nurses	{F 280}		

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{F 280}	Continued From page 71 were responsible for the updates on the care plan. Medical record review revealed Resident #123 was admitted to the facility on 10/18/16 with diagnoses including Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia, Anemia, Right Quadriceps Tendon Rupture and Repair and Chronic Obstructive Pulmonary Disease (COPD) with home oxygen. Medical record review of Resident #123's Care Plan dated 10/18/16 revealed " ...Potential for skin breakdown...Weekly skin assessment...Treatments as ordered...Rt [right] knee immobilizer as ordered..." Medical record review of a Daily Skilled Nurses Note dated 11/13/16 at 12:00 AM, revealed "...brace on R [right] leg, Brace is off due to rubbing quarter size area (open) to [lower] calf area, to have tx [treatment] nurse address..." Medical record review of a Wound and Skin Status Report revealed the wound was documented as identified on 11/15/16, and was the same wound identified in the nurses notes dated 11/13/16. Continued review revealed the right calf wound was a Stage 1 (defined by the MDS as intact skin with non-blanchable redness of a localized area usually over a bony prominence) and measured 1.5 x 2.3 x 0.0 (unit of measurement not identified, but usually in centimeters [cm]) on 11/17/16. Medical record review of a Wound Assessment	{F 280}		

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{F 280}	Continued From page 72 Report dated 11/17/16, revealed the wound type was a pressure ulcer; the location of the wound was the right calf; it was Stage 1 with measurements of 1.50 cm length x 2.30 cm width; and there was no description of the wound. Medical record review of an Interdisciplinary Progress Noted dated 11/18/16, revealed "...res [resident] with area to back of R calf 1.5 cm x 2.3 cm Stage 2 [defined by the MDS as partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.] Resident with new brace..." Medical record review of an Interdisciplinary Disciplinary Team (IDT) progress note dated 11/23/16, revealed "...area to the back of R calf noted to be scabbed, daily application of medihoney, et [and] wrap with kerlix [gauze dressing wrap]..." Medical record review of a Physicians Order dated 11/30/16, revealed "Clean area on back of R lower extremity with NS [normal saline] pat dry. Apply polymem [medicated dressing treatment] et cover with dry dsg [dressing] et wrap with kerlix change Tues, Friday." Interview with the DON on 12/1/16 at 8:30 AM, in the resident's room, confirmed the pressure ulcer was now unstageable due to the slough in the wound bed. Interview with the Treatment Nurse on 12/5/16 at 9:15 AM, in the conference room, confirmed the care plan for Resident #123 was not revised to include a pressure ulcer, treatments or	{F 280}		

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{F 280}	Continued From page 73 interventions, or time-sensitive goals. Medical record review revealed Resident #54 was admitted to the facility on 6/9/14, and re-admitted on 7/8/16, with diagnoses including Dementia, Chronic Obstructive Pulmonary Disease, and Bladder Disorder. Continued medical record review revealed the resident was on hospice and expired on 8/20/16. Medical record review of a Nurse's Note dated 7/8/16 revealed "...Scratch to R hip 2.5 x 0.3 cm and 0.9 x 0.4 cm..." Medical record review of the Admission Minimum Data Set (MDS) dated 7/13/16 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 2, indicating the resident was severely cognitively impaired. Continued review revealed the resident was totally dependent for bed mobility, transfers, personal hygiene, and required 1 person assist with bathing, and extensive assist with eating. Further review revealed Resident #54 had a Stage 1 or higher pressure ulcer identified upon admission to the facility. Medical record review of the Care Plan dated 7/14/16 revealed "...potential for increase in further skin breakdown...was admitted with staged area to Rt [right] buttocks...Weekly skin assessment...Treatment as ordered..." Medical record review of the Nursing Weekly Summary dated 7/31/16 revealed "...Ongoing tx [treatment] Rt hip..." Medical record review of the Wound Healing Progress Report revealed "...Measurement of	{F 280}		

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{F 280}	Continued From page 74 Wound Identified...blister Right Hip...0.6 [centimeters] x 3.60... 8/01/2016 [date the measurement was obtained]..." Medical record review of the Wound Assessment Report dated 8/5/16 revealed "...blister...Right hip...Cause Unknown..." Medical record review of the Wound Healing Progress Report revealed the blister on the right hip was documented as 2.8 x 3.30 on 8/12/16 (increase in size from 8/5/16). Medical record review of a Physician Telephone Order dated 8/16/16 revealed "...Clean area on R hip with NS [normal saline] pat dry...Apply medihoney [wound care dressing with honey] and cover with dry drsing [dressing] M/W/F [Monday, Wednesday and Friday] and prn..." Medical record review of the Nurses Note dated 8/16/16 revealed "...R hip area noted to have slough [a mass of dead tissue separating from an ulcer]..." Medical record review of the Resident #54's care plan revealed the care plan did not include the identification of the right hip blister or interventions to treat and prevent a decline in the wound. Interview with the Director of Nursing (DON) on 12/6/16 at 8:34 AM, in the conference room, confirmed "...A blister is a stage 2..." (pressure ulcer). Interview with the Treatment Nurse on 12/6/16 at 12:55 PM, in the conference room, confirmed a Stage 2 pressure ulcer would require	{F 280}		

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{F 280}	Continued From page 75 interventions. Interview with RN #5 on 12/7/16 at 12:53 PM, in the conference room, confirmed the facility failed to revise Resident #54's care plan to include the right hip blister (a Stage 2 pressure ulcer). Refer to F-314 Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records dated 12/12/16 and 12/13/16 revealed 100% of the nursing staff were educated regading implementation and revision of care plans. On 12/12/16 the MDS nurses recieved education regarding MDS assessments and revising care plans to reflect the resident's current condition. 2. Verification through interviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN] and MDS Coordinators) was conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and confirmed the staff's understanding of implementation and revision of care plans per the education received and based on the MDS assessment. 3. Review of 19 resident records conducted on 12/19/16-12/21/16 revealed the residents' care plans had been revised and the current plans contained appropriate and specific areas which were triggered by the MDS assessment.	{F 280}		

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{F 280}	Continued From page 76 4. Observations on 12/19/16 through 12/21/16 revealed Resident #12 had the knee immobilizer in place and applied correctly. Further observation of the resident's wound revealed the wound had healed. 5. Verification through medical record review, observation, and interview, revealed the Weekly Wound and Pressure Ulcer Report and Splint Listing dated 12/13/16 revealed all residents with wounds or splint devices were correctly listed on the report. The report is provided weekly and reviewed by the interdisciplinary care team to ensure all wounds are identified by the direct care team and a care plan is implemented. 6. Verification with the Director of Nursing (DON) was completed on 12/20/16 at 10:30 AM, in the conference room, and revealed audits are conducted by the nursing staff to include 5 physicians orders or changes in condition 5 times per week. The Corporate team conducts oversight of the audits. Follow-up interviews with the Cooporate Nurses on 12/21/16 at 10:30 AM, in the conference room, confirmed Corporate follow-up was in process and ongoing. The facility remains out of compliance at a Scope and Severity level "D" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 280}		
{F 285} SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review	{F 285}		

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{F 285}	Continued From page 77 program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a	{F 285}	**F285 PaSRR Requirements** 1. PASRR resubmitted on 12-14-16. A new PaSRR was returned on 12/29/16. 2. An audit was conducted of 100% current resident population to to assure PASRR in place. Those that were absent from clinical record were requested by LTC.ops@TN.gov and resubmitted on 1-20-17. 3. Beginning 1/2/17, Social Services will review medical record of all NEW ADMISSIONS to assure valid PASRR in place prior to admission weekly x 4 weeks unless otherwise determined by the QA committee. • Educational Requirements for newly hired staff in relation to this deficiency is completed during the orientation process. If for any unforeseen reason this	1/20/17

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{F 285}	Continued From page 78 related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for 1 resident (#18) of 1 sampled resident, of 6 residents receiving health rehabilitative services for mental illness and or intellectuality developmentally disabled (MI/ID/DD) residents. The findings included: Medical record review revealed Resident #18 was admitted to the facility on 6/30/03 and readmitted on 12/2/15 with diagnoses including Athetoid Cerebral Palsy (a movement disorder caused by damage to the developing brain), Epilepsy, Profound Severe Intellectual Disabilities, Visual Loss Both Eyes, Psychotic Disorder with Hallucinations and Agitation, Schizoaffective Disorders, Major Depressive Disorder, Anxiety Disorders, Skull Deformity, Down's Syndrome, Neurocognitive Impairment, and Severe Mental Retardation with Self Harming Behaviors. Medical record review revealed a PASRR dated July 2003. Continued review of the PASARR MR summary of findings dated 2/14/2005 revealed "...recipient's mental retardation or developmental disability does not require specialized services Rational: This individual has CP (Cerebral Palsy) Down Syndrome and Seizures. Due to the overall level of functioning, he would not benefit from specialized services..."	{F 285}	does not occur, the employee will be not be assigned. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to obtaining PASRR prior to admission of residents. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o PASRR Requirement tool The QA committee will review the cumulative results of the daily audits noted. QA	

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{F 285}	Continued From page 79 Medical record review of a psychiatry consultation report from an outside acute care facility dated 12/1/15 revealed "...severe intellectual disability...has had history of agitation, aggression, and combativeness, which required restraints...is psychiatrically and mentally and emotionally disabled overall...long psychiatric history of neurocognitive impairment and intellectual disability...psychoses...anxiety, and delusional and paranoid psychosis...has seizure disorder, Down syndrome, severe intellectual disability, psychiatric issues, blindness of both eyes...inability to take care of himself overall...thought processes are illogical, nonlinear, and not goal directed...impulse control is poor. Judgment and insight are poor. Intelligence is severely profoundly below average. Communication and language skills are, otherwise, minimal...in terms of his complicated mental health, he has profound MR [mental retardation]...staffing states that he has also been agitated and aggressive to the point where he starts kicking and hollering..." Medical record review of a physician discharge summary from the acute care facility dated 12/2/15 revealed "...aggressive type unsocialized behavior disorder...profound mental retardation (I.Q. below 20)...severe intellectual disability from Down's Syndrome...blindness both eyes..." Medical record review of a physician progress note dated 12/4/15 revealed "...readmission H&P [history and physical]...severe intellectual disability form Down syndrome, epilepsy, blindness...depression...has been a resident...since 2003. He was transferred to [acute care facility] for evaluation and treatment due to his increasingly disruptive behaviors,	{F 285}	~~Committee consists of DON,~~ NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 285}	Continued From page 80 yelling out, and cursing. He was evaluated by psychiatry and Depakote [mood stabilizer medication] was added to his medication regimen as well as prn [as needed] Haldol [an antipsychotic medication used to treat certain types of mental disorders]...manage behaviors medically and with behavioral plan...I feel that he might be better suited in a smaller environment such as a group home, and I will discuss this possibility...he needs nursing home care..." Medical record review of a physician progress note dated 9/7/16 revealed "...seeing patient today to follow up on staff concerns that patient has increased agitation and screaming out. He continues to come out into the hallway and roll around in the floor...his irritability has increased...still screams out intermittently. There is great concern that his is a danger to himself because of his repeated behaviors...his safety has become a concern. All prior attempts at medication changes have been unsuccessful at changing his behaviors...patient is lying on the floor in his room...he is continually yelling out and grunting loudly...behavior disorder-due to severe increase in agitation, I feel that we need to seek impatient care for patient. I will have our psych NP [psychiatric nurse practitioner] evaluate him and we will try to expedite an inpatient psychiatric stay for him locally. I feel that we have exhausted our resources in trying to manage his agitation here...severe mental retardation with self-harming behaviors...I feel that he would be much better suited in an environment where more 1:1 type care can be provided as this seems to help his behaviors..." Medical record review of a psychiatric progress note dated 9/7/16 revealed "...pt. [patient] has	{F 285}		

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{F 285}	Continued From page 81 increasingly become more of a danger to himself...pt's safety is a concern...pt screams continuous (grunts) often. More recent any diversional activities have not been successful...Hopefully pt can find placement in appropriate environment-group home..." Medical record review revealed the only other PASRR form since the original 2003 submission was dated 9/26/16 and revealed Resident #18 had "...severe agitation...yells & [and] screams loudly for a long period of time...resident screams & yells causing exhaustion...continues screaming continuous for hours..." Further review revealed submission was not completed when the resident had the significant change in behaviord December 2015. Interview with Licensed Practical Nurse (LPN) #14 (who works in medical records) on 12/2/16 at 3:30 PM in the conference room, confirmed she had faxed a new PASRR to the State PASRR Coordinator on 9/26/16 for a change in status/decline, but had not received a response back since the submission.	{F 285}		
{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	{F 309}	**F309 Provide Care/Services for Highest well-being** **1.** **Resident #20-** was evaluated by the physician on 12/13/16 with no change to current plan of treatment related to dialysis.	1/20/17

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{F 309}	Continued From page 82 by: Based on medical record review, observation, interview, and facility policy review, the facility failed to provide wound assessment and treatment for 3 (#123, #145, and #170) residents of 3 residents reviewed for non-pressure wounds; failed to obtain weights as ordered for one resident with Congestive Heart Failure (#55); and failed to follow facility policy for taking pre-and post (before and after) vitals signs and monitoring of a dialysis catheter for 1 (#20) of 1 resident reviewed for dialysis, out of 43 residents reviewed. The facility's failure to provide assessment and treatment placed Residents #123 and #145 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death). The facility was cited F-309 at a scope and severity of "J" which constitutes Substandard Quality of Care. The Immediate Jeopardy is effective 10/27/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-309 at a "D" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility.	{F 309}	~~Resident #55 - was evaluated~~ by the nurse practitioner on 12/8/16 with no change in plan of treatment noted. **Resident #123** - Had an orthopedic appointment on October 27, 2016 and the brace was subsequently changed and treatment orders were initiated. Nurse Practitioner examined resident on December 7, 2016 and resident continues treatment as ordered. NP documented in agreement with the wound care treatment plan. **Resident #145** Resident was assessed by the Nurse Practitioner on 12/5/16. Reassessed on 12/7/16 by the Nurse Practitioner who approved wound management treatment plan. **Resident #170** Resident was assessed by the Nurse Practitioner on 12/5/16 r/t	

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{F 309}	Continued From page 83 The findings included: Medical record review revealed Resident #123 was admitted to the facility on 10/18/16 with diagnoses including Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia, Alcohol Abuse, Mitral and Aortic Valve Replacements, Anemia, Right Quadriceps Tendon Rupture and Repair, and Chronic Obstructive Pulmonary Disease (COPD) with home oxygen. Medical record review of the resident's care plan dated 10/18/16, revealed "...Potential for skin breakdown...Surgical incision...Weekly skin assessment...Treatments as ordered...Assist resident with repositioning as need for comfort and pressure relief...Rt [right] knee immobilizer as ordered..." Medical record review of a Physician's Order dated 10/21/16, revealed "...Please arrange appt [appointment] with [orthopedic doctor] ASAP [as soon as possible]...Clean surgical incision to R [right] knee with betadine, apply ABD [large wound dressing] wrap with...[named guaze] change QD [every day]..." Medical record review of a Wound Assessment Report dated 10/21/16 revealed "...Wound Type...Surgical Incision...Measurements Length 10.0 cm [centimeters] Width 0.00 Depth 0.00...Wound Bed Epithelial Tissue 100%...Incision Detail closed, healing. Staples present and intact..." Medical record review of an Orthopedic doctor's	{F 309}	rectal bleeding w/loose stools. Treatment initiated. Resident was assessed by the physician on 12/6/16 related to alteration in skin integrity and rule/out C-Diff; Resident was only positive for antigen; not toxin. Symptoms have subsided. 2. Residents having the potential to be impacted were identified by the following review: o Body audit was conduct by licensed nurses on all residents on 12/6/16 and 12/7/16 to assure wound assessment and treatments were properly executed on the treatment record. o Review of all residents receiving dialysis services by the Corporate RN on 12/13/16.	

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{F 309}	Continued From page 84 note dated 10/27/16, revealed "...His incision does have some eschar at the midportion...He will need to start twice daily Betadine dressing changes..." Medical record review of a Physician's Order dated 10/27/16, revealed "Twice daily Betadine dressings until seen back by [Orthopedic doctor]." Medical Record review of a Treatment Administration Record dated October 2016 revealed a dressing order dated 10/27/16 "Twice Daily Betadine dressing until seen by [Orthopedic Doctor] 11/3/16..." with 7 of 10 treatments not documented as completed between 10/27/16 through 10/31/16. Medical record review of a Wound Assessment Report dated 10/28/16, revealed "...Wound Type...Surgical Incision...Measurements Length 10.0 cm [centimeters] Width 0.00 Depth 0.00...Wound Bed Epithelial Tissue 100%...Incision Detail closed, healing. Staples present and intact..." Medical record review of an Orthopedic Doctor progress note dated 11/3/16, revealed "...He does have some erythema around eschar site at the middle third of his incision...Continue with twice daily Betadine dressing changes until that followup appointment..." Medical record review of a Wound Assessment Report dated 11/4/16, revealed "...WoundType...Surgical incision...Measurements Length 10.0 cm [centimeters] Width 0.00 Depth 0.00...Wound Bed Epithelial Tissue 100%...Incision Detail closed, healing. Staples present and intact..."	{F 309}	o Review of the weights of current residents was conducted on 12/10/16 by the Dietary Manager. Residents with weekly weights were reconciled with physician order. 3 • Root cause was conducted on 12/13/16 by the Director of Operations and 3 Corporate clinical consultants who are RNs, analysis revealed that assignments were not clearly defined as it relates to obtaining, weekly skin assessments, weights and dialysis communication. • A body audit of all current residents was conducted on 12/06 and 12/07/2016 by LPN charge nurses, the DON, Risk Manager, RN MDS coordinator and 2 RNs from sister facility. DON reconciled	

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{F 309}	Continued From page 85 Medical record review of a Physician's Order dated 11/8/16 revealed "...Rocephin [antibiotic] 1 gm [gram] IV [intravenous] daily x 7 days-Wound infection..." Medical record review of the Minimum Data Set (MDS) dated 11/15/16 revealed Resident #123 had a BIMS score of 15 out of a possible score of 15, indicating the resident was cognitively intact. Further review revealed the resident required limited assistance of 1 staff for bed mobility, personal hygiene, bathing and eating. Further review revealed the resident had a surgical incision. Medical record review of a Treatment Administration Record dated November 2016 revealed a dressing order dated 10/21/16 "...Clean Surgical Incision To RT Knee with Betadine, Apply ABD Pad & [and] Wrap with Kerlix, Change BID..." Further review revealed 27 of 60 treatments were not documented as completed 11/7/16 through 11/30/16. Medical record review of an Orthopedic Nurse Practitioner (NP) progress note dated 11/14/16 revealed "...He has a little eschar in the center...okay for us to remove the staples at this point...and apply Steri-Strips..." Medical record review of a Wound Assessment Report dated 11/17/16 revealed "...Wound Location Right Knee...Measurements Length-3.90 cm...Width- 0.00 cm Depth 0.00 cm...Wound Bed Granulation Tissue 75% Eschar 25%...Incision Detail Wound dehiscence [wound rupture along surgical line] noted-minor...Notes Staples removed from knee at Ortho	{F 309}	wound report to individual treatment records to assure treatment and care planning in place. All baseline-skin assessments were completed on December 8, 2016 and reconciled with existing treatment orders/wound report. One Stage 2 wound was identified with treatment orders obtained. • Written weight schedule was reviewed by the Director of Nursing on 12/12/16 and provided to restorative team, who is responsible for obtaining weights, on 12-12-16. • Compliance with obtaining weekly or monthly weights will be assured by the Dietary Manager. Beginning 12/10/16, the Dietary Manager receives weights obtained by the Restorative aides for recording in the computer on weight record. Weights not obtained are identified and reported to	

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{F 309}	Continued From page 86 appointment, steri strips intact, wound dehisced in mid incision line, scant amount of drainage noted..." Medical record review of an Interdisciplinary Progress Note dated 11/23/16 revealed "...reviewed current surgical incision, area noted to improve dehised [dehiscence] area noted to be scabbed, steri strips in place..." Medical record review of a Wound Assessment dated 11/25/16, revealed "...Wound location Right Knee...Measurements Length 2.80 cm Width 0.00 cm Depth 0.00 cm...Wound Bed Granulation Tissue- 100.00 %...Incision Detail Closed, healing. Steri-strips present and intact... Medical record review of a Wound Assessment Report dated 12/2/16 revealed "...Wound Location Right Knee...Measurements Length- 2.5 cm Width- 0.4 cm Depth 0.00 cm...Wound bed Granulation Tissue- 75.00 % Eschar- 25.00 %...Incision Detail Open/healing by secondary intension..." Observation of the Treatment Nurse changing the resident's right knee dressing on 12/6/16 at 5:00 PM, in the resident's room, revealed the old right knee dressing that was removed by the treatment nurse was dated 12/6/16. Continued observation revealed the right knee had black tissue (eschar) and the surrounding skin was slightly reddened. During the wound treatment the Treatment Nurse mesured the wound and stated that the wound mesured 2.1 cm x 5.3 cm. Medical record review of a Wound Assessment Report dated 12/7/16 revealed "...Wound Location Right Knee...Measurements Length-5.30	{F 309}	~~the Director of Nursing for~~ immediate action. Once recorded; the Dietary Manager submits the weight trending report to the Director of Nursing for further evaluation. • Dialysis Communication Sheet reviewed and placed at Nurses station on 12-13-16 and was highlighted to include vital signs required on specified residents both pre and post dialysis. • Licensed Nurses were trained on the dialysis form by Risk Manager on 12-9-16 and the Corporate RN. On 12-13-16. Compliance will be assured by the Director of Nursing by review of the post dialysis form. This audit is completed on a weekly basis and began on 12/13/16. The Medical Records Coordinator (LPN) was assigned to on-going audit completion of weekly skin	

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{F 309}	Continued From page 87 cm Width- 3.00 cm...Wound bed Eschar-100.00%...Length of wound separation 5...Notes Steri strips in place, resident had shower, steri strips came off, wound dehisced noted, surrounding skin red..." Interview with the Director of Nursing (DON) on 12/6/16 at 8:13 AM, in the conference room, confirmed a wound assessment was not completed for the week of 11/11/16. Further interview confirmed the wound assessments were to be completed weekly. Interview with Registered Nurse (RN) #1 on 12/6/16 at 9:50 AM, in the 100 hall, confirmed there were times she was unable to complete treatments and dressing changes as ordered by the physician. Further interview confirmed she reported treatments not done to the next shift. Interview with the Treatment Nurse on 12/6/16 at 5:10 PM, in the 200 hallway, confirmed the wound assessment and measurements were not completed for the week of 11/11/16. Further interview confirmed the meaurements of the right wound performed on 12/2/16 were 2.5 cm x 0.4 cm. Continued interview confirmed the measurements during observation of the dressing change on 12/6/16 were 2.1 cm x 5.6 cm. Further interview confirmed the resident had a shower last night and went to an orthopedic appointment yesterday (12/5/16). Continued interview confirmed the wound had steri strips covering most of the wound and the Treatment Nurse was measuring the areas of the wound she could visualize only. Continued interview confirmed the wound measurements were inaccurate. Further interview confirmed the steri strips were now off so the current measurement was 2.1 cm x 5.6	{F 309}	assessment as a QA Initiative. Assessments found not to have been completed will be reported to the Director of Nursing, or, in her absence, the Nursing Home Administrator, for immediate assignment. • Weekly Skin Assessment Schedule was revised on 12/7/16 by the Director of Nursing and posted on the units. All licensed Staff was in-serviced on requirement to complete body audits per schedule by the Director of Nursing between 12-7-16 and 1-18-17. • Audit of completion of **skin assessments** began on 12/7/16 by the Medical Records Director (LPN) who conducts this audit daily x 5 days per week. Results will be reviewed by the Director of Nursing to assure compliance with goal of 100% completion of weekly skin assessment per	

