

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

PRINTED: 08/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>445273 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>07/30/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>BELCOURT TERRACE NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1710 BELCOURT AVENUE<br>NASHVILLE, TN 37212 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000         | INITIAL COMMENTS<br><br>Complaint #TN00034866, TN00036060 and TN00034162 were investigated during the recertification survey of 7/30/15. F279 D, F314 G and F 441 E were cited related to complaint #TN00034866. F248 D, F279 D, F312 D, F314 G and F441 E were cited related to complaint TN00034162. There were no deficiencies cited related to TN00036060.<br><br>The facility identified a census of 25 residents. The recertification survey sample included 23 residents.   | F 000 | Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.   |  |
| F 248<br>SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide an ongoing activity program, individualized to meet the resident's interests and specific needs was provided for 1 of 3 (Resident #12) residents sampled for activities.<br><br>The findings included:<br><br>Resident #12 was re-admitted to the facility on 11/11/11 with the diagnoses of Profound intellectual disabilities, Palsy, Infantile cerebral, | F 248 | F-248 Activities<br>S/S=D<br><br>I. Resident #12 has been re-assessed for appropriate activities. The outcome has been care planned.<br>II. The dependent residents have been re-assessed for appropriate activities.<br>III. The Activity Director has been in-serviced on identifying dependent levels of activities according to the residents' cognitive assessment.<br>IV. The Activity Director, Social Service Director and/or Designee will complete random observations of resident involvement in activities appropriate to cognition, weekly for four weeks then monthly for two months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.<br>V. Completion Date: 8/28/15 |  |

|   |                               |                             |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Barbara Collins</i> | TITLE<br><i>Administrator</i> | (X6) DATE<br><i>8/20/15</i> |
|---|-------------------------------|-----------------------------|

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided 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 required to continue program participation.

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AUG 24 2015

*This same POC was emailed 8/20/15*

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| F 248   | <p>Continued From page 1</p> <p>Convulsions, Psychosis, Anxiety and Persistent mental disorder.</p> <p>The annual Minimum Data Set (MDS) dated 11/4/14 documented the resident required extensive assistance to total assistance for activities of daily living such as bed mobility and transfers and had problems with short and long term memory and intellectual disabilities. It was very important for the resident to listen to music he/she liked, somewhat important to attend religious services and to get fresh air when the weather was good. The resident enjoyed favorite activities liked to do things in small groups, his/her interests included books, newspapers and magazines were all assessed as somewhat important to the resident. Resident #12, a cognitively impaired resident known by staff to have specific activity preferences.</p> <p>The Pre-Admission Screening and Resident Review (PASRR) for the resident dated 10/3/07 directed the resident's placement in a nursing facility was appropriate and the facility needed to provide psychotropic medication monitoring, assistance with activities of daily living and either group activities and or individual sensory stimulation for socialization.</p> <p>The Care Area Assessment (CAA) for activities did not trigger for this resident.</p> <p>Care plan for activities current and original date of 9/30/09 documented the resident had limited involvement in activities related to the diagnosis of Mental Retardation. The care plan directed staff to document the resident's participation in activities, provide materials for in room activities as needed / preferred and provide a monthly</p> | F 248  |   |                      |   |

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| F 248   | <p>Continued From page 2</p> <p>calendar in the resident's room to announce daily activities each morning and continue to invite the resident regardless of attendance. The staff failed to develop an individualized activity care plan for the resident's specific activity preferences.</p> <p>The activity assessment dated 11/4/14 documented the resident liked all music and music was important to the resident, it was somewhat important to do things with groups of people, and participate in favorite activities and to go outside to get fresh air when the weather was good. Daily activity preferences were books, newspapers or magazines, listening to music, doing things in groups of people and spending time outdoors.</p> <p>The 7/21/15 activity progress note documented the resident was alert, needed cueing and supervision for all daily tasks. The resident enjoyed the entertainers and groups that sing and the resident pointed and laughed and listened to them sing. The resident went in and out of the dining room during group activities at times.</p> <p>Observations on 7/29/15 from 8:15 A.M. to 10:45 A.M., revealed the resident wheeled about aimlessly in the hall not engaged in any activity. Staff did not attempt to engage the resident in the activity scheduled for that time, which was "Let's get moving or table talk activity."</p> <p>Observations on 7/29/15 from 1:00 P.M. to 2:45 P.M., the resident returned frequently to the Social Service doorway repeatedly yelling and talking. Staff #1 took the resident back into the hall and instructed the resident to stay out of the office and did not offer any activity for the resident. Staff did not offer for the resident to join</p> | F 248  |   |  |