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{F 309}	Continued From page 88 cm. Interview with the Physician on 12/6/16 at 5:20 PM, at the 100/200 nurses station, confirmed Resident #123's knee incision had eschar. Continued interview confirmed if dressing changes and treatments to the wound were not completed as ordered, it could delay healing of the wound. In summary the facility failed to provide care and services for Resident #123's wound as evidenced by a missing wound assessment for the week of 11/11/16 and discrepencies of wound measurements and wound descriptions by the Treatment nurse on 10/28/16 and 11/4/16, with no documentation of eschar. The Resident's Orthopedic Surgeon and Nurse Practitioner's notes on 10/27/16 and 11/3/16 showed documentation of eschar to the wound. During observation of the resident's wound on 12/6/16 with the Treatment Nurse, she stated the wound measurements were 2.1 cm x 5.3 cm. Review of the Wound Assessment dated the following day, 12/7/16 revealed documentation of wound mesurements of 3.0 cm x 5.3 cm. Review of the Treatment Administration Record revealed 34 of 70 missed treatments from 10/27/16-11/30/16, and the resident's wound had a decline. Medical record review revealed Resident #145 was admitted to the facility on 8/25/16 with diagnoses including: Peripheral Vascular Disease, Right above the Knee Amputation (R AKA), Left below the Knee Amputation (L BKA), Congestive Heart Failure and Diabetes Mellitus. Medical record review of the care plan dated 9/2/16 revealed "...admitted with...recent surgical	{F 309}	established assignment. 100% Audits will remain ongoing x 8 weeks to achieve our goal of 100% compliance of completed skin audits; once goal is achieved audit will be reduced to 10 random per week x 6 weeks then monthly x three months. • The Risk Manager (RN) is conducting 3 **wound audits** per day, 5 x per week to affirm accuracy of wound assessment performed by the treatment nurse. Accuracy Audits began on 12-15-16. Audits will remain ongoing x 8 weeks to achieve our goal of 100% compliance of accuracy of wound assessment; once goal is achieved audit will be reduced to 10 random per week x 6 weeks, then monthly x three months. • All newly hired licensed nurses will receive training	

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{F 309}	Continued From page 89 incisions with recent Rt. [right] amputation with...weekly skin assessment, treatments as ordered..." Medical record review of the 60 Day MDS dated 10/22/16 revealed Resident #145 had a BIMS score of 15 out of a possible 15 which indicated he was cognitively intact. Continued review revealed the resident was totally dependent for transfers with 1 person assist and required extensive assist for personal hygiene and bathing with 1 person assist. Further review revealed identification of the surgical wounds. Medical record review of the wound assessment reports for the R BKA and the L BKA revealed 15 out of 30 assessments for 8/25/16 through 12/7/16 were not completed. Medical record review of the physician's orders dated 10/12/16 revealed "...Clean LLE [left lower extremity] stump with NS [normal] saline...apply... [wound dressing]...change Q [every] day..." Medical record review of the Treatment Administration Record dated 11/2016 revealed the treatments to the left lower extremity stump and the right hip (R BKA) wound had not been initialed as having been completed for 5 out of 30 days (11/12/16, 11/13/16, 11/19/16, 11/26/16, and 11/27/16). Medical Record review of the telephone order dated 11/15/16 revealed "...culture wound of (L) [left] stump...Doxycycline (antibiotic) 100mg PO [by mouth] BID [twice daily] X [times] 10 days. Bacid PO Q Day X 14 days..." Medical record review of the wound culture dated	{F 309}	~~on completion of the Dialysis~~ Communication Sheet and required assessment of the dialysis resident and completion of weekly wound assessment (body audit). All newly hired restorative aides will be trained in obtaining of weights per schedule established by the Licensed Nurses. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to the provision of wound assessment and treatment, obtaining weight, as ordered, and assessment of the dialysis resident per communication sheet. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir,	

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{F 309}	Continued From page 90 11/18/16 revealed "...Source, Wound Stump Left...Critical result called to...MRSA [Methicillin Resistant Staphylococcus Aureus]..." Medical record review of the telephone order dated 11/18/16 revealed "...D/C [discontinue] Doxycycline. Gentamicin IM [intramuscular] X 7 days for MRSA wound infection..." Medical record review of the wound assessment report for the L BKA revealed on 8/26/16 the wound measured length (L) 2.5 cm (centimeters) by (X) width (W) 2.2 cm X depth (D) 0.8 cm. Medical record review of the wound assessment report for the L BKA revealed on 11/4/16 the wound measured L 0.9 cm X W 1.00 cm X D 0.0 cm. Medical record review of the wound assessment report for the L BKA revealed on 11/18/16 the wound measured L 1.2 cm X W 1.2 cm X D 0.0, an increase in size from 11/4/16. Medical record review of the wound assessment report for the L BKA revealed on 12/6/16 the wound measured L 1.8 cm X W 2.3 cm X D 0.7 cm, an increase in size from 11/18/16. Medical record review revealed there were no wound assessment measurements completed between 11/4/16 and 11/18/16. The wound had increased in size and had developed an infection. Telephone interview with Licensed Practical Nurse (LPN) #10 on 12/3/16 at 2:05 PM revealed on 11/14/16 she had changed Resident #145's 2 dressings. Continued interview revealed the dressings were dated 11/10/16 and 11/11/16 and	{F 309}	Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Wound accuracy of assessment audit conducted by the Risk Manager o Dialysis Communication audit reported by the Director of Nursing o Weight Reconciliation as reported by the Dietary Manager The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet	

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{F 309}	Continued From page 91 were ordered to be changed daily. Further interview revealed she had provided a written statement to the Director of Nursing (DON) and was also signed by LPN #13 as a witness to the dates on the dressings. Telephone interview with LPN #13 on 12/6/16 at 4:30 PM, confirmed she had witnessed Resident #145's dressings on 11/14/16 were dated 11/10/16 and 11/11/16 and were ordered to be changed daily. Interview with the Treatment Nurse on 12/7/16 at 3:20 PM in the conference room, confirmed she did not have any measurements for the wounds for Resident #145 between 11/4/16 and 11/18/16. Continued interview revealed "...if I work a cart [medication cart] I do the treatments on that hall only...the other nurses are supposed to do their treatments..." Further interview confirmed the treatment nurse was assigned to provide nursing care to residents when a staff nurse was not available to provide services. Interview with Resident # 145 on 12/6/16, in the 200 hall way revealed if the treatment nurse was not working, Resident #145's dressing did not always get changed every day as ordered. Interview with the DON on 12/5/16 at 11:15 AM, in the conference room when asked if she was aware of treatments were not being completed as ordered she stated "...knew there were holes in the MARS/TARS [medication administration records/treatment administration records]..." Interview with the Physician on 12/7/16 at 2:15 PM, in front of the building confirmed the dressing not being changed to the L BKA for 2 days would	{F 309}	Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 309}	Continued From page 92 contribute to the wound becoming infected. Medical record review revealed Resident #170 was admitted to the facility on 11/3/16 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus Type 2, Major Depressive Disorder, Anxiety Disorder, Hypertension, Chronic Diastolic Heart Failure, Pressure Ulcer of Sacrum, Chronic Kidney Disease, and Urinary Tract Infection. Medical record review of a physician order sheet dated 11/4/16 revealed orders for "...weekly skin assessment...bilateral nephrostomy tube site care q [every] shift & PRN [as needed]..." Medical record review of an acute care facility History and Physical (H&P) dated 11/23/16 revealed "...recent bilateral ureteric stents placement and bilateral nephrostomy tube placement done by interventional Radiology on 10/25/16..." Medical record review of a Treatment Administration Record (TAR) for November 2016 and December 2016 revealed bilateral nephrostomy tube site care was to be provided every shift 11/4/16 through 12/5/16, for an opportunity of 65 treatments. Continued review revealed the treatments were not documented as completed for 30 of those opportunities on the following dates: Day shift on 11/11/16, 11/13/16, 11/14/16, 11/19/16, 11/20/16, 11/22/16, 11/26/16, 11/27/16, and 12/2/16; Night shift on 11/7/16, 11/8/16, 11/9/16, 11/10/16, 11/11/16, 11/12/16, 11/14/16, 11/15/16, 11/16/16, 11/17/16, 11/18/16, 11/19/16, 11/21/16, 11/22/16, 11/26/16, 11/27/16, 11/30/16, 12/1/16, 12/2/16, 12/4/16, and 12/5/16.	{F 309}		

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{F 309}	Continued From page 93 Medical record review of a Nurse Practitioner (NP) Progress Note dated 11/8/16 revealed "...F/U [follow up] on report of R) [right] nephrostomy tube site red and painful..." Medical record review of a care plan dated 11/10/16 revealed "...Resident desires to be free from s/sx [signs and symptoms] of infection through next review...Monitor skin for reddened or excoriated areas...Potential for increase in skin breakdown...weekly skin assessment...treatments as ordered...bilateral nephrostomy tube site care as ordered..." Medical record review of a NP progress noted dated 11/15/16 revealed "R) nephrostomy tube purulent drainage. F/U on report of pt having green purulent drainage from R) nephrostomy tube site. Moderate amt [amount] noted..." Medical record review of the Interdisciplinary Progress Notes dated 11/23/16 revealed "...nephrostomy care to bil [bilateral] nephrostomy sites..." Medical record review of a NP progress noted dated 11/29/16 revealed "...Nephrostomy site redness. Pt [patient] /c [with] yeast around R) nephrostomy site..." Telephone interview with Licensed Practical Nurse (LPN) #10 on 12/3/16 at 2:05 PM confirmed she changed the dressing on 11/13/16 for the bilateral nephrostomy tubes and the date on the dressing she removed was 11/8/16. Further interview confirmed she informed the Director of Nursing (DON) regarding this finding of the dressing not being changed for 5 days, on the morning of 11/13/16, before she left her shift,	{F 309}		

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{F 309}	Continued From page 94 and was instructed by the DON to "...write a statement and leave in her office..." Revie of a hand written signed statement by LPN #10 revealed "...bilateral nephrostomy tubes /c dressings to be changed due to drainage, which was heavily saturated /c odor, dated 11/8/16...all were dated 11/8/16..." LPN #10 changed the dressing on 11/13/16. Interview with LPN #13 by telephone on 12/6/16 at 4:30 PM confirmed she did the treatments as ordered but "...have to stay over every day to get done..." Interview with Registered Nurse (RN) #1 on 12/6/16 at 5:19 PM at the 100/200 nursing station confirmed if she "...did not sign on any of those days..." she didn't do the treatment by "...passed it off to the night shift for them to do..." Review of a facility weight policy, undated, revealed "...all new admissions are weighed weekly x [times] 4 weeks...If there is a 5 pound discrepancy then the resident must be re-weighted on the next business day with a licensed nurse verifying that weight..." Medical record review revealed Resident #55 was admitted to the facility on 6/4/16 and readmitted on 9/2/16, 9/3/16, 9/25/16, and 10/29/16, with diagnoses including Chronic Atrial Fibrillation (a-fib), Chronic Respiratory Failure, Congestive Obstructive Pulmonary Disease (COPD), Clostridium Difficile (C-diff), Morbid Obesity, Congestive Heart Failure (CHF), and Chronic Kidney Disease (CKD).	{F 309}		

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{F 309}	Continued From page 95	{F 309}		

Medical record review of a care plan dated 6/10/16 and revised 10/29/16 revealed "...potential for significant weight change & [and] dehydration d/t [due to] resident morbidly obese...weigh resident, record results and report any significant changes to physician and dietician...9/4/16 daily weight as ordered..."

Medical record review of a nursing note dated 9/2/16 at 8:00 AM revealed "...restorative nursing informed this nurse that resident has went from 360 lbs on August 3rd to 435 lbs today..."

Medical record review of a nursing note dated 9/3/16, untimed, revealed "...readmitting...426.8 lbs..."

Medical record review of a nursing note dated 9/4/16, untimed, revealed "...resident's weight was 419 lbs this am..."

Medical record review of the Physician's orders revealed an order dated 9/4/16 for Resident #55 to be weighed daily due to fluctuating weights and a diagnosis of CHF.

Medical record review of the weight sheet from 6/3/16 through 12/1/16 revealed between 9/4/16 and 10/14/16, (41 days), the resident was in an acute care facility 4 days of the daily weights (leaving 37 days) and 8 days during the weekly weights. Medical record review of the daily weights revealed the weights were obtained 18 days and a total of 19 daily weights were not documented. Review of the weight sheet revealed no weights documented on the following days and the amount of weight change were as follows: missed weights on 9/5/16, 9/6/16, 9/7/16,

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{F 309}	Continued From page 96 9/8/16 with a 12.5 lbs (pounds) weight loss in 5 days; on 9/14/16 and 9/15/16 with a 3.2 lbs weight gain in 3 days; and on 9/17/16, 9/18/16, 9/19/16 with a 17.6 lbs weight gain in 4 days. Medical record review of a nursing note dated 9/20/16 at 11:30 AM revealed "...wt [weight] gain noted..." Medical record review revealed the resident was in an acute care facility from 9/22/16 through 9/25/16. Medical record review of a Physician's order dated 9/25/16 revealed "...daily weight d/t chf & fluctuating weights..." Medical record review of the weight sheet revealed no weights documented on the following days and the amount of weight change were as follows: 9/26/16, 9/27/16, and 9/28/16 with an 18.4 lbs weight loss in 8 days; on 10/1/16 with a 14.6 lbs weight gain in 1 day; on 10/3/16 and 10/4/16 with a 3.6 lbs weight gain in 3 days; on 10/9/16 with a 10.2 lbs weight loss in 2 days; on 10/11/16 with a 4.4 lbs weight loss in 2 days; and on 10/13/16 and 10/14/16. The last daily weight was documented on 10/12/16 at 409 lbs. Medial record review of a nursing note dated 10/2/16 at 11:30 AM revealed "...resident noted to have a weight gain of 15.4 lbs. resident was weighted 9/30/16 and was 409 lbs. Resident weighted 10/2/16 and is 424.4 lbs..." Medical record review of a Physician's order dated 10/14/16 revealed "...[symbol for change] to weekly [weights]..."	{F 309}		

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{F 309}	Continued From page 97 Medical record review of the weight sheet revealed the next weight was documented on 10/18/16, 6 days after the last weight, with a weight of 394.4 lbs, a 14.6 lbs weight loss. Medical record review revealed the resident was hospitalized 10/23/16 through 10/29/16, and returned to the facility on 10/29/16. Medical record review of a weight sheet revealed the first recorded weight after returning from the acute care facility was on 11/6/16 and was 385.8 lbs.; an 8.6 lbs weight loss since the previous weight on 10/18/16. Continued weekly weights were recorded on 11/12/16 (6 days) at 366 lbs, a 19.8 lbs weight loss and on 11/17/16 (5 days) with a 2.2 lbs weight gain Medical record review of a Physician's order dated 11/18/16 revealed "...wkly [weekly] weights..." Medical record review of a weight sheet revealed a weight on 11/24/16 with a 1.2 lbs weight gain. Telephone interview with Registered Dietitian on 12/2/16 at 3:15 PM confirmed there were days the resident wasn't weighed as ordered. Interview with Medical Doctor (MD) #1 on 12/2/16 at 3:45 PM in the conference room confirmed the resident "...weights were not completed daily. Doesn't surprise me...usually write orders like that just for more data points because they don't always get done as ordered..." Medical record review revealed Resident #20 was admitted to the facility on 9/25/15, and	{F 309}		

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{F 309}	Continued From page 98 re-admitted on 7/16/16, with diagnoses including End Stage Renal Disease, Schizophrenia, Blindness and Seizure Disorder. Review of the facility policy Dialysis Residents, undated, revealed "...Take blood pressure and pulse before going out to dialysis...take blood pressure and pulse upon return from dialysis...Document resident's condition and interventions..." Medical record review of the Minimum Data Set (MDS) dated 9/18/16, revealed a Brief Interview for Mental Status (BIMS) score of 9 indicating Resident #20 had moderate cognitive impairment. Medical record review of the vital signs and weight record revealed the last vital signs documented were on 11/2/16. Interview with Resident #20 on 12/1/16 at 10:15 AM, in the resident's room, confirmed the resident went to dialysis Monday, Wednesday and Friday, before 11:30 AM. Continued interview confirmed he had a temporary catheter in his right neck and he had an appointment to have another access placement. Interview with Licensed Practical Nurse (LPN) #2 on 12/1/16 at 10:30 AM, at the 300 nurse's station, confirmed there was not a policy on the care of a dialysis patient. Continued interview confirmed there iwas no communication documents sent to the dialysis clinic from the facility. Interview with LPN #12 on 12/1/16 at 4:20 PM, at the 300 nurse's station, confirmed no vital signs	{F 309}		

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{F 309}	Continued From page 99	{F 309}		

were documented on the resident since 11/2/16. Further interview confirmed vital signs were to be taken pre-dialysis, and upon return from dialysis, and documented on a nurses note or flow sheet. Continued interview revealed no communication documents were sent with the resident to dialysis.

Telephone interview with the RN at the dialysis clinic on 12/2/16 at 8:45 AM, confirmed "...I have worked here for 15 years and [the Nursing home] has never sent a dialysis communication sheet to the dialysis clinic." Continued interview confirmed the resident "...had a lot of fluid on and we got it off over time..." Further interview confirmed the resident did have bleeding from the dialysis access at the facility and was sent to the emergency room. Continued interview revealed the access was infected and was removed, and a catheter was inserted.

Telephone interview with the Clinical Manager of the dialysis clinic on 12/2/16 at 8:50 AM, confirmed the facility did not send a dialysis communication document with vital signs and a weight with the resident. If there were concerns with the resident, the clinic would notify the facility by phone.

Interview with the Director of Nursing (DON) on 12/5/16 at 2:47 PM, in the conference room, confirmed there was no documentation the resident's dialysis catheter site was being assessed, or documentation vital signs pre and post dialysis were completed.

Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation,

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{F 309}	Continued From page 100 review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records ensuring that 100% of staff was educated on skin assessments, body audits, and splints and immobilizers. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/7/16 and interviews with the facility leadership staff confirmed 100% of the staff had been educated on the facility policies by 12/7/16. 2. Verification by interview with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted on 12/19, 12/20, and 12/21/16, and confirmed the staff's comprehension of the facility's policies for skin assessment checks and splint and immobilizer positioning checks. 3. Review of 19 resident medical records on 12/19/16 and 12/20/16 verified skin assessments had been completed per facility policy. 4. Review of the facility's in-service records and staffing revealed that 100% of staff was educated on the written weight schedule on 12/13/16. Review included the facility's plan to ensure all staff was educated on the weight policies before being allowed to work a shift. Review of the in-service logs dated 12/13/16 and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16 confirmed 100% of the staff had been educated on facility policies by 12/13/16. 5. Review of the facility's in-service records confirmed that 100% of the staff was educated on dialysis communication and on assessment of a	{F 309}		

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

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{F 309}	Continued From page 101 resident's dialysis shunt site. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/13/16 and interviews with the facility leadership staff confirmed 100% of the staff had been educated on facility policies by 12/13/16. The facility remains out of compliance at a Scope and Severity level "D" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 309}		
{F 312} SS=D	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, observation, and interview, the facility failed to provide incontinence care for 3 residents(#65, #21, and #45)of 5 residents reviewed for activities of daily living. The facility's failure to provide incontinence care placed residents #65, #21, and #45 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death)and is	{F 312}	**F312 ADL Care provided for Dependent residents** 1. **Resident #65** - During the course of Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility.	1/20/17

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{F 312}	Continued From page 102 likely to put all residents requiring incontinence care in Immediate Jeopardy. The facility was cited F312 at a scope and severity of "J" which constitutes substandard Quality of Care (SQC). The Immediate Jeopardy is effective 2/7/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-312 at a "D" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Resident #65 was admitted to the facility on 12/11/09 with diagnoses including Diabetes Mellitus Type II, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anxiety, Depression, Spinal Stenosis, and Chronic Pain. Review of Annual MDS dated 11/18/15 revealed Resident #65 scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Continued review revealed the resident required extensive assist with transfers and dressing and total assist for person hygiene and bathing with	{F 312}	**Resident #21** Resident #21was interviewed by the Social Services Director on 12/13-16 and voiced no current concerns. **Resident #45** Resident #45 was interviewed by the social Services Director on 12/13/16 and voiced no current concerns. 2. All residents have the potential to be affected and were identified by interview of 100% of the patients to assure care needs being met. Interviews were conducted on 12/7/16 by the Social Services Director. For those residents who did not respond to the interview, a head to toe body audit was conducted by the charge nurse on 12/6 and 12/7, 2016 to identify the presence skin alteration. Body audits revealing alteration were immediately advanced to nurse management for	

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{F 312}	Continued From page 103 1-2 person assist and was always incontinent of bowel and bladder. Review of a facility investigation dated 2/7/16 revealed Resident #65 reported to RN# 2 she told CNA #14 she was soaking wet and requested incontinence care. Continued review revealed CNA #14 told the resident he was"... 2 hours behind and he could not get to her..." Further review revealed RN #2 reported the incident to the DON on 2/8/16. Continued review revealed the DON interviewed Resident #65 and the resident reported the same incident. Interview with Resident #65 on 11/9/16 revealed "...can't remember exactly what he said...didn't have time or something like that...it made me feel like I wasn't important..." Interview with Resident #65 on 11/19/16 at 11:25 AM confirmed CNA #14 did not return to the resident's room to provide incontinence care. Interview with the DON on 12/5/16 at 2:17 PM, in the conference room, confirmed she expected residents to be checked and changed every 2 hours and as needed. Medical record review revealed Resident #21 was admitted to the facility on 12/9/15 with diagnoses including Paraplegia, Dysphagia, Contracture Right Ankle, Contracture Left Ankle, and Osteoporosis. Medical record review of the Interdisciplinary Progress Notes dated 12/12/15 revealed "...Resident is paraplegic and requires total care for ADL's [activities of daily living]...Incont [incontinent] of B&B [bowel and bladder] c [with]	{F 312}	evaluation of prior reporting. All baseline skin assessments have been completed on 12/7/16 and continue on a weekly basis. 3. • The DON conducted training on incontinence care with focus on dignity, resident need and prevention of skin impairment beginning on 12/12/16. Through 12-15-16The target audience for this inservice was Licensed Nurses and Certified Nursing Assistants. • Guardian Angel Rounds were established by the facility Administrator on 12/13/16 to provide means for residents openly discuss any concerns they may have Rounding has been assigned 7 days per week ; residents will be visited several times per week, per schedule and additionally, as needed. Assigned Staff include	

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{F 312}	Continued From page 104 peri care q2 [every 2 hours] + [and] PRN [as needed]..." Medical record review of the Interdisciplinary Progress Notes dated 8/2/16 revealed "...Total care c ADL's...Incontinent bowel and bladder..." Medical record review of the Annual Minimum Data Set (MDS) dated 10/17/16 revealed Resident #21 had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. Continued review revealed Resident #21 was totally dependent on staff with assistance of one person for mobility, transferring and toileting. Further review of the MDS revealed the resident was always incontinent. Medical record review of the Care Plan dated 10/18/16 revealed "...Self Care Deficit r/t [related to] paraplegia...Potential for skin breakdown d/t [due to] decrease mobility...Provide Peri care with each incontinent episode...Potential for urinary tract infection r/t incontinence of B&B...Self Care Deficit r/t paraplegia...Assist with ADLs as needed..." Medical record review of the Nurse Aide's Information Sheet (Kardex), undated, revealed Resident #21 was incontinent and required total care assistance. Continued review revealed the resident required a mechanical lift for transfers. Interview with Certified Nursing Assistant (CNA) #19 on 11/30/16 at 8:04 PM, in the 400 hall, revealed "...I have done my first dry rounds...Starting 8's [8:00 PM rounds] now...Last rounds were at 4 [4:00 PM] before I got here..." Observation on 11/30/16 at 8:08 PM, on the 400	{F 312}	Therapy Services, Social Services, Business Office, Maintenance, Dietary, Medical Records, Environmental, MDS, DON and Nursing Home Administrator. Assignments are conducted 7 days per week. • Weekly body audit was conducted by the charge nurse on 12/6 and 12/7, 2016. Weekly body audit schedule was reviewed by the DON on 12/7/16and body audits continue to be completed as assigned to identify care concerns for residents unable to verbalize these concerns. • Schedule was revised on 12-15-16 by the Corporate Team to assign Nurse Manager to 11-7 shift, 7 days per week to provide supervision and abuse surveillance.	

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{F 312}	Continued From page 105 hall, revealed Resident #21 had a strong urine odor. Continued observation revealed a wet stain to the resident's pants from the groin, inner thigh, and down to the knee. Interview with Resident #21 on 11/30/16 at 8:08 PM, on the 400 hall, confirmed "...They haven't changed or clean me yet...not since last state person [state surveyor] was here..." Interview with CNA #19 on 11/30/16 at 8:09 PM, on the 400 hall, confirmed "...I haven't changed her yet tonight..." Continue interview confirmed the resident had not been cleaned and changed since the rounds done between 4:00 PM and 5:00 PM. Observation with Licensed Practical Nurse (LPN) #13 on 11/30/16 at 8:12 PM, in the 400 hallway, revealed Resident #21 was in the wheelchair with a wet saturation on the resident's pants from the groin, to inner thigh, to knee. Interview with LPN #14 on 11/30/16 at 8:12 PM, on the 400 hall, confirmed "...She is soiled...She is a lift transfer...I expect her to be changed every 2 hours..." Medical record review revealed Resident #45 was admitted to the facility on 6/27/16 with diagnoses including Age-Related Osteoporosis, Muscle Spasm, Morbid Obesity, Chronic Obstructive Pulmonary Disease, and Contracture of Muscle. Medical record review of the Care Plan dated 3/25/16 and updated 9/15/16 revealed "...Self Care Deficit...Assist with ADL's as needed...Has incontinence bowel & bladder...Incontinence to be provided by staff as needed..."	{F 312}	• Corporate RN Staff has been assigned by the Director of Operations who reports directly to the Board of Directors for the managing entity. The Corporate staff began on 12/12/16 and will provide surveillance, education, and administrative oversight 7 days per week and will remain assigned to the facility until substantial compliance is achieved and as long as the board continues to deem necessary thereafter. • All grievances and incidents are logged for tracking for investigation and resolution by the Social Services Director and Risk Management Nurse, RN. (Concerns identified during guardian angel rounds will be recorded on grievance form to assure follow up per facility policy) The Social Services Director, the Risk	

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{F 312}	Continued From page 106 Medical record review of the Quarterly MDS dated 9/14/16 revealed Resident #45 had a Brief Interview for Mental Status Score of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed the resident was total dependence with toileting. Further review of the MDS revealed the resident was always incontinent. Medical record review of the Nurses Note dated 11/6/16 revealed "...we do not want any skin breakdown or skin issues that can arise d/t [due to] poor hygiene..." Medical record review of the Nursing Weekly Summary dated 11/19/16 revealed "...ass [assist] x [times] 2 c [with] ADL's + [and] t/f's [transfers]...Incont of B+B [bowel and bladder] peri care PRN + q2 [every 2 hours]...non amb [ambulatory] is in the bed most of the time..." Medical record review of the Bladder Evaluation dated 11/26/15 revealed "...Functional Status/Assist...Total dependence...multiple daily episodes [incontinence]..." Medical record review of Nurse Aide's Information Sheet (Kardex), undated, revealed "...Incontinent...Total care...Geri chair...Lift to chair...[mechanical lift]..." Interview with Resident #45 on 11/30/16 at 8:18 PM, in the resident's room, confirmed "...I haven't been changed since before supper before 5 [5:00 PM]..." Interview with Registered Nurse (RN) #2 on 11/30/16 at 8:25 PM, on the 300 hall, confirmed	{F 312}	Manager and the Administrator review each entry weekly to assure timely and complete investigation, reporting, if applicable, and resolution. All newly hired licensed nurses and CNA's will receive training ADL provision and incontinent care 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to prevention of abuse and neglect. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS	

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{F 312}	Continued From page 107 the CNAs were to check and change the residents every 2 hours. Continued interview confirmed the CNAs started their rounds at 6:00 PM. Telephone interview with CNA #18 on 12/1/16 at 8:38 PM, confirmed she was assigned to Resident #45 on the night of 11/30/16. Continued interview confirmed she finished her first dry rounds (rounds to check residents for incontinence and hygiene needs) after 10:00 PM (took 4 hours to complete 6:00 PM dry rounds). Interview with RN #5 on 12/2/16 at 2:37 PM, in the conference room, confirmed Resident #45 was incontinent and required a mechanical lift for mobility. Interview with the Director of Nursing on 12/5/16 at 2:17 PM, in the conference room, confirmed she expected the residents to be checked and changed every 2 hours and as needed. Interview with CNA #13 on 12/7/16 at 8:01 AM, on the 300 hall, confirmed she was assigned to Resident #45 on the dayshift on 11/30/16 and finished her dry rounds at 5 PM. Interview with Resident #45 on 12/7/16 at 9:39 AM in the resident's room, confirmed "...It is what it is. What can you do about it..." Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records	{F 312}	Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Grievance Log reported by Social Services Director o Incident Log reported by Risk Manager The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for	

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{F 312}	Continued From page 108 ensuring that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's Resident Rights and Grievance Policy by 12/13/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/13/16, review of facility staffing, and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 100% of the active staff had been educated on facility policies by 12/13/16. 2. Verification by interview with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted during the revisit survey on 12/19, 12/20, and 12/21/16, and confirmed those staff had received education on the facility's policies for resident rights and grievances and were able to verbalize the content of the education. 3. Verification of the implementation of the facility policy for Guardian Angel Rounds, established by the facility Administrator on 12/13/16, was completed through observations and interviews, and those rounds were ongoing during the revisit survey from 12/19/16 through 12/21/16. Review of facility documentation revealed Guardian Angel Rounds were ongoing 7 days per week to openly discuss any concerns residents had regarding their care. Review of the schedule revealed coverage assigned for the rounds was on a 24/7 basis, with corporate staff and assigned night shift Nurses to provide supervision and surveillance. 4. Interview with 11 residents during the revisit survey on 12/19, 12/20, and 12/21/16, revealed no complaints about the care the resident had received since implementation of the AoC.	{F 312}	amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 312}	Continued From page 109	{F 312}		
	The facility remains out of compliance at a Scope and Severity level "D" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.			
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	{F 314}		
	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.		**F314 Treatment/Services to prevent/heal Pressure Ulcers** 1. **Resident #12** immoblizer, Pressure Ulcers: care plan reviewed and revised by the nurse assessment coordinator 12/13/16. **Resident #106** - Sacral wound was healed on October 14, 2016 and skin assessment was completed by Nurse Practitioner on December 7, 2016. No skin issues identified.	1/20/17
	This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of facility standing orders, medical record review, observation, and interview, the facility failed to provide the necessary care to prevent avoidable pressure sores from developing or worsening for 3 residents (#12, #123, #106) of 8 residents reviewed for pressure sores. The facility's failure placed the residents #12, #123, #106 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death. The facility was cited F314 at a scope and severity of "J" which constitutes Substandard			

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{F 314}	Continued From page 110 Quality of Care. The Immediate Jeopardy is effective 7/20/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-314 at a "D" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Review of facility policy Pressure Ulcer Prevention, dated 2006, revealed "...If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided..." Review of the facility Standing Orders, dated 6/7/16 revealed "...Decubitus Care: Follow skin integrity and wound care protocol..." Medical record review revealed Resident #12 was admitted to the facility on 6/15/12 with diagnoses including Atrial Fibrillation, Aphasia, Chronic Obstructive Pulmonary Disease, Dysphagia, Dementia, Osteoporosis, Hypertension, Impulse Control Disorder, Anemia, Anxiety, Major Depressive Disorder, Generalized Osteoarthritis, Gastroesophageal Reflux Disease, and Insomnia.	{F 314}	**Resident #123** - Had an orthopedic appointment on October 27, 2016 and the brace was subsequently changed and treatment orders were initiated. Nurse Practitioner examined resident on December 7, 2016 and resident continues treatment as ordered. NP documented in agreement with the wound care treatment plan. 2. A body audit of all current residents was conducted on 12/06 and 12/07/2016 by LPN charge nurses, DON Risk Manager, RN MDS coordinator And 2 RNS from sister facility.DON reconciled wound report to individual treatment records to assure treatment and care planning in place. All baseline-skin assessments were completed on December 8, 2016 and reconciled with existing treatment orders/wound	

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{F 314}	Continued From page 111 Review of the Treatment Administration Record dated July 2016 revealed, "...Weekly Skin Assessment...Order Date 6/15/12...See Wkly [weekly] Nrsg [nursing] Note..." Review of a Physician's Progress Note dated 7/20/16 revealed "...Tib/fib [tibia/fibula bones of lower leg] fx [fracture]...Brace noted to LLE [left lower extremity]..." Review of a Physician's Telephone Orders dated 7/21/16 at 11:30 AM revealed "...knee immobilizer to LLE q [every] shift..." Review of the LAB (Laboratory) Record (record used by the facility for documenting some assessments) dated July 2016 revealed "...Leg imobilizer [immobilizer] to LLE check q shift..." Further review revealed no documentation the immobilizer had been checked until 7/26/16 on the 6A-6P shift. Review of the Nursing Supplemental Record dated August 2016 revealed "...Knee immobilizer to LLE, check skin integrity q shift...Order date 7/21/16...8/1/16 May continue to wear brace with activity and transfers but can remove @ [at] rest..." Further review revealed no documentation skin integrity was checked on the 8/11/16 6P-6A shift. Medical record review of the Quarterly Minimum Data Set (MDS) dated 8/30/16 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 3 of possible 15, indicating the resident had severe cognitive impairment. Continued review revealed the resident was totally dependent for bed mobility, bathing, and	{F 314}	report. One Stage 2 wound was identified with treatment orders obtained. 3. • Root cause analysis was conducted on 12/13/16 by the Director of Operations and 3 Corporate Clinical Consultants who are RNs, revealed that assignments were not clearly defined as it relates to obtaining, weekly skin assessments • Weekly Skin Assessment Schedule was revised on 12/7/16 by the Director of Nursing to reflect specific assignment and posted at the Nurses Station. The Weekly Skin Assessment identifies residents to be assessed and who is assigned to complete. • On December 8, 2016, DON initiated education with licensed nurses and CNAs, the intended audience, on splints with careful attention	

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{F 314}	Continued From page 112 personal hygiene with one person assistance. Further review revealed Resident #12 was totally dependent for transfers with 2 plus persons physical assistance and was at risk for developing pressure ulcers. Review of the LAB Record for September 2016 revealed, "...9/22/16 remove brace while in bed, but place it for transfers..." Review of the Nursing Supplemental Record dated September 2016 revealed "...Knee immobilizer to LLE with activity & [and] transfers but can remove @ rest; check skin integrity q shift Order Date: 8/01/16..." Continued review revealed no documentation the skin integrity had been checked on any days in September except the 9/1/16 6A-6P shift. Review of a Progress Note, authored by Nurse Practitioner (NP) #1 dated 9/23/16 revealed "...pt [patient] with 2 open areas on LLE. Ankle measures 3 x [by] 3 L [left] lateral leg area measures 1 [centimeter] x 4.8 [centimeters]...No infection or purulent drainage noted...Wound care nurse treating..." Review of the September 2016 Treatment Administration Record revealed "...9-23-16 Clean area on (L) ankle with NS [normal saline], pat dry apply...[treatment for wounds] et [and] cover with ABD [abdominal] pad et secure with tape... [change] QD [every day]..." Continued review revealed no documentation treatments had been done on 9/25/16, 9/29/16, and 9/30/16. Medical record review of the September 2016 Treatment Administration Record revealed "...9-23-16 Clean area on (L) lower leg with NS	{F 314}	to skin integrity and examining under any immobilizers or splints every shift by the licensed nurses for skin integrity. If alteration in skin integrity is noted, physician is contacted by the licensed nurse for treatment orders. Licensed nurses were educated on the importance of completion of treatment records prior to leaving their shift. This education was completed on 1/9/17 following an FMLA return. • Wound formulary has been reviewed and revised by the Director of Operations on 12-01-16 to assure to most recent standards of practice. The corporate nurse provided education to the DON on December 6, 2016 regarding the wound care formulary and it was placed on both Treatment Carts. A member of the corporate team will review the weekly wound report. The facility	

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{F 314}	Continued From page 113 pat dry apply...cover with ABD pad et wrap..." Continued review revealed no documentation the treatment had been completed on 9/24/16, 9/29/16 and 9/30/16. Medical record review of the Nursing Supplemental Record dated October 2016 revealed "...Remove LLE knee immobilizer brace while in bed, but place it with transfers, check skin integrity Q shift...Order Date: 9/22/16..." Review of a Nurse's Note dated 10/1/16 at 5:00 PM revealed "...leg and ankle small amount of drainage and blood noted..." Further review revealed a note on 10/2/16 at 8:00 AM "...leg and ankle small amount of drainage and blood noted. Foul odor...NP made aware and N.O. [Nursing Order] Doxycycline (antibiotic)...for wound infection. Culture to wound...Culture obtained..." Review of the Physician's Progress Note dated 10/6/16, authored by NP #1, revealed "...DC [discontinue] Doxycycline Clindamycin [antibiotic]...Rocephin [antibiotic] IM [intramuscular injection]..." Review of the October 2016 weekly Wound Assessment Reports revealed no documentation of wound measurements on 10/7/16 for the left shin or the left ankle. Review of the Treatment Administration Record dated October 2016 revealed "Clean areas on Lt outer ankle with ABD pad and secure with tape, change Q day...Order Date: 9/23/16..." Further review revealed no documentation of the treatment being completed on 10/10/16, 10/16/16, 10/18/16, and 10/30/16. Continued review revealed "Clean area on Lt lower leg with	{F 314}	has arranged supportive services with a vendor to provide teleconferencing with a Certified Wound Nurse when ordered. An order will be obtained when treatment resistant wounds are identified. This service provides consultation regarding evidence based best practice for identified wounds. • Certified wound care nurse consultant provided wound training on December 13, 2016 for DON, wound nurse and Charge Nurse. Training included identification of wounds, staging, measurement, evidence based treatment option. A. On 12/10/16, • The Medical Records Coordinator (LPN) was assigned to on-going audit completion of weekly summaries (skin assessment) as a QA Initiative. Assessments found not to have been completed will be	

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{F 314}	Continued From page 114 NS, pat dry...change q day...Order Date: 9/23/16..." Further review revealed no documentation of the treatments being completed on 10/10/16, 10/16/16, 10/18/16, and 10/30/16. Review of the November 2016 weekly Wound Assessment Reports revealed no documentation of wound measurements for the weekly assessments of 11/4/16, 11/11/16, or 11/18/16 for the left ankle, and 11/25/16 for the left ankle and shin. Review of the Nursing Supplemental Record dated November 2016 revealed, "...check skin integrity Q shift..." Further review revealed documentation skin integrity was not checked on 11/14/16 6A-6 P shift. Review of the Physician's Progress Note dated 11/22/16, authored by the physician, revealed "...out of immobilizer which was causing wounds." Interview with Resident #12's Physician on 12/2/16 at 3:55 PM, in the conference room, confirmed the pressure ulcers should have been discovered at a Stage 1 and the Stage 3 pressure ulcers would take 2-5 days to develop. Further interview confirmed the pressure ulcers could have been avoided if the skin had been checked every shift. Interview with the Treatment Nurse on 12/5/16 at 9:15 AM, at the 100/200 nurses station, confirmed on 9/23/16 a CNA discovered 2 pressure ulcers to Resident #12's left shin and ankle during a shower and reported those to the treatment nurse. Continued interview revealed it was the nurses responsibility to check the skin when "check skin integrity" was ordered.	{F 314}	reported to the Director of Nursing, or, in her absence, the Nursing Home Administrator, for immediate assignment. 100% Audits will remain ongoing x 8 weeks to achieve our goal of 100% compliance of completed skin audits; once goal is achieved audit will be reduced to 10 random per week x 6 weeks, then monthly x three months. • The Risk Manager (RN) is conducting 3 wound audits per day , 5 x per week to affirm accuracy of assessment. Accuracy Audits began on 12-15-16. Audits will remain ongoing x 8 weeks to achieve our goal of 100% accuracy of completed assessment; once goal is achieved audit will be reduced to 10 random per week x 6 weeks, then monthly x three months.	

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{F 314}	Continued From page 115 Continued interview confirmed there were no wound assessments done for a total of 7 weekly assessments (2 assessments for the shin and 5 assessments for the ankle) while the pressure ulcers were present. Telephone interview with Licensed Practical Nurse (LPN) #15 on 12/5/16 at 8:38 PM, confirmed she did not remove the brace every shift and look at the skin, she just made sure the resident could wiggle her toes, made sure the brace was not too tight, and ensured the circulation was good. Telephone interview with LPN #11 on 12/5/16 at 8:52 PM, confirmed the LPN did not check the skin integrity every shift, she only made sure the brace was off. Interview with the Director of Nursing (DON) on 12/6/16 at 8:45 AM, in the conference room, confirmed when a nurse initials that skin integrity was checked every shift, the nurse would be expected to look under the brace for any open areas or skin issues. Further interview confirmed the pressure ulcer should have been discovered prior to becoming a Stage 3 pressure ulcer. Medical record review revealed Resident #123 was admitted to the facility on 10/18/16 with diagnoses including Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia, Anemia, Right Quadriceps Tendon Rupture and Repair and Chronic Obstructive Pulmonary Disease (COPD) with home oxygen. Medical record review of Resident #123's Care Plan dated 10/18/16 revealed "...Potential for skin breakdown...Weekly skin	{F 314}	• All newly hired licensed nurses and CNA's will receive training on "Treatment and Services to Heal and Prevent Pressure Ulcers" policy as part of new employee orientation to include: o Splint application and monitoring of skin condition with splint. (Licensed Nurses and C.N.A.s) o Skin Assessment Requirement (Licensed Nurses) 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to treatment and prevention of pressure ulcers. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services	

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{F 314}	Continued From page 116 assessment...Treatments as ordered...Rt [right] knee immobilizer as ordered..." Medical record review of a Daily Skilled Nurses Note dated 11/13/16 at 12:00 AM, revealed "...brace on R [right] leg, Brace is off due to rubbing quarter size area (open) to [lower] calf area, to have tx [treatment] nurse address..." Continued review revealed there was no documentation of a wound assessment, no physician orders, and no treatment completed on 11/13/16. Medical record review of the Minimum Data Set (MDS) dated 11/15/16 revealed Resident #123 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15, indicating the resident was cognitively intact. Further review revealed the resident required limited assistance of 1 staff for bed mobility, personal hygiene, bathing, and eating. Medical record review of a Wound and Skin Status Report revealed the wound was identified on 11/15/16 (the same wound identified in the nurses note dated 11/13/16). Continued review revealed the right calf wound was a Stage 1 (defined by the MDS as intact skin with non-blanchable redness of a localized area usually over a bony prominence). Medical record review of a Nurse Practitioner's note dated 11/15/16, revealed "...Pt [patient] has eschar [dead tissue] on posterior RLE [right lower extremity] that was caused by brace..." Medical record review of a Physician's Note dated 11/17/16 revealed "...Patient notes that he has some discomfort on the back of his right leg	{F 314}	~~Mgr., Maintenance Dir, Bus~~ Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Grievance Log reported by Social Services Director The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued	

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{F 314}	Continued From page 117 where the brace rubbed an area on it...There is a 2 cm ulceration on the posterior right calf..." Medical record review of a Wound Assessment Report dated 11/17/16, revealed the wound type was a pressure ulcer; the location of the wound was the right calf; it was Stage 1 with measurements of 1.50 cm length x 2.30 cm width; and there was no description of the wound appearance. Medical record review of daily skilled nursing notes dated 11/15/16 through 11/18/16, 11/22/16, 11/26/16, 11/28/16, 11/30/16, and 12/5/16, revealed no documentation of skin assessments or the status of the pressure ulcer. Medical record review of a Treatment Administration Record (TAR) for November 2016 revealed the weekly skin assessments for 11/8/16, 11/15/16, 11/22/16, and 11/29/16 had not been signed as completed. Medical record review of an Interdisciplinary Disciplinary Team (IDT) progress note dated 11/23/16, revealed "...area to the back of R calf noted to be scabbed, daily application of medihoney, et [and] wrap with kerlix [gauze dressing wrap]..." Medical record review of a Physicians Order dated 11/30/16, revealed "Clean area on back of R lower extremity with NS [normal saline] pat dry. Apply polymem [medicated dressing treatment] et cover with dry dsg [dressing] et wrap with kerlix change Tues, Friday." Medical record review of a Wound Assessment Report dated 12/2/16 revealed "...Stage	{F 314}	need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 314}	Continued From page 118 Unstageable due to slough [mass of dead tissue separating from living tissue]/eschar [dead tissue]...measurements Length - 1.60 cm [centimeters] Width - 2.50 cm...Wound Bed Granulation Tissue - 90.00 %, Slough - 10.00 %..." Observation of a dressing change to the right calf of Resident #123 on 12/1/16 at 8:15 AM, with the Treatment Nurse in the resident's room, revealed a wound to the right calf with visible slough noted in the wound bed. Continued observation revealed the treatment nurse measured the pressure ulcer at 1.7 cm x 2.1 cm. Further observation revealed the treatment nurse requested the Director of Nursing (DON) to observe the wound. Interview with the DON on 12/1/16 at 8:30 AM, in the resident's room, confirmed the pressure ulcer was now unstageable due to the slough in the wound bed. Interview with the Physician on 12/2/16 at 4:00 PM, in the conference room, confirmed if skin checks had been completed every shift, the pressure ulcer could have been prevented. Continued interview confirmed she expected the nurse supervisors to be trained in wound staging and wound management. Interview with the Treatment Nurse on 12/5/16 at 9:15 AM, in the conference room, confirmed it was the responsibility of the nurses to check skin integrity on Resident #123 every shift. Further interview confirmed she had not received wound education beyond the Licensed Practical Nursing (LPN) program. The treatment nurse stated it was difficult to complete all wound treatments when	{F 314}		

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{F 314}	Continued From page 119 she was reassigned to other duties, which included assignment to the medication cart to administer medications. Further interview confirmed wound treatments not completed by the Treatment Nurse were not always completed by the nurses on the oncoming shift . During an interview with LPN #5 on 12/6/16 at 8:00 AM, in the 200 hallway, the LPN described her method for checking skin integrity was to check the skin on the back of the resident's hand by pinching the resident's skin. Interview with the DON on 12/6/16 at 8:15 AM, in the conference room, confirmed she did not have formal training in wound management. Continued interview confirmed she was not aware the pressure ulcer was identified on 11/13/16 instead of 11/15/16. Further interview confirmed no wound treatment was initiated until 11/15/16. The DON was asked about the Nurse Practitioner (NP) and Physician notes on 11/15/16 and 11/17/16 stating eschar and a 2 cm ulceration to the calf. The DON stated, "...I don't remember seeing eschar..." Further interview confirmed the treatment nurse completed the measurement and treatments "...I pop in and do the staging..." Interview with the Treatment Nurse on 12/7/16 at 3:30 PM, in the conference room, confirmed wound assessments with measurements were to be completed weekly by the treatment nurse. Further interview confirmed the wound assessment and measurements for the week of 11/24/16 had not been completed. Continued interview confirmed the DON was responsible for the staging of pressure ulcers. Further interview confirmed the treatment nurse had staged wounds without the DON present, even though it	{F 314}		