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| F 248   | <p>Continued From page 3</p> <p>in on the Bingo activity which was offered to other residents at that time. Staff also did not offer to provide an activity of less complexity to meet the interests of this residents cognitive abilities.</p> <p>Frequent observations on 7/29/15 from 3:14 P.M. to 5:00 P.M. revealed the resident laid in bed dressed in a hospital gown in his/her room awake with the room light off and he/she tore a piece of card board into many pieces which were scattered about the bed and floor. Staff responded to the resident's call light several different times during that time period, but only to turn off the call light. At 4:51 P.M. Staff #13 entered the room and turned off the light, then exited the room and stated, "The resident tore that cad board box to shreds." Staff did not attempt to provide any in room activities or make any reasonable attempt to engage the resident in music, books, magazines or verbal stimulation related to the resident's assessed activity interests.</p> <p>During an interview on 7/29/15 at 4:15 P.M., Staff #11 reported the resident required assistance with transfers, to get in and out of bed. The resident enjoyed Bingo, visiting, pet therapy, loved to listen to talking about animals or anything that had to do with animals, country music, and Atlanta Braves baseball.</p> <p>During an interview on 7/29/15 at 5:38 P.M., Staff #14 reported no knowledge that this resident had any activity preferences and stated the resident didn't participate in activities.</p> <p>Observations on 7/30/15 at 7:50 A.M., revealed the resident sat in the wheelchair in the hall with a piece of blue paper yelling.</p> | F 248  |   |                      |   |

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| F 248  | <p>Continued From page 4</p> <p>Observations on 7/30/15 from 7:50 A.M. to 9:30 A.M., revealed the resident repeatedly wheeled up to the Social Service office from the hall with a blue piece of torn paper yelling into the office and in the hall. Staff #1 and Staff #4 repeatedly attempted to redirect the resident away from the office back into the hall then left the resident without any attempt to offer a meaningful activity to accommodate the resident's individual needs.</p> <p>Observations on 7/30/15 at 12:30 P.M., the resident sat in the wheelchair in the hall holding a box yelling. Staff pushed the resident a little way down the hall then left the resident in the hall idle without offering any activity. A word game activity was scheduled at that time, but staff did not make any attempt to provide the resident with a less complex activity to meet this resident's cognitive abilities.</p> <p>Frequent observations on 7/30/15 from 2:00 P.M. to 3:05 P.M., revealed the resident sat in a wheelchair in the small entry hall room by the front door facing the corner yelling out nonsensical sounds, screaming at times and not engaged in any meaningful activity. The resident was not engaged in the "Tammy Helms" activity group which was scheduled at that time.</p> <p>During an interview on 7/30/15 at 3:38 P.M., Staff #1 and Staff #2 reported the resident wanders in the wheelchair in the halls and in and out of offices, tears the paper and boxes and that is the residents activities in which he/she is involved.</p> <p>During an interview on 7/30/15 at 4:37 P.M., Staff #4 reported, "The resident comes to some group activities, but does not stay and wanders out in</p> | F 248  |   |   |

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| F 248   | Continued From page 5<br>the wheelchair and I can't make him/her stay."<br>Staff #4 acknowledged staff did not provide music in the resident's room, no one to one activities were provided for in room activities. Staff acknowledged there was not an ongoing activity plan for the lower functioning residents in the facility. Often she would attempt to bring the resident into group activities, but the resident became agitated and yelled and wandered back out of the activity.   | F 248  |   |                      |   |
| F 279<br>SS=D   | The facility did not provide a policy for activities.<br>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced | F 279  |   |                      |   |