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{F 314}	Continued From page 120 was the DON's responsibility and the treatment nurse had not received formal training in staging wounds. Continued interview revealed several months ago the treatment nurse requested education on wound management from the DON and the Administrator, but there had been no response to the request. Medical record review revealed Resident #106 was re-admitted to the facility on 7/25/16 with diagnoses including Dementia, Sepsis, Osteoporosis, Osteoarthritis, Knee Pain, Anxiety, and Depression. Medical record review of the Re-Admission Resident Data Set dated 7/25/16 revealed Resident #106 had the sacral area circled on the body diagram with "...shearing [skin injury caused by opposite but parallel sliding motion]..." written out beside of the area. There were no measurements or description of the wound, and no treatment was initiated. Continued review of the risk for pressure ulcers assessment revealed the resident scored a 13 out of a possible 23 which indicated the resident was high risk for the development of pressure ulcers. Medical record review of the care plan dated 7/25/16 revealed "...Stage 1 to sacrum. Stage I to R [right] buttock...Treatments as ordered...Measure wound at least weekly. Record..." Medical record review of the Nursing Weekly Summary dated 7/29/16 revealed "...open area in coccyx area. Bilateral buttocks reddened irritated, blood noted in brief from irritated areas on buttocks..." There were no measurements or description of the wound.	{F 314}		

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{F 314}	Continued From page 121 Medical record review of the Physician's Telephone Order dated 7/30/16 revealed "...clean coccyx [with] ns [normal saline], skin prep apply hydrocolloid to coccyx Q [every] three days and prn [as needed] till resolved..." Medical record review of the Treatment Administration Record (TAR) revealed the treatment was initiated on 7/30/16. Medical record review of the 5 Day Minimum Data Set (MDS) dated 7/31/16 revealed Resident #106 had a Brief Interview for Mental Status (BIMS) score of 5 indicating the resident had a severe cognitive impairment. Continued review revealed the resident was totally dependent for bed mobility, transfers, personal hygiene, bathing with 1-2 person assistance and required limited assistance for eating with 1 person assistance. Further review revealed the resident had a Stage 1 (intact skin with a localized area of non-blanchable erythema, presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes) and a Stage 2 (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) pressure ulcers identified upon admission. Medical record review of the Daily Skilled Nurses Note dated 8/1/16 revealed "...Res [resident] has 2 areas, 1 on sacrum that measures 0.7 [cm] X [by] 0.4 [cm]...1 on R [right] buttock that measures 0.7 [cm] X [by] 0.5 [cm]..." Medical record review of the Physician's Telephone Order dated 8/1/16 revealed "...d/c	{F 314}		

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{F 314}	Continued From page 122 [discontinue] hydrocolloid...Greer's Goo to buttocks and sacrum QD [every day]..." Medical record review of the Wound Assessment Report dated 8/5/16 revealed "...wound type pressure ulcer...location sacrum...present upon admission yes...stage 2...measurements length - 0.7 cm width - 0.4 cm....wound type pressure ulcer...wound location right buttock...present upon admission...yes...stage 1...measurements length - 0.7 cm width - 0.50 cm..." Medical record review of the Wound Assessment Report, dated 8/12/16 revealed "...location sacrum...measurements length - 0.8 cm width - 0.4 cm length..." There were no measurements for the wound to the right buttock. Interview with the Treatment Nurse on 11/8/16 at 4:45PM, in the small conference room, confirmed no orders were obtained for wound care upon until 7/30/16 (5 days after the resident was admitted). Continued interview confirmed the sacral wound had increased in size from 8/5/16 to 8/12/16. Further interview confirmed there were no weekly wound assessments completed on 8/12/16 for the right buttock and 9/8/16 for the sacrum. Interview with the Director of Nursing on 11/8/16 at 5:05 PM, in her office revealed the DON stated the facility does not have a protocol for the treatment of pressure ulcers. Continued interview revealed "...with stage 1 pressure ulcers we basically reposition and then notify the Doctor or Nurse Practitioner when they visit to do their assessment...if more than a stage one they [nurses] would call the doctor for an order..."	{F 314}		

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{F 314}	Continued From page 123 Interview with the Nurse Practitioner on 11/9/16 at 10:25 AM, in the small conference room revealed "...not notified of the shearing...I know they use turning and repositioning for stage I pressure ulcers...should have been treated with something..." Continued interview confirmed standing orders for Decubitus Care were to follow wound care protocol and was she was unaware the facility did not have a wound care protocol. Interview with the DON on 12/5/16 at 11:40 AM in the conference room confirmed the facility had failed to obtain an order for treatment of the wound when it was identified on admission, 7/25/16. Further interview confirmed Resident #106's wound continued to decline after it had been identified and treatment was not implemented. Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records ensuring that 100% of staff was educated on skin assessments, body audits, and on splints and immobilizers. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs as of 12/7/16, staff listing, and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 100% of the staff had been educated on the facility policies as of 12/7/16. 2. Verification was completed through interview with 13 licensed nurses and Certified Nurse	{F 314}		

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{F 314}	Continued From page 124 Assistants (CNAs) on 12/19, 12/20, and 12/21/16, on all shifts, to validate the staff's understanding of the facility's policies for skin assessment checks and splint and immobilizer positioning checks. 3. Review of 19 resident medical records on 12/19/16 and 12/20/16 verified skin assessments had been completed per facility policy. 4. Observation of wound care for 5 residents during the revisit survey on 12/19 and 12/20/16, revealed the wound care nurse followed proper technique during the dressing changes, and the documentation of the wound stages and sizes correlated with the wound observations. The facility remains out of compliance at a Scope and Severity level "D" that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 314}		
{F 323} SS=G	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 facility policy review, medical record	{F 323}	**F323 Free of Accident Hazards/Supervision and Devices** 1. **Resident #12** was assessed by Nurse Practitioner on 7/13/16 for complaint of pain and edema. Order received for venous Doppler study; negative for DVT, resident continued to complain of pain, MD assessed 7/19/16; order received for x-ray; positive for fracture of left leg. Resident transferred to ER for evaluation and treatment. Immobilizer to Left leg with orders to follow up to orthopedic appointment.	1/2017

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{F 323}	Continued From page 125 review, review of a facility investigation, observation, and interview, the facility failed to identify an accident hazard and implement interventions to reduce the risk of injury for 1 resident (#12) of 7 residents reviewed for accidents, of 43 sampled residents. This failure resulted in Harm (a fractured tibia/fibula) to Resident #12. The findings included: Review of the facility policy Accidents and Incidents, dated May 2001, revealed "...An incident is any occurrence, which is not consistent with the routine operation of the institution or the routine care of a particular patient. It may involve an injury...charge nurse shall: Examine all...victims...Notify the...physician and inform of the accident /incident...Regardless of how minor...it must be reported to the department supervisor, and a report form is to be completed on the shift...must be reported to the Director of Nursing and the Director of Risk Management...All details are to be recorded in the nurses' notes, including disposition and follow up care for a period of 72 hours...The Risk Manager will review...investigation as needed..." Medical record review revealed Resident #12 was admitted to the facility on 6/15/12 with diagnoses including Aphasia, Chronic Obstructive Pulmonary Disease, Dysphagia, Dementia, Osteoporosis, Impulse Control Disorder, Anxiety, Major Depressive Disorder, Generalized Osteoarthritis, and Insomnia. Medical record review of the Quarterly Minimum Data Set (MDS) dated 6/6/16 revealed Resident #12 had a Brief Interview for Mental Status	{F 323}	2. Residents experiencing accident hazards have the potential to be affected. Body Audits were conducted by the Charge Nurses to determine other residents who may have been affected by alleged deficient practice on 12-6, 12-7 2016. A patient room audit was conducted on 1-19-17 to identify accident hazards as it relates to resident preference for bed placement. RN Supervisor conducted hazard review of beds similarly positioned on 1/11/17. 3. The Licensed Nurses and CNAs were re-inserviced by the Director of Nursing from 12-12-16 through 12-15-16 to enhance awareness and importance of reporting and documenting resident condition changes and	

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{F 323}	Continued From page 126 (BIMS) score of 2 out of 15, indicating the resident had severe cognitive impairment. Continued review revealed the resident was totally dependent for bed mobility and personal hygiene with one person physical assist and was totally dependent for transfers and bathing with 2+ person physical assist. Continued review revealed the resident was always incontinent of bladder and bowel. Review of a Physician's Progress Note dated 7/13/16, authored by Nurse Practitioner (NP) #2, revealed "...nursing report pt [patient] w/ [with] LLE [left lower extremity] bruising, edema...LLE w/ large bruised/reddened area, warm to touch...painful (grimacing w/palp [palpate]...assessment/plan...venous Doppler R/O [rule out] blood clot..." Review of Nurse's Notes revealed no documentation of the problem identified by the NP and no documentation of nursing assessments or interventions. Review of a Physician's Progress Note dated 7/19/16 authored by Physician #1 revealed "...new bruising and swelling of the left leg...no injuries that have been reported by staff...xray to rule out underlying fracture...Ultrasound negative for DVT [deep vein thrombosis]..." Review of the facility's investigation revealed a Resident Incident Report dated 7/19/16 "...Resident C/O [complained of] pain when turned order received for xray...Green bruising noted to shin and calf area..." Continued review revealed 4 witness statements authored by staff with no knowledge of the cause of the fractured leg. Further review revealed an unsigned typed	{F 323}	incidents to evaluate potential hazards. • The Enviornmental Services Director inserviced the Environmental Services Team, the intended audience on surveillance and recognition and reporting of potential hazards on 1/2/17. 100% of the targeted audience was inserviced. • Guardian Angel Rounds were established by the facility Administrator on 12/13/16 to provide means for residents openly discuss any concerns they may have Rounding has been assigned 7 days per week; residents will be visited several times per week, per schedule and additionally, as needed. • Rounding tool was amended on 1-12-17 to include surveillance of potential hazards. Assigned Staff include Therapy Services,	

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{F 323}	Continued From page 127 summary of the investigation, "...noted protrusion in wall and bruise consistent with rolling toward wall and coming in contact with the protrusion...resident unable to recall direct force incident...According to research a side ways bend at ankle or knee could have caused practure [fracture]..." Review of the Physician's Progress Note dated 7/20/16 revealed "...Tib/fib [tibia/fibula bones of lower leg] fx [fracture]..." Observation and interview with Resident #12 on 11/29/16 at 3:30 PM, in the resident's room, revealed the resident lying in bed on her back with no response to questions from this surveyor. Continued observation revealed the resident replied to staff members with "yes" or "no" to questions. Interview with the Director of Nursing (DON) on12/1/16 at 8:51 AM, in the conference room, confirmed bruises should be documented by the assigned nurse upon discovery. Continued interview with the DON confirmed "...this was not an injury of unknown origin [bruise]...the bruise was consistent with a protrusion on the wall..." Further interview confirmed no investigation had been started until the fracture was discovered on 7/20/16. Interview and observation with the Maintenance Director on 12/1/16 at 4:10 PM, in resident's room, confirmed there was a buffer on the bed side of the wall 18 inches from the floor, below the top of the mattress, and extended the entire length of the left wall. Continued observation and interview revealed the protrusion had a curved, smooth surface on the top edge which protruded	{F 323}	Social Services, Business Office, Maintenance, Dietary, Medical Records, Environmental, MDS, DON and Nursing Home Administrator. Assignments are conducted 7 days per week. Any Guardian Angel Round resulting in patient concern is being reported immediately to administration, as trained. Guardian Angel Rounds will remain ongoing. • All newly hired staff, all departments, will receive training on "Safety and identification of hazards as part of new employee orientation. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy	

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{F 323}	Continued From page 128 outward 9/16 of an inch from wall. Observation and interview with the DON on 2/2/16 at 9:57AM, in Resident #12's room, confirmed the resident's left leg was "...probably bent when the resident was turned on her left side. The resident's left leg probably went between the wall and the mattress and hit the protrusion on the wall..." Observation revealed the DON was referring to the buffer on the bed side of the wall, below the top of the mattress, and extending the entire length of the left wall, as the protrusion. Interview with Licensed Practical Nurse (LPN) #12 on 12/2/16 at 12:45 PM, at the 300/400 nurses station, confirmed a Certified Nurses Aide (CNA) (couldn't remember which one) reported bruising and swelling to Resident #12's leg. Continued interview revealed LPN #12 notified the NP on the same day (7/13/16) but did not document in the nurse's notes or fill out an incident report. Further interview confirmed LPN #12 should have documented the bruising and swelling and initiated an incident report. Continued interview confirmed Resident #12 was unable to roll over in the bed independently. Interview with Physician #1 on 12/2/16 at 3:55 PM, in the conference room, confirmed Resident #12 was seen by NP #2 on 7/13/16 for edema and discoloration of the left lower leg. Continued interview revealed the Physician was "surprised" when the xray report revealed a fracture because the resident was so cooperative with care. Further interview with the Physician revealed the fracture most likely occurred around 7/13/16. Continued interview with Physician #1 on 12/2/16 in the resident's room confirmed it was possible	{F 323}	to assure identification and remedy of hazards. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Guardian Angel Rounding Tool The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing	

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{F323}		{F323}	interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 323}	Continued From page 129 the fracture had resulted if the resident's foot fell between the bed and the wall and staff repositioned her during that time.	{F 323}	**F353 Sufficient 24 Hour Nursing per Care Plans**	1/20/17
{F 353} SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of daily staffing assignments, review of staffing schedules, and interview, the facility failed to ensure adequate staffing to provide necessary personal care assistance and incontinence care in a timely manner for 11 residents (#106, #123, #75, #103, #65, #27, #68, #21, #45, #12, #145) of	{F 353}	1. **Resident #21** was interviewed by the Social Services Director on 12/13/16 and voiced no current concerns. **Resident #45** was interviewed by the social Services Director on 12/13/16 and voiced no current concerns. **Resident #75** - On February 6, 2016, CNA was suspended after allegation of verbal abuse with request by resident to assist with incontinent care on February 6, 2016. CNA was subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility.	

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{F 353}	Continued From page 130 43 residents reviewed. The facility's failure placed Residents #106, #123, #75, #103, #65, #27, #68, #21, #45, #12, #145 in Immediate Jeopardy (a situation which the provider's non compliance has caused, or is likely to cause, serious harm, injury, impairment of death). The Immediated Jeopardy was effective 2/6/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-353 at a "E" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Medical record review of the Treatment Administration Record (TAR) for Resident #54 dated 7/2016 revealed pressure ulcer treatment to the right buttocks was not completed on 9 out of 24 days. Review of the Daily Staffing Sheet revealed no treatment nurse scheduled for 7/9/16, 7/10/16, 7/16/16, 7/17/16, 7/22/16, 7/23/16, 7/24/16, 7/27/16, and 7/28/16. Medical record review of the TAR for Resident	{F 353}	**Resident #103** - During the course of the #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that same CNA involved with #75 was verbally inappropriate when ADL assistance was requested, CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #65** - During the course of the #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's incontinent needs in a timely manner. CNA had previously	

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{F 353}	Continued From page 131 #54 dated 8/16 revealed pressure ulcer treatment to the right buttocks was not completed on 3 out of 19 days. Review of the Daily Staffing Sheet revealed no treatment nurse scheduled for 8/7/16, 8/13/16, and 8/14/16. Interview with the Director of Nursing (DON) on 12/6/16 at 8:34 AM, in the conference room, confirmed no pressure ulcer treatments to the right buttocks were documented on 9 occasions in July 2016 and 3 occasions in August 2016. Interview with the Treatment Nurse on 12/7/16 at 3:22 PM, in the conference room, confirmed "...They pull me off the cart [treatment cart] somedays at 3PM [and assigned patient care]...I also work the cart [medication cart] if don't have a scheduled nurse working to cover shift..." Continued interview confirmed the nurse failed to provide pressure ulcer treatment to Resident #54's pressure ulcers. Medical record review of the Interdisciplinary Progress Notes dated 12/12/15 for Resident #21 revealed "...Resident is paraplegic and requires total care for ADL's [activities of daily living]...Incont [incontinent] of B&B [bowel and bladder] c [with] peri care q2 [every 2 hours] + [and] PRN [as needed]..." Interview with Certified Nursing Assistant (CNA) #19 on 11/30/16 at 8:04 PM, in the 400 hall, revealed "...I have done my first dry rounds [6:00PM rounds]...Starting 8's [8:00 PM rounds] now...Last rounds at 4 [4:00 PM] before I got here..."	{F 353}	been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #106 -** On July 8, 2016, Facility administrator was notified of unprofessional conduct by agency CNA. (failure to assist resident as requested) Facility contacted staffing agency on July 8, 2016 notifying agency the CNA was not to return. Resident was assessed on July 8, 2016 with no complaints at the time and no skin issues noted. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility.	

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{F 353}	Continued From page 132 Observation on 11/30/16 at 8:08 PM, on the 400 hall, revealed Resident #21 had a strong urine odor. Continued observation revealed a wet stain to the resident's pants from the groin, inner thigh, down to the knee. Interview with Resident #21 on 11/30/16 at 8:08 PM, on the 400 hall, confirmed "...They haven't changed or clean me yet...not since last state person (state surveyor) was here..." Interview with CNA #19 on 11/30/16 at 8:09 PM, on the 400 hall, confirmed "...I haven't changed her [Resident #21] yet tonight..." Observation and Interview with Licensed Practical Nurse(LPN) #13 on 11/30/16 at 8:12 PM, on the 400 hallway, revealed Resident #21 sitting in a wheelchair with wet saturation pants from the groin, to inner thigh, down to the knees. Interview with LPN #13 confirmed "...She [Resident #21] is soiled...She is a lift transfer...I expect her to be changed every 2 hours..." Medical record review of Resident #45's Care Plan dated 3/25/16 and updated 9/15/16 revealed "...Self Care Deficit...Assist with ADL's as needed...Has incontinence bowel & bladder...Incontinence to be provided by staff as needed..." Medical record review of Resident #45's Nursing Weekly Summary dated 11/19/16 revealed "...ass [assist] x [times] 2 c ADL's + t/f's [transfers]...Incont of B+B [bowel and bladder] peri care PRN [as needed] + q2 [every 2 hours]...non amb [ambulatory] is in the bed most of the time..."	{F 353}	~~Resident #123 - Resident has~~ been discharged on 12/10/16. **Resident #27** - Discharged to home on October 24, 2016 **Resident #68-** Discharged to home on August 31, 2016. **Resident #12** –was assessed by Nurse Practitioner on 7/13/16 for complaint of pain and edema. Order received for venous Doppler study; negative for DVT, resident continued to complain of pain, MD assessed 7/19/16; order received for x-ray; positive for fracture of left leg. Resident transferred to ER for evaluation and treatment. Immobilizer to Left leg with orders to follow up to orthopedic appointment. **Resident #145** Resident was assessed by the Nurse Practitioner on 12/5/16.	

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{F 353}	Continued From page 133 Interview with Resident #45 on 11/30/16 at 8:18 PM, in the resident's room, confirmed "...I haven't been changed since before supper before 5 [PM]..." Continued interview revealed the resident was aware she was soiled and needed to be changed. Interview with RN #2 on 11/30/16 at 8:25 PM, on the 300 hall, confirmed the CNAs were to check and change the residents every 2 hours. Continued interview confirmed the CNAs started their rounds at 6:00 PM. Further interview confirmed CNA's were not to change residents during meals times. Telephone interview with CNA #18 on 12/1/16 at 8:38 PM, confirmed she was assigned to Resident #45 on the night of 11/30/16. Continued interview confirmed she finished her first dry rounds after 10:00 PM. Further interview confirmed the CNA's were instructed in training not to change residents while passing trays or when trays are on the halls. Interview with the DON on 12/5/16 at 2:17 PM, in the conference room, confirmed she expected the residents to be checked and changed every 2 hours and as needed. Interview with Resident #45 on 12/7/16 at 9:39 AM, in the resident's room, confirmed "...It is what it is. What can you do about it..." Medical record review of a TAR for Resident #123 dated 10/2016 revealed "...Twice Daily Betadine dressing until seen by [Orthopedic Doctor] 11/3/16..." Further review revealed treatment was not documented as completed on 10/29/16. Continued medical record review of a TAR dated	{F 353}	Reassessed on 12/7/16 by the Nurse Practitioner who approved wound management treatment plan. 2. • All residents have the potential to be affected. Resident 672 and 802 was reviewed by the Administrator, Director of Nursing and Corporate RN's for accuracy on 12-13-16; as it relates to personal care andtreatment administration to assure adequate direct care coverage. Future admissions will be commensurate with adequate staffing as determined by the Administrator and QA Committee based on compliance with state guidelines and direct care need by feedback provided on Guardian Angel Rounds.	

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{F 353}	Continued From page 134 11/2016 revealed a dressing order dated 10/21/16 "...Clean Surgical Incision To RT [right] Knee with Betadine, Apply [named dressing] & [and] Wrap with [named gauze], Change BID [twice a day]..." Continued review revealed treatments were not documented as completed on 11/8/16,11/11/16, 11/12/16 and 11/14/16. Review of the monthly staff schedules, revealed no treatment nurse on the schedule for 10/29/16, 11/8/16, 11/11/16,11/12/16, and 11/14/16. Interview with the Treatment Nurse on 11/29/16 at 2:37 PM, at the 100 nursing station, confirmed Resident #123 had a pressure area on the posterior right leg. Further interview confirmed the pressure ulcer was not measured on 11/28/16 because the Treatment Nurse was working on the medication cart. Interview with the Treatment Nurse on 12/5/16 at 9:15 AM, in the conference room, confirmed it was difficult to complete all wound treatments when she was pulled to the medication cart. Further interview confirmed wound treatments not completed by the treatment nurse are not always completed by the other nurses. Interview with Registerd Nurse (RN) #1 on 12/6/16 at 9:50 AM, in the 100 hall, confirmed there were times she was unable to complete treatments and dressing changes as ordered by the physician. Review of a facility investigation dated 2/7/16 revealed Resident #65 reported on 2/7/16 she told CNA #14 she was soaking wet and requested to be changed. CNA #14 told the resident he was 2 hours behind and he could not get to her and	{F 353}	3. • On 12/12/16, Root cause analysis was conducted by the Director of Operations and 3 Corporate Clinical Consultants who are RNs, revealed direct care hiring and subsequent staffing was not optimally assigned. • The Director of Nursing established monthly direct care staffing schedule on December 27th, 2017. Assignments have been designated to assure oversight of direct care and the completion of treatments. • The Administrator is monitoring staffing on a daily basis beginning 12/22/16 taking into consideration census and direct care needs. The Administrator calculates PPD to determine compliance with state guidelines and evaluates direct care need by feedback	

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{F 353}	Continued From page 135 did not return. RN #2 reported the incident to the DON on 2/8/16. The DON interviewed Resident #65 and the resident repeated the same incident. Interview with Resident #65 on 11/9/16, in the resident's room, revealed "...can't remember exactly what he said...didn't have time or something like that...it made me feel like I wasn't important..." Medical record review of the Admission Resident Data Set for Resident #106 dated 7/25/16 revealed the resident had a sacral area circled on the body diagram with "...shearing..." written out beside of the area. There were no measurements or description of the wound and no treatment was initiated. Medical record review of the care plan dated 7/25/16 revealed "...treatments as ordered...Measure wound at least weekly...Record..." Medical record review of the Nursing Weekly Summary dated 7/29/16 revealed "...open area in coccyx area. Bilateral buttocks reddened irritated, blood noted in brief from irritated areas on buttocks..." Continued review revealed there were no measurements of the wound. Review of the Daily Staffing Sheets for 7/22-7/31/16 revealed there was no Treatment Nurse scheduled. Medical record review of the wound assessment report dated 8/12/16 revealed no measurements for the right buttock wound. Medical record review of the TAR dated 8/2016	{F 353}	provided on Guardian Angel Rounds. • Corporate RN Staff has been assigned by the Director of Operations who reports directly to the Board of Directors for the managing entity. The Corporate staff began on 12/12/16 to provide surveillance, education, and administrative oversight 7 days per week and will remain assigned to the facility until substantial compliance is achieved and as long as the board continues to deem necessary thereafter. Substantial Compliance will be affirmed by review of supportive audit documentation and subsequent survey revisit. • As a result of the survey, the facility revalidated all current employees on 12-16-16 via Tennessee State Abuse Registry.	

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{F 353}	Continued From page 136 revealed no treatment of pressure ulcer to the sacral and right buttocks was completed on 8/7/16, 8/13/16, and 8/14/16. Review of the Daily Staffing Sheets revealed there was no Treatment Nurse scheduled on 8/7/16, 8/13/16, and 8/14/16. Interview with the Treatment Nurse on 11/8/16 at 4:45PM, in the small conference room, confirmed there were no weekly wound assessments completed on 8/12/16 for the right buttock. Interview with the Treatment Nurse on 12/5/16 at 9:15 AM, in the conference room, confirmed it was difficult to complete all wound treatments when she was pulled to the medication cart. Further interview confirmed wound treatments not completed by the treatment nurse are not always completed by the other nurses. Interview with Registerd Nurse (RN) #1 on 12/6/16 at 9:50 AM, in the 100 hall, confirmed there were times she was unable to complete treatments and dressing changes as ordered by the physician. Medical record review revealed Resident #145 was admitted to the facility on 8/25/16 with diagnoses including: Peripheral Vascular Disease, Right above the Knee Amputation (R AKA), Left below the Knee Amputation (L BKA), Congestive Heart Failure and Diabetes Mellitus. Medical record review of the wound assessment reports for the R BKA and the L BKA revealed 15 out of 30 assessments for 8/25/16 through 12/1/16 were not completed.	{F 353}	• Ads have been placed on prominent job boards beginning 1/2/17 for supervisory positions. Direct Care CNA job board was updated mid December. Recruitment efforts will remain ongoing. • Upon employment, the Human Resources Coordinator will be responsible for obtaining professional licensure verification, certification and other required screening. Background checks are obtained according to state requirements. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to staffing. The QA	

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{F 353}	Continued From page 137 Review of the daily staffing revealed no Treatment Nurse was scheduled for 11 days out of 30 days. Medical record review of the TAR dated 11/2016 revealed the treatments to the left lower extremity stump and the right hip wound had not been initialed as complete for 5 out of 30 days (11/12/16, 11/13/16, 11/19/16, 11/26/16, and 11/27/16). Interview with the Treatment Nurse on 12/7/16 at 3:20 PM, in the conference room, confirmed she did not have any additional measurements for the wounds for Resident #145. Continued interview revealed "...if I work a cart [medication cart] I do the treatments on that hall only...the other nurses are supposed to do their treatments..." Interview with Resident #145 on 12/6/16, in the 200 hall way, revealed "...yes, they change it pretty much every day especially if the treatment nurse is here, but if she's not it's usually every other day..." Medical record review of Resident #145's September 2016 TAR revealed no documentation the treatment had been completed on 9/29/16 and 9/30/16. Review of the Monthly Schedule, Daily Staffing Sheets, and Payroll Reports for September 2016, revealed no Treatment Nurse was working at the facility on 9/29/16 and 9/30/16. Interview with the DON on 12/5/16 at 11:15 AM, in the conference room, revealed "...knew there were holes in the MARS/TARS so we can't prove they were done..."	{F 353}	~~committee consists of DON,~~ NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Direct care PPD Review –Nursing Home Administrator o Grievance Log reported by Social Services Director o Incident Log reported by Risk Manager The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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{F 353}	Continued From page 138 Interview with CNA #7 on 11/19/16 at 10:20 AM, on the 100 hallway, revealed "... it's hard to cover both hallways with 2 people...can't hear alarms down the other hall especially if you are in a room or giving a shower..." Interview with Resident #46 at 10:45 AM, in her room, revealed "...we have not got enough help...just once in a while someone will come in here...takes a half a day or longer sometimes to answer call light..." Interview with CNA #21 on 11/19/16 at 11:00 AM, on the 400 hallway, revealed "...no I haven't gotten to everyone yet...no haven't told my nurse..." Interview with CNA #20 on 11/19/16 at 11:20 AM, on the 300 hallway, revealed "...still have 3 or 4 residents to get to...came in at 6:00 AM...typical day...it takes time...the nurses know..." Interview with LPN #15 on 11/19/16 at 12:15 PM, in the 300-400 nurses station, revealed she was unaware the CNA's were behind on their rounds. Continued interview revealed "...think staffing could be better...If we have call ins we really don't have a lot of prn help..." Interview with LPN #1 on 11/19/16 at 12:35 PM, in the 300 hallway, revealed "...not aware the CNA's were behind...just happens sometimes..." Interview with Resident #93 on 11/30/16 at 10:07 AM, in the resident's room, revealed she requires a walker and assistance of staff to ambulate to the bathroom. Further interview confirmed she is incontinent at times because it takes up to 30	{F 353}	QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 353}	Continued From page 139 minutes for staff to come to her room. Interview with Resident #47 on 12/1/16 at 7:40 AM, in resident's room, revealed "...we don't have enough help cause sometimes don't have enough people to get me up cause it takes 2 people..." Telephone interview with LPN #10 on 12/3/16 at 2:05 PM revealed "...I had someone fall...I can't get the treatments done...the DON is here and I ask for help and she told me not to get so worked up over this. I could do it and if I couldn't I just needed to write a statement and clock out and go home. I had to work over 21 ½ hours last weekend because someone called in last Saturday and we have had another call in today...I can't do it again...It's not safe to work here. We can't get everything done...These people are not being taken care of like they should be. On 11/13 into 11/14/16 when I was working there were several dressings that had not been changed since 11/8/16. I called the DON and told her about it and she told me to just write a statement of who the residents were. So I did and [LPN #13] signed it too...everybody has been mad since then...[RN #1] told me I lied and I told her if they were done then why did the dressing say 11/8/16...the Treatment Administration Records were not signed but they probably are now...if I don't get to them I don't initial that I did them. I'm sure sometimes others initial when they didn't change the dressing..." Interview with the DON on 12/5/16 at 11:15 AM, in the conference room, revealed she was aware treatments were not being completed as ordered. Interview with the Medical Director on 12/5/16 at 1:55 PM, in his office, confirmed he was aware of	{F 353}		

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{F 353}	Continued From page 140 the staffing issues at the facility. Continued interview revealed "...I have been the Medical Director for 15 years and it's always been an issue here..." Interview with the Treatment Nurse on 12/6/16 at 3:40 PM, on the 100 hall, confirmed sometimes she has come back to work after being off and discovered wound treatment had not been done while she was off. Telephone interview with LPN #13 on 12/6/15 at 4:30 PM revealed "...we found multiple, multiple, multiple dressings that had been signed as done but the dressings were dated 11/8/16. I cannot remember everybody...[LPN #10] and I wrote a statement out of how many dressings were dated 11/8, 11/9, and 11/10 [2016] had been initialed as having been changed but were not...I have to stay over every day...I do my med pass and treatments and have to stay over to do documentation and charting...things like that...it's too much to get done in one shift..." Interview with the Treatment Nurse on 12/7/16 at 3:20 PM, in the conference room, revealed "...If I work a cart [medication cart] I work a cart and then do treatments on that hall. Sometimes I get to work on treatments ½ day...I'm not going to lie...it's been hell around...I actually do 3 peoples jobs. I am the treatment nurse, a cart nurse, and I do the scheduling too. If there is no one to schedule to work the shift I have to work the cart...we don't have any open positions right now..." Refer to F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-241 (J); F-280 (J); F-309 (J); F-312 (J); and F-314 (J).	{F 353}		

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{F 353}	Continued From page 141 Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's staffing hours per patient day (HPD), provided by the Administrator, for the week of 12/12/16-12/18/16 revealed: 12/12/16 - 2.28, 12/13/16 - 2.74, 12/14/16 - 2.35, 12/15/16 - 2.34, 12/16/16 - 2.95, 12/17/16 - 3.00, and 12/18/16 - 2.35. 2. Review of the nursing staffing schedule for 12/5/16-1/1/17, revealed LPNs, RNs and CNAs were scheduled to work the assigned shifts with no gaps in coverage. 3. Observation on 12/19/16 at 8:30 PM revealed the following: 200 hallway: 1 Licensed Practical Nurse (LPN) and 2 Certified Nurse Assistants (CNA); 300 hallway: 1 LPN and 2 CNA; 400 hallway: 1 RN and 2 CNAs. Further observation revealed the Nursing Staffing was posted in the lobby and was correct. Observations on 12/20/16 and 12/21/16 revealed staffing patterns to be adequate and correctly posted. 4. Observations from 12/19/16-12/21/16 revealed nursing staff on the hallways providing care to the residents and answering call lights. Further observations revealed no time delay in answering the call lights by the staff. 5. Interviews with 11 interviewable residents on 12/19, 12/20, and 12/21/16, revealed there were no complaints of waiting for call lights to be answered and no issues with incontience care.	{F 353}		

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{F 353}	Continued From page 142 6. Interviews with 5 CNAs and 4 Licensed staff on 12/19, 12/20, and 12/21/16, on all shifts, revealed no issues or complaints of not having enough staff to provide care to the residents. 7. Interview on 12/21/16 at 8:15 AM, with the Administrator and the DON, in the conference room, revealed the administrator reviews the HPD and census to determine the number of staff needed to provide care of the residents. The administrator or the DON post the staffing. Further interview revealed the facilty staffs as follows: 7a-7p: 3 Licensed Staff and 8 CNAs; 7p-7a: 3 Licensed staff and 6 CNAs. Further interview revealed an RN is always scheduled 8 hours per day. Further interview revealed the coorporate staff have been in the facility since 12/12/16 to ensure appropriate staffing and monitoring for resident safety. Further interview revealed the facility implemented a Managers schedule and a management team member is in the facility every day of the week for at least 4-8 hours. 8. Verification of implementation of the Guardian Angel Rounds through observations, interivews, and medical record reviews, revealed the administrative staff had made rounds on the residents on a daily basis to ensure the resident's safety. 9. Review of the Cooporate schedule revealed an administrative staff member was assigned to be present in the facility 7 days a week to provide supervision and abuse survillance. Further review revealed an Administrative schedule for Manager on Duty was implemented and ongoing. Observation on 12/19/16 at 8:30 PM revealed	{F 353}		

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{F 353}	Continued From page 143 administrative staff was present in the building when the survey team arrived in the facility to conduct the Revisit survey. 10. The Coorporate RN staff was assigned by the Regional Director to be present at the facility to ensure 7 days per week survillance occurred, and will remain in the building until substatainal compliance is achieved. Observations during the survey revealed the coorporate nurses were present in the building. The facility remains out of compliance at a Scope and Severity level E that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 353}		
{F 356} SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	{F 356}	**F356 Posted Nurse Staffing Information** 1. Facility posting was corrected on 11/19/16 by the Director of Nursing 2. All residents have the potential to be affected. 3. The business office personnel were informed on 12/22/16 by the Administrator to verify the daily posting is present on the wall. 100% of business office staff was inserviced. Nurse leadership to include the DON, Risk Manager and MDS RN was inserviced by the Administrator on 12-28-16 on the posting	1/20/17

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{F 356}	Continued From page 144 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to accurately post the daily nurse staffing data for 2 of 9 days observed. The findings included: Observation on 11/19/16 at 10:10 AM, in the lobby, revealed "...Today's Staffing...Day shift...Night shift...Census 100..." Further review revealed the posted staffing was dated 11/18/16. Interview with Registered Nurse (RN) #6 on 11/19/16 at 10:35 AM, at the 300-400 nurses station, confirmed the posted staffing was dated 11/18/16 (1 day prior) and the facility "...had not posted the nurse staffing sheet yet..." Observation on 11/28/16 at 9:55 AM, in the lobby, revealed "...Today's Staffing...Day shift...Night shift...Census 104..." Further review revealed the posted staffing was dated 11/23/16. Interview with RN #6 on 11/28/16 at 10:16 AM, in	{F 356}	requirements as related to staffing to include facility name, date, total and actual hours worked by licensed and unlicensed staff directly responsible for resident care per shift to include Registered nurses, licensed practical nurses and certified nursing assistants. The Risk Manager has also provided training on staff posting for all managers commencing on 12/29/16. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to Staff Posting. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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{F356}		{F356}	Audits/tools include Posted Nurse Staffing Audit. The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 356}	Continued From page 145 the lobby, confirmed the facility posted staffing was dated 11/23/16 (5 days prior) and the facility failed to post the current daily staffing.	{F 356}		
{F 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to maintain sanitary conditions in the kitchen during 2 of 2 observations made. The findings included: Review of the facility policy Dietary Services-Departmental Operations, dated December 2008 revealed "...Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens..." Observation with the Certified Dietary Manager (CDM) on 11/28/16 at 10:20 AM, in the kitchen, revealed 4 metal racks with rusted shelves. Continued observation revealed 2 of the rusted shelves held wet plastic Further observation	{F 371}	**F371 Food Procure / Store / Prepare / Serve Sanitary** 1. Items stored on shelving was properly cleaned and dried and placed on plastic trays on 12/13/16 to assure sanitary storage of items. Male staff member with beard was inserviced 12/14/16 by the Registered Dietitian on the importance of wearing protective covering to keep hair from contacting exposed food, equipment and linens and immediately complied.	1/20/17

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{F371}		{F371}	2. All residents have the potential to be affected. 3. • New shelving was ordered on 12-13-16 and installed on 12/26/16 by the Dietary Manager. • All Dietary Staff was in-serviced on the proper cleaning and drying of items prior to storage by the Dietary Manager on 12/13/16 and 12/14/16Dietary staff was the intended audience. • All Dietary Staff was in-serviced on 12-14-16 by the Registered Dietitian on proper covering of hair to avoid contact with food items, equipment, utensils and linens. Dietary staff was the intended audience. • Dietary Manager is conducting weekly audit on	

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{F371}		{F371}	food procurement, sanitary conditions and storage. Audits began on 1-2-17 and remain ongoing weekly times 3 months. • All newly hired Dietary Staff will receive training on "Food Procurement, sanitary conditions and storage" as part of new employee orientation. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to prevention of abuse and neglect. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS	

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{F371}		{F371}	Coordinator, Med Rec Mgr, and activities director. Audits/tools include: Kitchen Sanitation The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter	

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{F 371}	Continued From page 146 revealed the water pitchers was dripping liquid on plastic coffee mugs and cereal bowls located on the shelf beneath the water pitchers. Observation and interview with the CDM on 11/28/16 at 11:45 AM, in the kitchen, revealed a male kitchen staff member with an uncovered beard plating food for resident lunch trays. Interview with the CDM confirmed the beard was not covered and the facility failed to follow facility policy. Interview with the CDM on 12/2/16 at 4:00 PM, outside the conference room, confirmed dishes should be dry before placing on the shelves and the "...the rusted shelves need to be replaced..."	{F 371}		
{F 372} SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to safely dispose of regulated waste for 1 of 2 dumpsters observed. The findings included: Review of the facility policy Waste Disposal, dated December 2008, revealed "...Immediately after use, sharps shall be disposed of in closable, puncture resistant, disposable containers that are leak-proof on the sides and bottom and are labeled or color coded..."	{F 372}	**F372 Dispose Garbage and Refuse Properly** 1. Area around the dumpster was cleared of hazardous debris 12-9-16 by the Environmental Services Director. 2. All residents have the potential to be affected. 3. • All Licensed staff were in-serviced on the proper disposal of sharps including needles and lancets in designated containers by The	1/20/17

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{F372}		{F372}	Risk Manager and the Evening Supervisor on 12-28-16 through 1-11-17. Licensed staff was the intended audience. On 12/28/16, • The Maintenance Director who serves as Safety Officer will assure compliance by review and surveillance of the area surrounding the dumpster to assure compliance 3 x per week x 60 days then weekly x 4 weeks, then monthly thereafter. Violations will be reported to the Administrator. • All Licensed Staff will receive training on "Safety (sharps disposal) and identification of hazards as part of new employee orientation. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the	

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{F372}		{F372}	daily audits noted to assure adherence to facility policy related to disposal of garbage and refuse. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: • Disposal of Garbage and Refuse presented by the Safety Officer The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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{F372}		{F372}	QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 372}	Continued From page 147 Observation with the Certified Dietary Manager (CDM) on 1/28/16 at 10:30 AM, of the outside dumpsters, revealed 1 syringe, 1 blood glucose lancet, 2 medicine cups, and 1 glove lying on the ground outside of the dumpsters. Interview with the Director of Nursing (DON) on 12/5/16 at 11:30 AM, in the DON office, confirmed staff were to dispose of syringes and lancets in the sharps container and the facility failed to follow facility policy.	{F 372}		
{F 441} SS=E	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, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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	{F 441}	**F441 Infection Control, Prevent Spread, Linens** 1. Resident in room 105 was re-cultured for infection on 12/8/16 and results were negative. Staff member entering room to provide lunch tray absent following the required isolation precaution separated from company on 1/2/16. 2. All residents with isolation precautions implemented per physician order effective 11/28/16. Have the potential to be affected.	1/20/17

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{F 441}	Continued From page 148 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE) before entering an isolation room for 1 of 2 isolation rooms observed. The findings included: Review of the facility policy, Isolation- Categories of transmission-Based Precautions, revised August 2010, revealed "...In addition to Standard Precautions, implement Contact Precaution for residents known or suspected to be infected...Examples of infections requiring Contact Precautions include...Diarrhea associated with Clostridium difficile...wear gloves...when entering room...wear a gown...for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment..." Observation on 11/28/16 at 12:52 PM, on the 100 hallway, revealed an isolation cart containing gowns and gloves outside of resident room #105.	{F 441}	3. • All Staff were inserviced by the Director of Nursing on 12/12/16-12-15 on the survey findings to include the use of personal protective precautions as it relates to residents in isolation. On 12/31/16, • The Risk Manager will assure compliance by observation during meal Delivery3x per week x 4 weeks to assure compliance. If non-compliance is noted; immediate corrective action will be taken and reported to Administrator. • All newly hired staff will receive training on "Universal Precautions and the use of personal protective equipment when indicated" as part of new employee orientation.	

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{F441}		{F441}	4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to use of personal protective equipment. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Observation Audit presented by the Risk Manager The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ	

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{F441}		{F441}	Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 441}	Continued From page 149 Continued observation revealed a sign on the outside of the door to room #105 to check at the Nurse's Station before entering. Further observation revealed Licensed Practical Nurse (LPN) #5 entered room 105 without donning PPE; sat a lunch tray on the resident's bedside table; exited the resident's room; donned a gown and gloves; and then reentered the resident's room. Interview with LPN #5 on 11/28/16 at 12:53 PM, in the 100 hallway, confirmed the resident was on contact isolation precautions for a Clostridium difficile infection (infection in the colon causing diarrhea). Further interview confirmed staff were to don a gown and gloves before entering a contact isolation room and LPN #5 failed to do so. Continued interview confirmed LPN #5 failed to follow facility policy. Interview with the Director of Nursing (DON) on 11/29/16 at 7:30 AM, in 100 hallway, confirmed staff were to wear a gown and gloves before entering a contact isolation room. Continued interview confirmed LPN #5 failed to follow facility policy.	{F 441}		
{F 464} SS=F	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced	{F 464}	**F464 Requirements for Dining and Activity Room** 1. There were no specific residents identified in this deficiency. 2. All residents have the potential to be affected.	1/28/17

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{F 464}	Continued From page 150 by: Based on observation and interview, the facility failed to provide adequate ventilation during and after resident and staff smoking breaks for 2 of 4 resident hallways, 2 of 2 main hallways (A and B), 1 of 1 activity rooms, where residents gather to watch movies, and 1 of 1 main dining room where residents gather to visit. The findings included: Observation and interview with Licensed Practical Nurse (LPN) #15 on 11/28/16 at 2:00 PM, at the 300/400 nursing station, revealed a strong smell of cigarette smoke. Further observation revealed 2 residents were sitting in wheelchairs at the nurse's station. Interview with LPN #15 confirmed the smell of cigarette smoke. Observation on 11/28/16 at 2:10 PM revealed the resident smoking area was accessed through double glass doors off of the activity room. Observations on 11/28/16-11/30/16 revealed the residents entered and exited by themselves or were transferred by staff through the double glass doors located in the activity room to the outside to the resident smoking area for smoking breaks. Further observations revealed nonsmoking residents sitting in the activity room in their wheelchairs watching movies. Continued observations revealed the odor of cigarette smoke in the activity room and in hallway A. Interview with LPN #15 on 11/29/16 at 8:06 AM, on the 400 hall, confirmed "...You can smell it [cigarette smoke] on the back nursing station sometimes..."	{F 464}	3. The current air curtain ventilation units were serviced by the Maintenance Director on 12/13/16. On 12/14/16 an additional ventilation aide was installed in the resident smoking area to enhance air quality on entry and exit to the smoking area. New air curtains are ordered 1/4/17 and was installed on 1-18-17. On 12/19/16, a boundary line was painted on the sidewalk of the employee smoking area approximately 18 feet from the facility entrance to denote a NO SMOKING zone. An additional NO SMOKING sign was prominently posted on 1/3/17 and staff members are verbally reminded when non-compliance is observed by the Nursing Home Administrator and Safety Director.	

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{F 464}	Continued From page 151 Observation on 11/30/16 at 9:30 AM, revealed 3 staff members standing outside smoking in the staff smoking area. Further observation revealed the administrator exited through the door and a strong smell of cigarette smoke entered the building. Continued observation revealed the smoke was smelled in the dining room, the hallway B outside the dining room, and the 300/400 hallways. Interview with the Dietician on 11/30/16 at 2:29 PM, confirmed "...I'm very surprised more people don't complain. The smell [cigarette smoke] is very overpowering especially over there [activity room]..." Continued interview confirmed the smell of cigarette smoke was observed in the activity room, the dining room, and hallway A (located between the activity room and the dining room). Interview with the Administrator on 11/30/16 at 2:55 PM, in the conference room, confirmed the facility had a "...antiquated ventilation system over the door...I don't think it works...I really don't...they [the residents] are not supposed to come back...through the activity room unless it is inclement weather...I implemented that..." Interview with Physician #1 on 12/2/16 at 4:44 PM, in the conference room, confirmed the cigarette smoke odor extended to her office on the B hallway. Further interview confirmed "...the cigarette smoke can affect the residents in the facility...due to the residents with respiratory problems and difficulties..." Interview with the Administrator on 12/5/16 at 7:07 PM, in the activity room, confirmed cigarette smoke could be smelled in the activity room.	{F 464}	• The Maintenance Director will assure safety and function of the installed air curtain devices in accordance with functional testing rounds weekly x 4 weeks, then monthly thereafter, starting on 1/4/17. on 1/4/17 • The Administrator will monitor the designated employee smoking area 3 times a week for 9 weeks to ensure compliance, then weekly times 4 weeks, with proximity requirements. Both the Maintenance Director and Administrator will report findings to the QA department. • All newly hired licensed nurses and CNA's will receive training on "Smoking Policy" as part of new employee orientation. 4. Findings noted on the following audits/tools will be reported to the Quality	

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{F464}		{F464}	Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to Requirements for Dining and Activity Rooms. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: • Requirement for Dining and Activity Audit presented by Maintenance Director • Smoking Area Surveillance Audit presented by Nursing Home Administrator. The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet	

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{F }		{F }	Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 490} {F 490} SS=E	Continued From page 152 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of facility investigations, observation, and interview, the facility failed to be administered in a manner to ensure wound care protocols were available and followed to assess and treat all wounds; to ensure residents with medical devices (immobilizers) did not develop pressure ulcers related to use of the device; to ensure the physician was notified for changes in condition and to obtain treatment orders; to ensure all residents were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure residents were safe from accidents; and to ensure adequate staffing to provide care and services to residents according to their needs and care plans. The facility's failure placed 10 residents (#106, #123, #75, #103, #65, #27, #68, #21, #45, #12, #145) in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirement of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Corporate Director of Clinical Services and the Administrator were informed of the Immediate Jeopardy (IJ) in the conference room on 12/7/16	{F 490} {F 490}	**F490 Effective Administration / Resident Well-Being** 1. **Resident #12** – Left leg wound was resolved prior to annual survey. Nurse Practitioner examined resident on December 7, 2016 and no areas of concern noted. **Resident #21** Resident #21was interviewed by the Social Services Director on 12/13-16 and voiced no current concerns. **Resident #27** - Discharged to home on October 24, 2016. Employee #4 terminated 8/18/16. **Resident #45** Resident #45 was interviewed by the social Services Director on 12/13/16 and voiced no current concerns. **Resident #65** - During the course of Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet	1/20/17

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{F 490}	Continued From page 153 at 9:30 AM. The facility was cited an Immediate Jeopardy at F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-353 (K); F-490 (K); F-493 (K); F-501 (K); and F-520 (K). The facility was cited Substandard Quality of Care (SQC) at F-223 (K), F-224 (J), F-225 (K), F-241 (J), F-309 (J), F-312 (J), and F-314 (J). The IJ was effective on 2/6/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-490 at a "E" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Interview with the Director of Nursing (DON) on 11/8/16 at 5:05 PM, in her office, confirmed the facility did not have a protocol the nursing staff could refer to for the identification, assessment and treatment of pressure ulcers. Interview with the Nurse Practitioner (NP) on 11/9/16 at 10:25 AM, in the small conference room, revealed she thought standing orders for Decubitus Care stated refer to wound care	{F 490}	resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #68** - Discharged to home on August 31, 2016. CNA #15 was banned from returning to the facility from the agency 8/22/16 **Resident #75** - On February 6, 2016, CNA was suspended after allegation of verbal abuse by resident on February 6, 2016. CNA was subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #103** - During the course of the Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident	

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{F 490}	Continued From page 154 protocol and were to be followed. She was unaware the facility did not have a wound care protocol to follow. Interview with the Administrator on 11/28/16 at 3:55 PM, in the conference room, confirmed he would expect the facility to follow the procedures outlined in the facility Abuse policy. Interview with the DON on 12/5/16 at 11:40 AM, in the conference room, confirmed the facility had failed to obtain an order for treatment of Resident #106's wound when it was identified on admission. Continued interview confirmed Resident #106's wound declined between the time it was first identified and the time treatment was initiated. Further interview revealed the DON was unaware of the online protocols for the treatment of wounds. Interview with the Medical Director on 12/5/16 at 1:55 PM, in his office, confirmed he was unaware the facility did not have protocols in place for wound care. Continued interview confirmed he does not do training or teaching on wound care with the Director of Nursing or the Treatment Nurse. Continued interview confirmed the facility did not have enough staff to care for the residents. Further interview confirmed he has been the Medical Director at this facility for 15 years and it had always been an issue. Interview with the Regional Director on Clinical Services on 12/6/16 at 10:00 AM, at the 100-200 hall nurses station, confirmed the facility did have access to wound care protocols and they were located on the company's website portal, available to staff, and could be printed out.	{F 490}	indicated that same CNA involved with the resident #75 event was verbally inappropriate to resident 103. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #106** – Family attended Care Plan meeting on 8-11-16, skin condition was reviewed with family member in attendance. 11-11-16. Nurse practitioner examined resident knee on 12-7-16. Resident currently has no wounds. **Resident #123** – Nurse Practitioner was notified of Right Lower extremity posterior skin condition on 11/15/16. MD reviewed and co-signed (undated). Resident was aware and self-responsible. Resident #123 was discharged home on 12-10-16. **Resident #145** Resident was assessed by the Nurse Practitioner	

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{F 490}	Continued From page 155 Refer to F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-323 (G); F-353 (K); F-493 (K); F-501 (K); and F-520 (K). Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records revealed that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's new Abuse Prohibition and Investigation Policy initiated 11/18/16. Education was conducted on 11/18/16 and 12/9/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 11/18/16 and 12/9/16 and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 107 staff members, contract staff, and volunteers were educated on facility policies between 11/18/16 and 12/9/16. 2. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs), the Director of Nursing, Administrator, and Medical Director was conducted on 12/19, 12/20, and 12/21/16, on all shifts, and confirmed the staff's understanding of the facility's policies for reporting and investigating abuse and the timeframe the allegations and investigation were to be reported in. 3. Interviews were conducted with 11 residents during the revisit survey on 12/19, 12/20, and 12/21/16, and revealed no residents complained about being abused or seeing any other resident	{F 490}	on 12/5/16. Reassessed on 12/7/16 by the Nurse Practitioner who approved wound management treatment plan. 2. All residents have the potential to be affected and were evaluated for impact by personal interview, body audit and ongoing surveillance. 3. On 11/29/16, The RN Clinical Consultant reviewed/instructed. NHA and DON on the suspension guidelines for allegation of abuse. The requirement to remove the person accused of committing abuse from the situation immediately and brought to an area of supervision while statement is obtained and suspension notice is issued. They are to be removed from the facility immediately and not to return until the investigation is concluded and is notified per the NHA of the outcome of the investigation.	

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{F 490}	Continued From page 156 being abused. 4. Interview with the Administrator on 12/20/16 at 3:45 PM, in the conference room, revealed an in-service had been provided by the Director of Operations on abuse prohibition and reporting. 5. Interview with the Quality Assurance Team on 12/21/16 at 11:40 AM, in the conference room, revealed weekly Quality Assurance and Ad Hoc meetings had taken place since 11/18/16 and included Corporate staff. 6. Review of the facility's in-service records dated 12/9/16 and 12/13/16 revealed 100% of the nursing staff were educated regading Patient Rights, Incontinence Care and Dignity. Review of the facility's plan of action revealed all nurses were educated on the policies before being allowed to return to work. Interviews with Administrative staff conducted on 12/19, 12/20, and 12/21/16, confirmed all employees received the education. 7. Iinterviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN]) was conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and with 9 Certified Nurse Assistants (CNA) beween the same time frames and dates, and confirmed the staff's understanding of Patient Rights, Dignity and Incontience Care. 8. Review of 19 resident records on 12/19/16-12/21-16 revealed no evidence of incontience care not being provided timely. 9. Interviews were conducted 12/19/16 - 12/21/16	{F 490}	• Root cause analysis was conducted on 12/13/16 by the Director of Operations and 3 corporate Clinical Consultants who are RNs by reviewing cited examples and policies related to the citations. Root cause was determined to relate primarily to the implementation of the abuse policy, wound management policy, notification of change in condition policy and subsequent follow up. • The Director of Nursing established monthly direct care staffing schedule on December 27, 2016. Assignments have been designated to assure oversight of direct care and completion of treatments. • The Corporate team launched a recruitment initiative on 12/15/16 to include ad placement in web-based job posting and followed up on respondents;	

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{F 490}	Continued From page 157 with 11 interviewable residents and revealed there were no complaints regarding any issues with dignity or Patient Rights. 10. Verification of the implementation of the facility policy for Guardian Angel Rounds, established by the facility Administrator on 12/13/16, was completed through observations and interviews, and those rounds were ongoing during the revisit survey 12/19/16 - 12/21/16. Review of facility documentation revealed Guardian Angel Rounds were ongoing 7 days per week to openly discuss any concerns residents had regarding their care. Review of the schedule revealed coverage assigned for the rounds was on a 24/7 basis, with corporate staff and assigned night shift Nurses to provide supervision and surveillance. 11. Review of the Cooporate Staff schedule revealed an administrative staff member was assigned to be present in the facility 7 days a week to provide supervision and abuse surveillance. Further review revealed an Administrative schedule for Manager on duty was implemented and in place. Observation on 12/19/16 at 8:30 PM revealed administrative staff were in the building when the team arrived in the facility to begin the Revisit survey. 12. The Coorporate RN staff was assigned by the Regional Director to be present in the facility to ensure 7 days per week survillance would occur and they will remain in the building until substatainal compliance is achieved. Observations during the survey revealed the coorporate nurses were present and active in the building.	{F 490}	coordinating interviews pre-employment screening process. • Ad Hoc QA Meeting was held on 12-8-16, known deficiencies were reviewed and immediate plan of action was established. The meeting was conducted by the Administrator, Corporate Nurse and Area Manager. • Corporate team arrived to the facility beginning on 12-12-16.Meetings with the Administrator and interdisciplinary team were held to determine root cause analysis assure resident remedy, impact to others and methodical remedy have been ongoing. Training needsto restore program integrity were identified, reviewed by the team and implemented as evidenced by the inservices and surveillance tools noted herein. Facility is holding morning and afternoon	

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{F 490}	Continued From page 158 13. Interviews with the Cooporate nurses on 12/21/16 at 10:30 AM confirmed the nurses were assigned to the building. 14. Review of the facility's in-service records dated 12/12/16 and 12/13/16 revealed 100% of the nursing staff were educated regading implementation and revision of care plans. On 12/12/16 the MDS nurses recieved education regarding MDS assessments and revising care plans to reflect the resident's current condition. 15. Interviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN] and MDS Coordinators) was conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and confirmed the staff's understanding of implementation and revision of care plans per the education received and based on the MDS assessment. 16. Review of 19 resident records conducted on 12/19/16-12/21/16 revealed the residents' care plans had been revised and the current plans contained appropriate and specific areas which were triggered by the MDS assessment. 17. Observations on 12/19/16 through 12/21/16 revealed Resident #12 had the knee immobilizer in place and applied correctly. Further observation of the resident's wound revealed the wound had healed. 18. Medical record review, observation, and interview, revealed the Weekly Wound and Pressure Ulcer Report and Splint Listing dated 12/13/16 correctly identified all residents with wounds or splint devices. The report is provided	{F 490}	meetings to provide status update of the cited citations. The Department Managers attend to include the Administrator, DON, Risk Manager, Care Planning, Director of Rehab, Medical Records, Social Services Director. • The Area Manager who is an NHA, met with the facility Administrator and DON on 12-15-16 on the importance of having daily staffing meetings with the DON and scheduler to discuss o Review current schedule for the next two to three days and what is being done if staffing is less than optimal. o Having a plan for the weekend to have nursing management come in if call-offs could result in having less than the minimum 2.0 staffing. o Openings and current	

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{F 490}	Continued From page 159 weekly and reviewed by the interdisciplinary care team to ensure all wounds are identified by the direct care team and a care plan is implemented. 19. Verification with the Director of Nursing (DON) was completed on 12/20/16 at 10:30 AM, in the conference room, and revealed audits are conducted by the nursing staff to include 5 physicians orders or changes in condition 5 times per week. The Corporate team conducts oversight of the audits. Follow-up interviews with the Cooporate Nurses on 12/21/16 at 10:30 AM, in the conference room, confirmed Corporate follow-up was in process and ongoing. 20. Review of the facility's in-service records ensuring that 100% of staff was educated on skin assessments, body audits, and splints and immobilizers. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/7/16 and interviews with the facility leadership staff confirmed 100% of the staff had been educated on the facility policies by 12/7/16. 21. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted on 12/19, 12/20, and 12/21/16, and confirmed the staff's comprehension of the facility's policies for skin assessment checks and splint and immobilizer positioning checks. 22. Review of 19 resident medical records on 12/19/16 and 12/20/16 verified skin assessments had been completed per facility policy. 23. Review of the facility's in-service records ensuring that 100% of active staff was educated	{F 490}	applicants current recruiting needs. • On 12/15/16, the Corporate compliance officer met with the Administrator and the Director of Nursing to discuss the use of the Administrators Incident/Occurrence Worksheet to assure appropriate steps are taken in the investigative process are taken . • Clinical Nurse Staff Meeting and Inservice regarding splinting, completion of treatments, and completion of assessments was conducted by the DON to re-educate 12-7-16 through 1-18-17. • Revision of Weekly Skin Assessment Schedule was completed by the Director of Nursing to eliminate the rooms temporarily closed from schedule 12-7-16.	

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{F 490}	Continued From page 160 by the Social Services Director and Risk Manager on the facility's Resident Rights and Grievance Policy by 12/13/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/13/16, review of facility staffing, and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 100% of the active staff had been educated on facility policies by 12/13/16. 24. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted on 12/19, 12/20, and 12/21/16, and confirmed staff had received education on the facility's policies for resident rights and grievances and were able to verbalize the content of the education. 25. Interviews with 11 residents on 12/19, 12/20, and 12/21/16, revealed no complaints about the care the resident had received since implementation of the AoC. 26. Observation of wound care for 5 residents during the revisit survey on 12/19 and 12/20/16, revealed the wound care nurse followed proper technique during the dressing changes, and the documentation of the wound stages and sizes correlated with the wound observations. 27. Review of the facility's staffing hours per patient day (HPD), provided by the Administrator, for the week of 12/12/16-12/18/16 revealed staffing was adequate to provide for residents' needs. 28. Review of the nursing staffing schedule for 12/5/16-1/1/17, revealed LPNs, RNs and CNAs	{F 490}	• The Licensed Nurses and CNAs were re-inserviced by the Director of Nursing on 12-12-16 through 1-18-17 to increase awareness of need for immediate reporting by CNAs to nurses, and prompt notification to physician , resident and representative by nurses with incident, change in condition or treatment. • Abuse Training conducted by the Risk Manager to all staff to enhance awareness of what is abuse, how to investigate, importance of protecting the resident and when and how to report it 12-9-16 through 1-20-17. • To determine other residents who may have been affected by alleged deficient practice a 100% Interview of Residents by Social Worker on 12-6 and 12-7-16was conducted. For those residents who did not respond to the interview,	

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{F 490}	Continued From page 161 were scheduled to work the assigned shifts with no gaps in coverage. 29. Observation on 12/19/16 at 8:30 PM revealed the following: 200 hallway: 1 Licensed Practical Nurse (LPN) and 2 Certified Nurse Assistants (CNA); 300 hallway: 1 LPN and 2 CNA; 400 hallway: 1 RN and 2 CNAs. Further observation revealed the Nursing Staffing was posted in the lobby and was correct. Observations on 12/20/16 and 12/21/16 revealed staffing patterns to be adequate and correctly posted. 30. Observations 12/19/16-12/21/16 revealed nursing staff on the hallways providing care to the residents and answering call lights. Further observations revealed no time delay in answering the call lights by the staff. 31. Interviews with 11 interviewable residents on 12/19, 12/20, and 12/21/16, revealed there were no complaints of waiting for call lights to be answered and no issues with the incontience care. 32. Interviews with 5 CNAs and 4 Licensed staff on 12/19, 12/20, and 12/21/16, on all shifts, revealed no issues or complaints of not having enough staff to provide care to the residents. 33. Interview on 12/21/16 at 8:15 AM, with the Administrator and the DON, in the conference room, revealed the administrator reviews the HPD and census to determine the number of staff needed to provide care of the residents. The administrator or the DON post the staffing. Further interview revealed the facilty staffs as follows: 7a-7p: 3 Licensed Staff and 8 CNAs; 7p-7a: 3 Licensed staff and 6 CNAs. Further	{F 490}	Body Audits were conducted by the Charge Nurses12-6-16 and 12-7-16. • Resident Council Meeting conducted by Social Services Director 12-7-16 to discuss facility initiatives related to abuse reporting and investigations. Residents informed that they should report concerns immediately and may remain anonymous. • The Administrator trained Department Managers on 12-9-16 on the implementation of Guardian Angel Rounds to include goals, review of Assignment, frequency and utilization of tool. The Administrator instructed the team to complete Grievance form if care concerns were voiced during rounds. • Inservice with DON and MDS Coordinators on coding of Section M of MDS and revisions to care plans	

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{F 490}	Continued From page 162 interview revealed an RN is always scheduled 8 hours per day. Further interview revealed the coorporate staff have been in the facility since 12/12/16 to ensure appropriate staffing and monitoring for resident safety. Further interview revealed the facility implemented a Managers schedule and a management team member is in the facility every day of the week for at least 4-8 hours. 34. Review of the facility's in-service records revealed Licensed staff and CNAs received education regarding proper notification to the physician, resident, and representative with any changes in condition and treatment by 12/12/16. 35. Interviews with 9 Licensed caregivers on 12/19, 12/20, and 12/21/16, on all shifts, confirmed the staff received the required training regarding proper notification and were able to verbalize the training received. 36. Surveyors verified through observation and interview with staff on 12/19, 12/20, and 12/21/16, the Notification Tool was initiated on 12/15/16 and was being completed to include all telephone orders and a 24 hour report for any change of condition. Interviews confirmed the supervisors had been educated to complete the log and document all notifications to the physician, resident, or representative. 37. Interview with the Medical Director on 12/21/16 at 10:05 AM, in the conference room, revealed the physician was available by phone for any resident issues. Further interview revealed the physician or Nurse Practitioner was, and had been, making freqent visits to the facility. The staff were calling the Medical Director with any	{F 490}	conducted by Corporate Resident Assessment Specialist on 12-12-16.. • Accuracy Audit Tool was initiated on 12-15-16 by the DON to assure pressure ulcer treatment was completed and clinical record documented. • Weekly and Monthly Weight Calendar established by the Director of Nursing 12-14-16. • Dialysis Communication Sheet was Inserviced12-9-16 through 12-13-16 by Risk Manager and Corporate Nurse to the Licensed Nurses. • Weekly body audit schedule was reviewed by the DON on 12-7-16; body audits continue to be completed as assigned. • Audit of completion of assigned body audits began on 12-7-16 by the Medical Records Director(LPN) Audits	

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{F480}		{F480}	are conducted weekly to assure goal of 100% compliance of completed skin audits; once goal is achieved, audit will be reduced to 10 random per week x 6 week, then monthly x months. • On 12-13-16, a Certified Wound Nurse (RN) trained the facility treatment nurse and Director of Nursing on Wound Staging, assessment, protocol, supportive surfaces and prevention. • The Director of Operations on 12-15-16 established the Notification Exception Report to serve as tool for audit of physician notification. • Manager on Duty schedule was revised by the Administrator on 12-26-16. • Corporate Personnel Facility On-site Support Schedule established by the Director of Operations on 12-12-16.	

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{F490}		{F490}	• Educational Postings related to abuse prevention developed by the Director of Operations 12-12-16. • Administrator Incident/Unusual Occurrence Worksheet implemented by the Director of Operations (12-15-16). • The HR Coordinator revalidated all current employees on 12-16-16 via Tennessee State Abuse Registry. • Upon employment, and during annual performance evaluation the Human Resources Coordinator will be responsible for obtaining professional licensure verification, certification and other required screening. Background checks are obtained according to state requirements 4.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F490}		{F490}	Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to prevention of abuse and neglect, staffing,, notification of change and wound prevention and management. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Grievance Log reported by Social Services Director	

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{F490}		{F490}	o Incident Log reported by Risk Manager o New Hire Abuse Education reported by Risk Manager o Notification Exception Tool reported by the Director of Nursing o Wound Accuracy Audit reported by the Risk Manager o Direct Care PPD Review reported by the Administrator The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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(F480)		(F480)	QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	

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{F 490}	Continued From page 163 issues related to resident care. 38. Interview on 12/21/16 with the Director of Nursing, in the conference room, revealed the notification tool had been implemented. Further interview revealed any change in a resident's condition was documented in the medical record and on the notification tool to ensure proper follow-up. Further review revealed key staff had been chosen and in-serviced regarding the log to assume responsibility in the absence of the DON. The facility will remain out of compliance at a Scope and severity of "E", a deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 490}		
{F 493} SS=E	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of facility investigations, observation, and interview, the Governing Body failed ensure wound care protocols were	{F 493}	**F493 Governing Body** 1. **Resident #12** – Left leg wound was resolved prior to annual survey. Nurse Practitioner examined resident on December 7, 2016 and no areas of concern noted. **Resident #21** Resident #21was interviewed by the Social Services Director on 12/13-16 and voiced no current concerns. **Resident #27** - Discharged to home on October 24, 2016. Employee #4 terminated 8/18/16.	1/20/17

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{F 493}	Continued From page 164 available and followed to assess and treat all wounds; to ensure residents with medical devices (immobilizers) did not develop pressure ulcers related to use of the device; to ensure the physician was notified for changes in condition and to obtain treatment orders; to ensure facility policy was followed so all residents were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure residents were safe from accidents; and to ensure adequate staffing to provide care and services to residents according to their needs and care plans. The facility's failure placed 10 residents (#106, #123, #75, #103, #65, #27, #68, #21, #45, #12, #145) in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirement of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Corporate Director of Clinical Services and the Administrator were informed of the Immediate Jeopardy (IJ) in the conference room on 12/7/16 at 9:30 AM. The facility was cited an Immediate Jeopardy at F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-353 (K); F-490 (K); F-493 (K); F-501 (K); and F-520 (K). The facility was cited Substandard Quality of Care (SQC) at F-223 (K), F-224 (J), F-225 (K), F-241 (J), F-309 (J), F-312 (J), and F-314 (J). The IJ was effective on 2/6/16 and was removed 12/16/16. The facility provided an acceptable Allegation of	{F 493}	**Resident #45** Resident #45 was interviewed by the social Services Director on 12/13/16 and voiced no current concerns. **Resident #65 -** During the course of Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #68** - Discharged to home on August 31, 2016. Employee. CNA #15 was banned from returning to the facility from the agency 8/22/16. **Resident #75** - On February 6, 2016, CNA was suspended after allegation of verbal abuse by resident on February 6, 2016. CNA was subsequently terminated on	

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{F 493}	Continued From page 165 Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-493 at a "E" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Interview with the Director of Nursing (DON) on 11/8/16 at 5:05 PM, in her office, confirmed the facility did not have a protocol the nursing staff could refer to for the identification, assessment and treatment of pressure ulcers. Interview with the Nurse Practitioner on 11/9/16 at 10:25 AM, in the small conference room, revealed she thought standing orders for Decubitus Care stated refer to wound care protocol and were to be followed. She was unaware the facility did not have a wound care protocol to follow. Interview with the Administrator on 11/28/16 at 3:55 PM, in the conference room, confirmed he would expect the facility to follow the procedures outlined in the facility Abuse policy. Interview with the DON on 12/5/16 at 11:40 AM, in the conference room, confirmed the facility had failed to obtain an order for treatment of Resident #106's wound when it was identified on admission. Continued interview confirmed Resident #106's wound declined between the	{F 493}	February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #103 -** During the course of the Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that same CNA involved with the resident #75 event was verbally inappropriate to resident 103. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #106** – Family attended Care Plan meeting on 8-11-16, skin condition was reviewed with family member in attendance. 11-11-16. Nurse practitioner examined resident knee on 12-7-16. Resident currently has no wounds.	

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{F 493}	Continued From page 166 time it was first identified and the time treatment was initiated. Further interview revealed the DON was unaware of the online protocols for the treatment of wounds. Interview with the Medical Director on 12/5/16 at 1:55 PM, in his office, confirmed he was unaware the facility did not have protocols in place for wound care. Continued interview confirmed he does not do training or teaching on wound care with the Director of Nursing or the Treatment Nurse. Continued interview confirmed the facility did not have enough staff to care for the residents. Further interview confirmed he has been the Medical Director at this facility for 15 years and it had always been an issue. Interview with the Regional Director on Clinical Services on 12/6/16 at 10:00 AM, at the 100-200 hall nurses station, confirmed the facility did have access to wound care protocols and they were located on the company's website portal, available to staff, and could be printed out. Refer to F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-323 (G); F-353 (K); F-490 (K); F-501 (K); and F-520 (K). Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records revealed that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's new Abuse Prohibition and Investigation Policy initiated 11/18/16. Education	{F 493}	**Resident #123** – Nurse Practitioner was notified of Right Lower extremity posterior skin condition on 11/15/16. MD reviewed and co-signed (undated). Resident was aware and self-responsible. Resident #123 was discharged home on 12-10-16. **Resident #145** Resident was assessed by the Nurse Practitioner on 12/5/16. Reassessed on 12/7/16 by the Nurse Practitioner who approved wound management treatment plan. 2. All residents have the potential to be affected and were evaluated for impact by personal interview on 12/7/16 , body audit on 12/6/16 and 12/7/16 and ongoing surveillance. 3. • Corporate Staff has been assigned by the Director of Operations who reports directly to the Board of Directors for the managing entity. The Team will remain	

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{F 493}	Continued From page 167 was conducted on 11/18/16 and 12/9/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 11/18/16 and 12/9/16 and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 107 staff members, contract staff, and volunteers were educated on facility policies between 11/18/16 and 12/9/16. 2. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs), the Director of Nursing, Administrator, and Medical Director was conducted on 12/19, 12/20, and 12/21/16, on all shifts, and confirmed the staff's understanding of the facility's policies for reporting and investigating abuse and the timeframe the allegations and investigation were to be reported in. 3. Interviews were conducted with 11 residents during the revisit survey on 12/19, 12/20, and 12/21/16, and revealed no residents complained about being abused or seeing any other resident being abused. 4. Interview with the Administrator on 12/20/16 at 3:45 PM, in the conference room, revealed an in-service had been provided by the Director of Operations on abuse prohibition and reporting. 5. Interview with the Quality Assurance Team on 12/21/16 at 11:40 AM, in the conference room, revealed weekly Quality Assurance and Ad Hoc meetings had taken place since 11/18/16 and included Corporate staff. 6. Review of the facility's in-service records dated 12/9/16 and 12/13/16 revealed 100% of the	{F 493}	assigned to the facility and be present a minimum of 8 hours per day, varying hours, until substantial compliance is achieved and as long as the board continues to deem necessary thereafter. The team remains on-call when not in the facility. • The Team's responsibilities include surveillance, education, Administrator oversight and restoration of system integrity and assist with the evaluation of the effectiveness of measures and tools implemented to assure continued safety and services to the resident population. • The Governing Body assigned the Director of Operations on 12-7-16 to direct and oversee the restoration of substantial compliance. Team Members include:	

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{F 493}	Continued From page 168 nursing staff were educated regading Patient Rights, Incontinence Care and Dignity. Review of the facility's plan of action revealed all nurses were educated on the policies before being allowed to return to work. Interviews with Administrative staff conducted on 12/19, 12/20, and 12/21/16, confirmed all employees received the education. 7. Iinterviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN]) was conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and with 9 Certified Nurse Assistants (CNA) beween the same time frames and dates, and confirmed the staff's understanding of Patient Rights, Dignity and Incontience Care. 8. Review of 19 resident records on 12/19/16-12/21-16 revealed no evidence of incontience care not being provided timely. 9. Interviews were conducted 12/19/16 - 12/21/16 with 11 interviewable residents and revealed there were no complaints regarding any issues with dignity or Patient Rights. 10. Verification of the implementation of the facility policy for Guardian Angel Rounds, established by the facility Administrator on 12/13/16, was completed through observations and interviews, and those rounds were ongoing during the revisit survey 12/19/16 - 12/21/16. Review of facility documentation revealed Guardian Angel Rounds were ongoing 7 days per week to openly discuss any concerns residents had regarding their care. Review of the schedule revealed coverage assigned for the rounds was	{F 493}	• Director of Operations, RN, RMC, LNHA • Corporate Resident Assessment Specialist RN, RAC-CT, QCP, NHA • Corporate Clinical Consultant, RN, NHA • Corporate Compliance Officer, RN, RAC CT, BC-Gerontology • Corporate Resident Assessment Specialist RAC-CT • Area Manager, LNHA • Corporate Clinical Consultant, RN, RMC, OSHA Certified • Assistant Corporate Director of Rehabilitation, MACCCSLP	

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{F 493}	Continued From page 169 on a 24/7 basis, with corporate staff and assigned night shift Nurses to provide supervision and surveillance. 11. Review of the Cooporate Staff schedule revealed an administrative staff member was assigned to be present in the facility 7 days a week to provide supervision and abuse surveillance. Further review revealed an Administrative schedule for Manager on duty was implemented and in place. Observation on 12/19/16 at 8:30 PM revealed administrative staff were in the building when the team arrived in the facility to begin the Revisit survey. 12. The Coorporate RN staff was assigned by the Regional Director to be present in the facility to ensure 7 days per week survillance would occur and they will remain in the building until substatainal compliance is achieved. Observations during the survey revealed the coorporate nurses were present and active in the building. 13. Interviews with the Cooporate nurses on 12/21/16 at 10:30 AM confirmed the nurses were assigned to the building. 14. Review of the facility's in-service records dated 12/12/16 and 12/13/16 revealed 100% of the nursing staff were educated regading implementation and revision of care plans. On 12/12/16 the MDS nurses recieved education regarding MDS assessments and revising care plans to reflect the resident's current condition. 15. Interviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN] and MDS Coordinators) was	{F 493}	4. Facility will conduct Quality Assurance Committee Meetings every week and discuss progress towards substantial compliance to include staffing, wound management, service provision and timeliness of reporting, investigation and applicable actions. Weekly meetings began on 12/27/16 and will continue until the current survey deficiencies are cleared or as determined by the committee. The QA committee will review the cumulative results of the daily audits to include; assigned body audits, guardian Angel rounds, grievance and incident logs. Meetings will be attended by DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director.	

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{F 493}	Continued From page 170 conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and confirmed the staff's understanding of implementation and revision of care plans per the education received and based on the MDS assessment. 16. Review of 19 resident records conducted on 12/19/16-12/21/16 revealed the residents' care plans had been revised and the current plans contained appropriate and specific areas which were triggered by the MDS assessment. 17. Observations on 12/19/16 through 12/21/16 revealed Resident #12 had the knee immobilizer in place and applied correctly. Further observation of the resident's wound revealed the wound had healed. 18. Medical record review, observation, and interview, revealed the Weekly Wound and Pressure Ulcer Report and Splint Listing dated 12/13/16 correctly identified all residents with wounds or splint devices. The report is provided weekly and reviewed by the interdisciplinary care team to ensure all wounds are identified by the direct care team and a care plan is implemented. 19. Verification with the Director of Nursing (DON) was completed on 12/20/16 at 10:30 AM, in the conference room, and revealed audits are conducted by the nursing staff to include 5 physicians orders or changes in condition 5 times per week. The Corporate team conducts oversight of the audits. Follow-up interviews with the Cooporate Nurses on 12/21/16 at 10:30 AM, in the conference room, confirmed Corporate follow-up was in process and ongoing.	{F 493}	Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter. QA frequency will continue until substantial compliance is achieved or otherwise determined by the committee thereafter prior to the resumption of monthly.	

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{F 493}	Continued From page 171 20. Review of the facility's in-service records ensuring that 100% of staff was educated on skin assessments, body audits, and splints and immobilizers. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/7/16 and interviews with the facility leadership staff confirmed 100% of the staff had been educated on the facility policies by 12/7/16. 21. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted on 12/19, 12/20, and 12/21/16, and confirmed the staff's comprehension of the facility's policies for skin assessment checks and splint and immobilizer positioning checks. 22. Review of 19 resident medical records on 12/19/16 and 12/20/16 verified skin assessments had been completed per facility policy. 23. Review of the facility's in-service records ensuring that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's Resident Rights and Grievance Policy by 12/13/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/13/16, review of facility staffing, and interviews with the facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 100% of the active staff had been educated on facility policies by 12/13/16. 24. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted on 12/19, 12/20, and 12/21/16, and confirmed staff had received education on the facility's	{F 493}		

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{F 493}	Continued From page 172 policies for resident rights and grievances and were able to verbalize the content of the education. 25. Interviews with 11 residents on 12/19, 12/20, and 12/21/16, revealed no complaints about the care the resident had received since implementation of the AoC. 26. Observation of wound care for 5 residents during the revisit survey on 12/19 and 12/20/16, revealed the wound care nurse followed proper technique during the dressing changes, and the documentation of the wound stages and sizes correlated with the wound observations. 27. Review of the facility's staffing hours per patient day (HPD), provided by the Administrator, for the week of 12/12/16-12/18/16 revealed staffing was adequate to provide for residents' needs. 28. Review of the nursing staffing schedule for 12/5/16-1/1/17, revealed LPNs, RNs and CNAs were scheduled to work the assigned shifts with no gaps in coverage. 29. Observation on 12/19/16 at 8:30 PM revealed the following: 200 hallway: 1 Licensed Practical Nurse (LPN) and 2 Certified Nurse Assistants (CNA); 300 hallway: 1 LPN and 2 CNA; 400 hallway: 1 RN and 2 CNAs. Further observation revealed the Nursing Staffing was posted in the lobby and was correct. Observations on 12/20/16 and 12/21/16 revealed staffing patterns to be adequate and correctly posted. 30. Observations 12/19/16-12/21/16 revealed nursing staff on the hallways providing care to the	{F 493}		

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{F 493}	Continued From page 173 residents and answering call lights. Further observations revealed no time delay in answering the call lights by the staff. 31. Interviews with 11 interviewable residents on 12/19, 12/20, and 12/21/16, revealed there were no complaints of waiting for call lights to be answered and no issues with the incontience care. 32. Interviews with 5 CNAs and 4 Licensed staff on 12/19, 12/20, and 12/21/16, on all shifts, revealed no issues or complaints of not having enough staff to provide care to the residents. 33. Interview on 12/21/16 at 8:15 AM, with the Administrator and the DON, in the conference room, revealed the administrator reviews the HPD and census to determine the number of staff needed to provide care of the residents. The administrator or the DON post the staffing. Further interview revealed the facilty staffs as follows: 7a-7p: 3 Licensed Staff and 8 CNAs; 7p-7a: 3 Licensed staff and 6 CNAs. Further interview revealed an RN is always scheduled 8 hours per day. Further interview revealed the coorporate staff have been in the facility since 12/12/16 to ensure appropriate staffing and monitoring for resident safety. Further interview revealed the facility implemented a Managers schedule and a management team member is in the facility every day of the week for at least 4-8 hours. 34. Review of the facility's in-service records revealed Licensed staff and CNAs received education regarding proper notification to the physician, resident, and representative with any changes in condition and treatment by 12/12/16.	{F 493}		

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{F 493}	Continued From page 174 35. Interviews with 9 Licensed caregivers on 12/19, 12/20, and 12/21/16, on all shifts, confirmed the staff received the required training regarding proper notification and were able to verbalize the training received. 36. Surveyors verified through observation and interview with staff on 12/19, 12/20, and 12/21/16, the Notification Tool was initiated on 12/15/16 and was being completed to include all telephone orders and a 24 hour report for any change of condition. Interviews confirmed the supervisors had been educated to complete the log and document all notifications to the physician, resident, or representative. 37. Interview with the Medical Director on 12/21/16 at 10:05 AM, in the conference room, revealed the physician was available by phone for any resident issues. Further interview revealed the physician or Nurse Practitioner was, and had been, making freqent visits to the facility. The staff were calling the Medical Director with any issues related to resident care. 38. Interview on 12/21/16 with the Director of Nursing, in the conference room, revealed the notification tool had been implemented. Further interview revealed any change in a resident's condition was documented in the medical record and on the notification tool to ensure proper follow-up. Further review revealed key staff had been chosen and in-serviced regarding the log to assume responsibility in the absence of the DON. The facility will remain out of compliance at a Scope and severity of "E", a deficient practice that constitutes no actual harm with potential for more	{F 493}		

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{F 493}	Continued From page 175 than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 493}	**F501 Responsibilities of the Medical Director, Notification of Change, Wounds, Abuse, Accidents, Staffing.**	12/27
{F 501} SS=E	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on review of the Medical Director Services Agreement, facility policy review, medical record review, review of facility investigations, observation, and interview, the facility failed to ensure the Medical Director participated in the implementation of resident care policies and in attendance of Quality Assurance (QA) meetings to ensure wound care protocols were available and followed to assess and treat all wounds; to ensure residents with medical devices (immobilizers) did not develop pressure ulcers related to use of the device; to ensure the physician was notified for changes in condition and to obtain treatment orders; to ensure facility policy was followed so all residents were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure residents were safe from accidents; and to ensure adequate staffing to provide care and services to residents according to their needs and care plans. The facility's failure placed 11 residents (#106, #123,	{F 501}	1. **Resident #12** – Left leg wound was resolved prior to annual survey. Nurse Practitioner examined resident on December 7, 2016 and no areas of concern noted. **Resident #21** Resident #21was interviewed by the Social Services Director on 12/13-16 and voiced no current concerns. **Resident #27** - Discharged to home on October 24, 2016. Employee #4 terminated 8/18/16. **Resident #45** Resident #45 was interviewed by the social Services Director on 12/13/16 and voiced no current concerns.	

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{F 501}	Continued From page 176 #75, #103, #65, #27, #68, #21, #45, #12, #145) in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirement of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Corporate Director of Clinical Services and the Administrator were informed of the Immediate Jeopardy (IJ) in the conference room on 12/7/16 at 9:30 AM. The facility was cited an Immediate Jeopardy at F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-353 (K); F-490 (K); F-493 (K); F-501 (K); and F-520 (K). The facility was cited Substandard Quality of Care (SQC) at F-223 (K), F-224 (J), F-225 (K), F-241 (J), F-309 (J), F-312 (J), F-314 (J). The IJ was effective on 2/6/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the Immediacy of the Jeopardy. Noncompliance continues for F-501 at a "E" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included:	{F 501}	**Resident #65** - During the course of Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #68** - Discharged to home on August 31, 2016.Employee. CNA #15 was banned from returning to the facility from the agency 8/22/16 **Resident #75** - On February 6, 2016, CNA was suspended after allegation of verbal	

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{F 501}	Continued From page 177 Review of the facility Medical Director Services Agreement dated 3/11/13 revealed "...Doctor agrees to perform the following duties under this Agreement...Assist in developing and implementing resident care policies, procedures and guidelines regarding admissions, transfers, discharges, infection control, safety...pressure sore reduction, physician privileges and practices, responsibilities of non-physician health care workers and other aspects of residents care to ensure adequate and comprehensive services. Participate in establishing policies related to accidents and incidents...overall quality of care...Review all new policies and procedures...Review all incident and accident reports from the Facility to identify clinical risks and safety hazards...Direct coordinate the medical care in Facility and ensure the Facility is providing appropriate care as required...Participate in Facility's resident care management system, which will include attendance and active participation in the Facility's monthly Quality Assurance Committee and Patient Care Policy Committee meetings...Participate in the development of the Comprehensive Care plan for resident for whom Medical Director serves as attending Physician...Advise Facility Administrator about the adequacy and appropriateness of the Facility's ...professional and support staff...Consult with Facility Administrator regarding (i) staffing...Conduct in-service education for Facility personnel as may be requires...Doctor will continually work to improve the quality of medical care..." Interview with the Medical Director on 12/5/16, at 1:55 PM, in his office, confirmed he was unaware the facility did not have protocols in place for	{F 501}	abuse by resident on February 6, 2016. CNA was subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #103** - During the course of the Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that same CNA involved with the resident #75 event was verbally inappropriate to resident 103. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility.	

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{F 501}	Continued From page 178 wound care. Continued interview confirmed he does not do training or teaching on wound care with the Director of Nursing or the Treatment Nurse. Further interview confirmed he was unaware the wound care nurse did not have formal training in the treatment of wounds. Continued interview confirmed the Medical Director was aware the facility did not have enough staff and the facility had issues with staff turn-over. Further interview confirmed he had been the Medical Director at the facility for 15 years and staffing had always been an issue. Continued interview confirmed there were times he was unable to attend the QA meetings and he gets filled in later. Further interview confirmed the facility has discussed concerns of abuse with the Medical Director. Refer to F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-323 (G); F-353 (K); F-490 (K); F-493 (K); and F-520 (K). Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records dated 12/9/16 and 12/13/16 to ensure 100% of the nursing staff were educated regading Patient	{F 501}	**Resident #106** – Family attended Care Plan meeting on 8-11-16, skin condition was reviewed with family member in attendance. 11-11-16. Nurse practitioner examined resident knee on 12-7-16. Resident currently has no wounds. **Resident #123** – Nurse Practitioner was notified of Right Lower extremity posterior skin condition on 11/15/16. MD reviewed and co-signed (undated). Resident was aware and self-responsible. Resident #123 was discharged home on 12-10-16. **Resident #145** Resident was assessed by the Nurse Practitioner on 12/5/16. Reassessed on 12/7/16 by the Nurse Practitioner who approved wound management treatment plan.	

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{F 501}	Continued From page 179 Rights, Incontinence Care and Dignity and Abuse. Review of the facility's plan of action revealed all nurses were educated on the policies before being allowed to return to work. Interviews with Administrative staff confirned all employees received the in-service. 2. Interviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN]) conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 conducted from 8:00 AM-5:00 PM, and with Certified Nurse Assistants (CNA) between the same time frames and dates confirmed the staff's understanding of Patient Rights, Dignity, Abuse, and Incontience Care. 3. Verification of the Weekly Wound and Pressure Ulcer Report and Splint Listing dated 12/13/16 revealed all residents with wounds or splint devices were correctly listed on the report. Verification the report is provided weekly and reviewed by the interdisciplinary care team to ensure all wounds are identified by the direct care team and a care plan is implemented. 4. Review of 19 resident records on 12/19/16-12/21/16 verified incontience care was provided and care plans revised. 5. Interviews on 12/19/16 - 12/21/16 with 11 interviewable residents revealed no complaints regarding Abuse, Dignity or Patient Rights. 6. Verification of facility documentation revealed the facility's administrator notified the Medical Director regarding the AoC on 12/7/16 to approve the facility's written plan and the plan was approved.	{F 501}	2. • All residents have the potential to be affected and were evaluated for impact by personal interview, body audit and ongoing surveillance. 3. • The Administrator met with the Medical Director in review of F501, additionally a schedule of QA meetings was established for 2017. The Medical Director will be an active participant in the Quality Assurance status Meetings scheduled each Friday to review facility compliance with cited deficiencies to include analysis of surveillance and tracking tools for effectiveness and consideration of modification. • The medical director began an enhanced initiative on 12/7/16 to collaborate with	

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{F 501}	Continued From page 180 7. Review of an Ad-Hoc Quality Assurance Meeting sign-in sheet dated 12/8/16 revealed the Medical Director was present at the meeting. Further review revealed an Ad-Hoc meeting sign-in sheet, dated 12/16/16, where the Medical Director was present at the meeting. 8. Review of a Training sign-in sheet titiled Abuse Prohibition for MDs and NP (nurse practitioner) dated 12/9/16 revealed all of the physicians and the NP who provide care in the facility received the training. 9. Interview with the Medical Director on 12/21/16 at 10:05 AM, in the conference room, revealed the Medical Director has reviewed the AoC and was in support of the plan. Further interview revealed the Medical Director attends the QA meetings and the facility ensures he is notified of any issues related to the residents. Further interview revealed the Medical Director is notified of any resident allegation of abuse and is always available for consult or to evaluate a resident related to any abuse allegation. Further interview revealed the QA team has set defined processes to ensure compliance with all regulatory requirements. The facility remain out of compliance at a Scope and Severity level E that constitutes no harm with potential for more than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 501}	the facility leadership, staff, other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice. The initiative is held in conjunction with the weekly QA meeting. Once substantial compliance is achieved as determined by audit and survey revisit, the QA team will resume monthly and as needed meeting schedule. • The medical director helps the facility assess the current patient population and the need to develop new clinical programs as the resident population changes. The initiative is held in conjunction with the weekly QA meeting. Once substantial compliance is achieved as determined by audit and survey revisit, the	
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	{F 520}		

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{FSC/ I}		{FSC/ I}	QA team will resume monthly and as needed meeting schedule. • The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues through notification of change, wound development, abuse and accidents at the time of notification and weekly as facility reviews the findings and trending of established audits. The initiative is held in conjunction with the weekly QA meeting. Once substantial compliance is achieved as determined by audit and survey revisit, the QA team will resume monthly and as needed meeting schedule. 4. QA meetings will be held weekly until substantial compliance is achieved as	

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

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{F501}		{F501}	evidenced by audit results and survey revisit. in review of compliance restoration with Notification of Change, Wound Identification, Management, and Staffing until substantial compliance is achieved or as directed by the Committee should continued enhanced intervention be indicated. QA Meetings scheduled each Friday will review facility compliance with cited deficiencies to include analysis of surveillance and tracking tools for effectiveness and consideration of modification of tools or process. Any modification will be immediately inserviced and implemented. The committee will strive to expediently identify additional issues which may impede optimal guest services.	

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{F 520}	Continued From page 181 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 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigations, observation, and interview, and review of Quality Assurance and Performance Improvement (QAPI) meeting documentation, the facility failed to ensure the QAPI committee identified issues and implemented corrective action plans to ensure wound care protocols were available and followed to assess and treat all wounds; to ensure residents with medical devices (immobilizers) did not develop pressure ulcers related to use of the device; to ensure the	{F 520}	**F520 QAA Committee-Members Meet Quarterly / Plans** 1. **Resident #12** – Left leg wound was resolved prior to annual survey. Nurse Practitioner examined resident on December 7, 2016 and no areas of concern noted. **Resident #21** Resident #21was interviewed by the Social Services Director on 12/13-16 and voiced no current concerns. Employee #4 terminated 8/18/16. **Resident #27** - Discharged to home on October 24, 2016.. Employee #4 terminated 8/18/16. **Resident #45** Resident #45 was interviewed by the social Services Director on 12/13/16 and voiced no current concerns. **Resident #65** - During the course of Resident #75 investigation, Social	1/20/17

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{F 520}	Continued From page 182 physician was notified for changes in condition and to obtain treatment orders; to ensure facility policy was followed so all residents were protected from neglect and abuse and all allegations of neglect and abuse were reported and investigated; to ensure residents were safe from accidents; and to ensure adequate staffing to provide care and services to residents according to their needs and care plans. The facility's failure placed 11 residents (#106, #123, #75, #103, #65, #27, #68, #21, #45, #12, #145) in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirement of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Corporate Director of Clinical Services and the Administrator were informed of the Immediate Jeopardy (IJ) in the conference room on 12/7/16 at 9:30 AM. The facility was cited an Immediate Jeopardy at F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-353 (K); F-490 (K); F-493 (K); F-501 (K); and F-520 (K). The facility was cited Substandard Quality of Care (SQC) at F-223 (K), F-224 (J), F-225 (K), F-241 (J), F-309 (J), F-312 (J), F-314 (J). The IJ was effective on 2/6/16 and was removed 12/16/16. The facility provided an acceptable Allegation of Compliance (AoC), with a compliance date of 12/16/16, and a revisit survey conducted 12/19/16 - 12/21/16 validated the corrective actions implemented by the facility removed the	{F 520}	Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that CNA failed to meet resident's needs in a timely manner. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no care concerns. Resident indicated she feels safe in facility. **Resident #68** - Discharged to home on August 31, 2016.Employee . CNA #15 was banned from returning to the facility from the agency 8/22/16 **Resident #75** - On February 6, 2016, CNA was suspended after allegation of verbal abuse by resident on February 6, 2016. CNA was subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility.	

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{F 520}	Continued From page 183 Immediacy of the Jeopardy. Noncompliance continues for F-520 at a "E" level for the facility's monitoring of the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes implemented by the facility. The findings included: Interview with the Director of Nursing (DON) on 11/8/16 at 5:05 PM, in her office, confirmed the facility did not have a protocol the nursing staff could refer to for the identification, assessment and treatment of pressure ulcers. Interview with the Nurse Practitioner on 11/9/16 at 10:25 AM, in the small conference room, revealed she thought standing orders for Decubitus Care stated refer to wound care protocol and were to be followed. She was unaware the facility did not have a wound care protocol to follow. Interview with the Nurse Practitioner revealed "...not notified of the shearing...I know they use turning and repositioning for stage I pressure ulcers...should have been treated with something..." Interview with the Administrator on 11/28/16 at 3:55 PM, in the conference room, confirmed he would expect the facility to follow the procedures outlined in the facility Abuse policy. Interview with the DON on 12/5/16 at 11:40 AM, in the conference room, confirmed the facility had failed to obtain an order for treatment of Resident #106's wound when it was identified on admission. Continued interview confirmed Resident #106's wound declined between the	{F 520}	**Resident #103** - During the course of the Resident #75 investigation, Social Services Director and DON interviewed resident on February 8, 2016 at which time resident indicated that same CNA involved with the resident #75 event was verbally inappropriate to resident 103. CNA had previously been suspended on February 6, 2016 and subsequently terminated on February 10, 2016. Social Services Director interviewed resident on December 7, 2016 and noted no findings. Resident indicated she feels safe in facility. **Resident #106** – Family attended Care Plan meeting on 8-11-16, skin condition was reviewed with family member in attendance. 11-11-16. Nurse practitioner examined resident knee on 12-7-16. Resident currently has no wounds. **Resident #123** – Nurse Practitioner was notified of Right Lower extremity posterior skin condition on 11/15/16. MD reviewed and co-signed (undated). Resident was	

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{F 520}	Continued From page 184 time it was first identified and the time treatment was initiated. Further interview revealed the DON was unaware of the online protocols for the treatment of wounds. Interview with the Medical Director on 12/5/16, in his office, confirmed he was unaware the facility did not have protocols in place for wound care. Continued interview confirmed he does not do training or teaching on wound care with the Director of Nursing or the Treatment Nurse. Continued interview confirmed the facility did not have enough staff to care for the residents. Further interview confirmed he has been the Medical Director at this facility for 15 years and it had always been an issue. Review of the Quality Assurance (QA) meeting attendees and interview with the Medical Director on 12/5/16 at 1:55 PM, in his office, confirmed he had not attended a QA meeting in the second quarter of 2016. Continued interview revealed he was not aware the treatment nurse did not have a certification in wound care. Interview with the DON on 12/6/16 at 8:15 AM, in the conference room, confirmed she did not have formal training in wound management. Continued interview confirmed she was not aware Resident #106's pressure ulcer was identified on 11/13/16 instead of 11/15/16. Further interview confirmed no wound treatment was initiated until 11/15/16. The DON was asked about the Nurse Practitioner (NP) and Physician notes on 11/15/16 and 11/17/16 stating eschar [dead tissue] and a 2 cm [centimers]ulceration to the calf. Continued interview confirmed "...I don't remember seeing eschar..." Further interview confirmed the treatment nurse completed the measurement and treatments "...I pop in and do the staging..."	{F 520}	aware and self-responsible. Resident #123 was discharged home on 12-10-16. **Resident #145** Resident was assessed by the Nurse Practitioner on 12/5/16. Reassessed on 12/7/16 by the Nurse Practitioner who approved wound management treatment plan. 2. All residents have the potential to be affected and were evaluated for impact by personal interview 12/6 and 12/7/16, body audit 12/7/16and ongoing surveillance. 3. • Root cause analysis conducted by the Director of Operations on 12/12/16 and 3 Corporate Clinical Consultants who are RNs revealed that staffing and clearly defined assignment were not consistently maintained for optimal outcome.	

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{F 520}	Continued From page 185 Interview with the Regional Director on Clinical Services on 12/6/16 at 10:00 AM, at the 100-200 hall nurses station, confirmed the facility did have access to wound care protocols and they were located on the company's website portal, available to staff, and could be printed out. Refer to F-157 (J); F-223 (K); F-224 (J); F-225 (K); F-280 (J); F-309 (J); F-312 (J); F-314 (J); F-323 (G); F-353 (K); F-490 (K); F-493 (K); F-501 (K). Validation of the AoC was completed 12/19/16 - 12/21/16 through review of facility documentation, review of medical records, observations, and interviews. Surveyors verified the AoC by: 1. Review of the facility's in-service records revealed that 100% of active staff was educated by the Social Services Director and Risk Manager on the facility's new Abuse Prohibition and Investigation Policy initiated 11/18/16. Education was conducted on 11/18/16 and 12/9/16. Review included the facility's plan to ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 11/18/16 and 12/9/16 and interviews with the	{F 520}	• ~~The Administrator met with~~ the Medical Director on 12/7/16 in review of F501, additionally a schedule of QA meetings was established for 2017. The Medical Director will be an active participant in the Quality Assurance status Meetings scheduled each Friday to review facility compliance with cited deficiencies to include analysis of surveillance and tracking tools for effectiveness and consideration of modification. • Beginning on 12/8/16 QA meetings will be held weekly in review of compliance restoration with Notification of Change, Wound Identification, Management, and Staffing until substantial compliance is achieved or as directed by the Committee if continued enhanced intervention be indicated. QA Meetings scheduled weekly will review facility	

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{F 520}	Continued From page 186 facility leadership staff on 12/19, 12/20, and 12/21/16, confirmed 107 staff members, contract staff, and volunteers were educated on facility policies between 11/18/16 and 12/9/16. 2. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs) , the Director of Nursing, Administrator, and Medical Director was conducted on 12/19, 12/20, and 12/21/16, on all shifts, and confirmed the staff's understanding of the facility's policies for reporting and investigating abuse and the timeframe the allegations and investigation were to be reported in. 3. Interviews were conducted with 11 residents during the revisit survey on 12/19, 12/20, and 12/21/16, and revealed no residents complained about being abused or seeing any other resident being abused. 4. Interview with the Administrator on 12/20/16 at 3:45 PM, in the conference room, revealed an in-service had been provided by the Director of Operations on abuse prohibition and reporting. 5. Interview with the Quality Assurance Team on 12/21/16 at 11:40 AM, in the conference room, revealed weekly Quality Assurance and Ad Hoc meetings had taken place since 11/18/16 and included Corporate staff. 6. Review of the facility's in-service records dated 12/9/16 and 12/13/16 revealed 100% of the nursing staff were educated regading Patient Rights, Incontinence Care and Dignity. Review of the facility's plan of action revealed all nurses were educated on the policies before being allowed to return to work. Interviews with	{F 520}	compliance with cited deficiencies to include analysis of surveillance and tracking tools for effectiveness and consideration of modification of tools or process. Any modification will be immediately inserviced and implemented. The committee will strive to expediently identify additional issues which may impede optimal guest services. The Committee will be led by the facility Administrator; members in attendance will include the Medical Director, DON, Risk Manager, Social Services Director, Medical Director, Safety Designee and a member of the Corporate Team. • The Director of Nursing reviewed and revised the direct care staffing schedule on 12/27/16 to optimize coverage and staff planning x 1 month.	

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{F 520}	Continued From page 187 Administrative staff conducted on 12/19, 12/20, and 12/21/16, confirmed all employees received the education. 7. Interviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN]) was conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and with 9 Certified Nurse Assistants (CNA) between the same time frames and dates, and confirmed the staff's understanding of Patient Rights, Dignity and Incontience Care. 8. Review of 19 resident records on 12/19/16-12/21/16 revealed no evidence of incontience care not being provided timely . 9. Interviews were conducted on 12/19/16 - 12/21/16 with 11 interviewable residents and revealed there were no complaints regarding any issues with dignity or Patient Rights. 10. Verification of the implementation of the facility policy for Guardian Angel Rounds, established by the facility Administrator on 12/13/16, was completed through observations and interviews, and those rounds were ongoing during the revisit survey 12/19/16 - 12/21/16. Review of facility documentation revealed Guardian Angel Rounds were ongoing 7 days per week to openly discuss any concerns residents had regarding their care. Review of the schedule revealed coverage assigned for the rounds was on a 24/7 basis, with corporate staff and assigned night shift Nurses to provide supervision and surveillance. 11. Review of the Cooporate Staff schedule	{F 520}	• The Corporate team launched a recruitment initiative on 12/15/16 to include ad placement in web-based job posting and followed up on respondents; coordinating interviews pre-employment screening process. • Ad Hoc QA Meeting was held on 12-8-16, known deficiencies were reviewed and immediate plan of action was established. The meeting was conducted by the Administrator, Corporate Nurse and Area Manager. • Corporate team arrived to the facility beginning on 12-12-16.Meetings with the Administrator and interdisciplinary team were held to determine root cause analysis assure resident remedy, impact to others and methodical remedy have been ongoing. Training needs to restore program integrity were identified,	

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{F 520}	Continued From page 188 revealed an administrative staff member was assigned to be present in the facility 7 days a week to provide supervision and abuse surveillance. Further review revealed an Administrative schedule for Manager on duty was implemented and in place. Observation on 12/19/16 at 8:30 PM revealed administrative staff were in the building when the survey team arrived in the facility to begin the Revisit survey. 12. Coorporate RN staff was assigned by the Regional Director to be present in the facility to ensure 7 days per week survillance would occur and they will remain in the building until substatainal compliance is achieved. Observations during the survey revealed the coorporate nurses were present and active in the building. 13. Interviews with the Cooporate nurses on 12/21/16 at 10:30 AM confirmed the nurses were assigned to the building. 14. Review of the facility's in-service records dated 12/12/16 and 12/13/16 revealed 100% of the nursing staff were educated regading implementation and revision of care plans. On 12/12/16 the MDS nurses recieved education regarding MDS assessments and revising care plans to reflect the resident's current condition. 15. Interviews with 13 licensed nurses (to include Licensed Practical Nurses [LPN] and Registered Nurses [RN] and MDS Coordinators) was conducted on 12/19/16 from 8:30 PM-11:30 PM and 12/20/16 from 8:00 AM-5:00 PM, and confirmed the staff's understanding of implementation and revision of care plans per the education received and based on the MDS	{F 520}	reviewed by the team and implemented as evidenced by the inservices and surveillance tools noted herein. Facility is holding morning and afternoon meetings to provide status update of the cited citations. The Department Managers attend to include the Administrator, DON, Risk Manager, Care Planning, Director of Rehab, Medical Records, Social Services Director. • Clinical Nurse Staff Meeting and Inservice regarding splinting, completion of treatments, and completion of assessments was conducted by the DON to re-educate 12-7-16 through 1-18-17. • Revision of Weekly Skin Assessment Schedule was completed by the Director of Nursing to eliminate the rooms temporarily closed from schedule 12-7-16.	

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{F 520}	Continued From page 189 assessment. 16. Review of 19 resident records conducted on 12/19/16-12/21/16 revealed the residents' care plans had been revised and the current plans contained appropriate and specific areas which were triggered by the MDS assessment. 17. Observations on 12/19/16 through 12/21/16 revealed Resident #12 had the knee immobilizer in place and applied correctly. Further observation of the resident's wound revealed the wound had healed. 18. Verification through medical record review, observation, and interview, revealed the Weekly Wound and Pressure Ulcer Report and Splint Listing dated 12/13/16 correctly identified all residents with wounds or splint devices. The report is provided weekly and reviewed by the interdisciplinary care team to ensure all wounds are identified by the direct care team and a care plan is implemented. 19. Verification with the Director of Nursing (DON) was completed on 12/20/16 at 10:30 AM, in the conference room, and revealed audits are conducted by the nursing staff to include 5 physicians orders or changes in condition 5 times per week. The Corporate team conducts oversight of the audits. Follow-up interviews with the Cooporate Nurses on 12/21/16 at 10:30 AM, in the conference room, confirmed Corporate follow-up was in process and ongoing. 20. Review of the facility's in-service records ensuring that 100% of staff was educated on skin assessments, body audits, and splints and immobilizers. Review included the facility's plan to	{F 520}	• The Licensed Nurses and CNAs were re-inserviced by the Director of Nursing on 12-12-16 through 1/18/17 to increase awareness of need for immediate reporting by CNAs to nurses, and prompt notification to physician, resident and representative by nurses with incident, change in condition or treatment. • Abuse Training conducted by the Risk Manager to all staff to enhance awareness of what is abuse, how to investigate, importance of protecting the resident and when and how to report it 12-9-16 through 1-20-17. • To determine other residents who may have been affected by alleged deficient practice a 100% Interview of Residents by Social Worker on 12-6 and 12-7-16 was conducted. For those residents who did not respond to the interview,	

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{F 520}	Continued From page 190 ensure all staff was educated on the policies before being allowed to work a shift. Review of the in-service logs dated 12/7/16 and interviews with the facility leadership staff confirmed 100% of the staff had been educated on the facility policies by 12/7/16. 21. Interviews with 13 licensed nurses and Certified Nurse Assistants (CNAs) was conducted on 12/19, 12/20, and 12/21/16, and confirmed the staff's comprehension of the facility's policies for skin assessment checks and splint and immobilizer positioning checks. 22. Review of 19 resident medical records on 12/19/16 and 12/20/16 verified skin assessments had been completed per facility policy. 23. Observation of wound care for 5 residents during the revisit survey on 12/19 and 12/20/16, revealed the wound care nurse followed proper technique during the dressing changes, and the documentation of the wound stages and sizes correlated with the wound observations. 24. Review of the facility's staffing hours per patient day (HPD), provided by the Administrator, for the week of 12/12/16-12/18/16 revealed adequate staff coverage to provide for the residents. 25. Review of the nursing staffing schedule for 12/5/16-1/1/17, revealed LPNs, RNs and CNAs were scheduled to work the assigned shifts with no gaps in coverage. 26. Observation on 12/19/16 at 8:30 PM revealed the following: 200 hallway: 1 Licensed Practical Nurse (LPN) and 2 Certified Nurse Assistants	{F 520}	~~Body Audits were conducted~~ by the Charge Nurses12-6-16 and 12-7-16. • Resident Council Meeting conducted by Social Services Director 12-7-16 to discuss facility initiatives related to abuse reporting and investigations. Resident informed that they should report immediately and may remain anonymous. • The Administrator trained Department Managers on 12-9-16 on the implementation of Guardian Angel Rounds to include goals, review of Assignment, frequency and utilization of tool. The Administrator instructed the team to complete Grievance form if care concerns were voiced during rounds. • Inservice with DON and MDS Coordinators on coding of Section M of MDS and revisions to care plans	

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{F 520}	Continued From page 191 (CNA); 300 hallway: 1 LPN and 2 CNA; 400 hallway: 1 RN and 2 CNAs. Further observation revealed the Nursing Staffing was posted in the lobby and was correct. Observations on 12/20/16 and 12/21/16 revealed staffing patterns to be adequate and correctly posted. 27. Observations during the suvey (12/19/16-12/21/16) revealed nursing staff on the hallways providing care to the residents and answering call lights. Further observations revealed no time delay in answering the call lights by the staff. 28. Interviews with 11 interviewable residents on 12/19, 12/20, and 12/21/16, revealed there were no complaints of waiting for call lights to be answered and no issues with the incontience care. 29. Interviews with 5 CNAs and 4 Licensed staff on 12/19, 12/20, and 12/21/16, on all shifts, revealed no issues or complaints of not having enough staff to provide care to the residents. 30. Interview on 12/21/16 at 8:15 AM, with the Administrator and the DON, in the conference room, revealed the administrator reviews the HPD and census to determine the number of staff needed to provide care of the residents. The administrator or the DON post the staffing. Further interview revealed the facilty staffs as follows: 7a-7p: 3 Licensed Staff and 8 CNAs; 7p-7a: 3 Licensed staff and 6 CNAs. Further interview revealed an RN is always scheduled 8 hours per day. Further interview revealed the coorporate staff have been in the facility since 12/12/16 to ensure appropriate staffing and monitoring for resident safety. Further interview	{F 520}	conducted by Corporate Resident Assessment Specialist on 12-12-16.. • Accuracy Audit Tool was initiated by DON to assure pressure ulcer treatment was completed and clinical record documented 12-15-16. • Weekly and Monthly Weight Calendar established by the restorative RN 12-14-16. • Dialysis Communication Sheet / Inservice 12-9-16 & 12-13-16 by Risk Manager and Corporate Nurse to licensed nurses. • Audit of completion of assigned body audits began on 12-7-16 by the Medical Records Director (LPN) Audits are conducted weekly to assure goal of 100% compliance of completed skin audits; once goal is achieved, audit will be reduced to 10 random per	

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{F 520}	Continued From page 192 revealed the facility implemented a Managers schedule and a management team member is in the facility every day of the week for at least 4-8 hours. 31. Review of the facility's in-service records revealed all Licensed staff and CNAs received education regarding proper notification to the physician, resident, and representative with any changes in condition and treatment by 12/12/16. 32. Interviews conducted with 9 Licensed caregivers on 12/19, 12/20, and 12/21/16, on all shifts, confirmed the staff received the required training regarding proper notification and were able to verbalize the training received. 33. Surveyors verified through observation and interview with staff on 12/19, 12/20, and 12/21/16, a Notification Tool was initiated on 12/15/16 and was being completed to include all telephone orders and a 24 hour reporting for any change of conditions. Interviews confirmed the supervisors had been educated to complete the log and document all notifications to the physician, resident, or representative. 34. Interview with the Medical Director on 12/21/16 at 10:05 AM, in the conference room, revealed the physician was available by phone for any resident issues. Further interview revealed the physician or Nurse Practitioner was, and had been, making freqent visits to the facility. The staff were calling the Medical Director with any issues related to resident care. 35. Interview on 12/21/16 with the Director of Nursing, in the conference room, revealed the notification tool had been implemented. Further	{F 520}	week x 6 week, then monthly x months. • On 12-13-16, a Certified Wound Nurse (RN) trained the facility treatment nurse and Director of Nursing on Wound Staging, assessment, protocol, supportive surfaces and prevention. • The Director of Operations on 12-15-16 established the Notification Exception Report to serve as tool for audit of physician notification. • Manager on Duty schedule revised by the Administrator on 12/26/16. • Corporate Personnel Facility On-site Support Schedule established by the Director of Operations on 12-12-16. • Educational Postings related to abuse prevention developed by the Director of Operations 12-12-16.	

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{F 520}	Continued From page 193 interview revealed any change in a resident's condition was documented in the medical record and on the notification tool to ensure proper follow-up. Further review revealed key staff had been chosen and in-serviced regarding the log to assume responsibility in the absence of the DON. 36. Review of an Ad-Hoc Quality Assurance Meeting sign-in sheet dated 12/8/16 revealed the Medical Director was present at the meeting. Review of an Ad-Hoc meeting sign-in sheet, dated 12/16/16, revealed the Medical Director was present at the meeting. 37. Interviews with the Administrator on 12/21/16 at 10:30 AM, in the conference room, revealed QA meetings were held 12/6/16 and 12/7/16 and ad-hoc meetings were held 12/8/16 and 12/16/16. 38. Interview with the Administrator and the QA Team on 12/22/16 at 11:40 AM, in the conference room, revealed the team has met on 12/8/16 and 12/16/16 and continues to meet on a weekly basis. Further interview revealed abuse prohibition has been reinforced with all staff and the reporting requirements. Further interview revealed the team is monitoring pressure ulcers, resident assessment, and staffing using the tools which the facility implemented for the allegation of compliance. Further interview revealed the team will monitor the compliance and for any modifications staff education will be provided. Further interview revealed the coorporate staff will be actively involved in the QA team and avaliable for the facilty. The facility will remain out of compliance at a Scope and severity of "E", a deficient practice that constitutes no actual harm with potential for more	{F 520}	• Administrator Incident / Unusual Occurrence Worksheet developed by the Director of Operations (12-15-16). • The HR Coordinator revalidated all current employees on 12-16-16 via Tennessee State Abuse Registry. • Upon employment, and during annual performance evaluation the Human Resources Coordinator will be responsible for obtaining professional licensure verification, certification and other required screening. Background checks are obtained according to state requirements • Educational Requirements for newly hired staff in relation to this deficiency is completed during the orientation process. If for any unforeseen reason this does not occur, the	

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{F 520}	Continued From page 194 than minimal harm that is not immediate jeopardy, until it provides an acceptable plan of correction and corrections are verified on-site.	{F 520}	employee will be not be assigned • Upon employment, and during annual performance evaluation the Human Resources Coordinator will be responsible for obtaining professional licensure verification, certification and other required screening. Background checks are obtained according to state requirements • Facility will conduct Quality Assurance Committee Meetings every week and discuss progress towards substantial compliance to include adequate staffing, wound management, incontinence assistance, timeliness of reporting, investigation and applicable actions. Weekly meetings began on 12/27/16 and will continue until the current survey deficiencies are cleared or as determined by the committee. The QA	

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{F520}		{F520}	committee will review the cumulative results of the daily audits to include; assigned body audits, guardian Angel rounds, grievance and incident logs. Meetings will be attended by DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter. QA frequency will continue until substantial compliance is achieved or otherwise determined • The Administrator met with the Medical Director on 12/6/17 in review of F501, additionally a schedule of QA meetings was established for	

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{F520}		{F520}	2017. The Medical Director will be an active participant in the Quality Assurance status Meetings scheduled each Friday to review facility compliance with cited deficiencies to include analysis of surveillance and tracking tools for effectiveness and consideration of modification. 4. Findings noted on the following audits/tools will be reported to the Quality Assurance Committee. The QA committee will review the cumulative results of the daily audits noted to assure adherence to facility policy related to prevention of abuse and neglect, staffing,, notification of change and wound prevention and management. The QA committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445174		R 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F520}		{F520}	Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. Audits/tools include: o Body Audit Schedule Completion reported by Medical Records Custodian o Grievance Log reported by Social Services Director o Incident Log reported by Risk Manager o New Hire Abuse Education reported by Risk Manager o Notification Exception Tool reported by the Director of Nursing o Wound Accuracy Audit reported by the Risk Manager	

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

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OMB NO. 0938-0391

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{F520}		{F520}	o Direct Care PPD Review reported by the Administrator The QA committee will review the cumulative results of the daily audits noted. QA Committee consists of DON, NHA, Risk Mgr, SSD, MD, Diet Mgr, Rehab Dir, Environ Services Mgr., Maintenance Dir, Bus Office, MDS Coordinator, Med Rec Mgr, and activities director. QA Committee Meetings will be held weekly times 3 months and monthly x 6 months to evaluate need for amendment or continued need for ongoing interventions. Any trends or patterns will be addressed and corrective action plan revised, if applicable to assure sustainability. QA meetings in relation to this citation began on 12-7-16 and weekly thereafter.	