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| F 279  | <p>Continued From page 6</p> <p>by:</p> <p>Based on observation, interview, record review and policy review, the facility failed to provide care plan interventions to promote healing of current pressure ulcers and interventions to prevent new pressure ulcers or activities of specific interest for 3 of 23 (Residents #35, 12 and 10) residents sampled.</p> <p>The findings included:</p> <p>1. Resident #35 was admitted to the facility on 6/13/14 and the closed electronic record documented the resident with the diagnoses of End Stage Renal Disease, Diabetes, Hypertension, Ischemic heart disease, Peripheral Vascular Disease, Diarrhea and a Below the knee amputation status.</p> <p>The care plan for Pressure Ulcers dated 6/13/14, prior to the development of the right heel ulcer and subsequent right below the knee amputation documented the resident was at risk for pressure ulcers and directed staff as follows: encourage mobility and or assist with turning and repositioning as resident will comply, monitor nutrition/hydration and assist as needed as resident will comply, observe skin with daily cares and notify nurse / doctor of any changes or resident complaints, pressure reduction mattress to bed if needed and as resident will comply, boots when out of bed and assist resident to keep skin clean and dry as resident will allow. The care plan lacked interventions to prevent heel pressure while in bed for this resident (who in the Nurse's Notes staff identified as daily refused to get out of bed) such as padded boots, heel lift boots or floating of the heels and also lacked interventions to address the pressure ulcer which developed on</p> | F 279   | <p>F-279 Care Plans<br/>S/S=D</p> <p>I. a) Resident #12 has been assessed and care planned for the appropriateness of activities.<br/>b) Resident #35 was a closed record review. Resident #10 is no longer in the facility.<br/>II. a) The residents have been assessed and care planned for appropriateness of activities.<br/>b) The residents will have skin assessments performed at admission. A care plan will be implemented based on the assessment.<br/>III. a) The Activity Director has been in-serviced on identifying dependent levels of activities according to the residents' cognitive assessment.<br/>b) Nursing staff has been in-serviced on performing skin assessments at admission and implementing the care plan based on the assessment.<br/>IV. The MDS Coordinator, Director of Nursing, and/or Designee will complete random care plan audits for residents with wounds and resident involvement in activities appropriate to cognition, weekly for four weeks then monthly for two months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.<br/>V. Completion Date: 8/28/15</p> |                      |   |

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| F 279   | <p>Continued From page 7</p> <p>the right heel identified on 7/2/14 and the identification of a new pressure ulcer on 10/1/14 which was a stage 2 pressure ulcer on the coccyx that measured 4 centimeter (cm) by (x) 2 cm that developed during a hospitalization. The coccyx wound required a treatment dressing Mediplex which staff also failed to address on the care plan.</p> <p>The electronic record revealed on 6/13/14 staff documented a skin risk assessment and indicated the resident had no skin issues and a BRADEN (assessment to determine a resident's risk for the development of pressure ulcers) score of 16, which indicated the resident was at risk for pressure ulcer development.</p> <p>The admission Minimum Data Set (MDS) dated 6/20/14 documented the resident with a Brief Interview for Mental Status Score (BIMS) of 15, which indicated the resident had intact cognition. The resident required extensive assistance for bed mobility. Staff assessed the resident to be at risk for the development of pressure ulcers, but the resident did not have any pressure ulcers.</p> <p>The Care Area Assessment (CAA) for pressure ulcers dated from the 6/20/14 admission MDS documented the resident was at risk for pressure ulcers.</p> <p>Review of the nurse's notes revealed the following:</p> <p>a. 6/29/14 staff documented the resident refused therapy and refused to get up from bed daily and the family had concerns.</p> <p>b. 7/2/14 at 1:14 A.M. staff documented the resident's heels were black with a chronic peeling of the skin and both heels were rough, but had no</p> | F 279  |   |   |

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| F 279  | <p>Continued From page 8</p> <p>open areas. Heel protectors were applied and the physician was made aware.</p> <p>c. 7/3/14 at 1:34 P.M. staff documented the resident had a necrotic (dead tissue) area to the right heel that measured 9.0 cm x 12.0 cm with no odor and no drainage. A treatment was started of skin prep to the right heel twice daily. The family was notified and the family wanted the resident to wear heel protectors at all times. Staff informed the family they would encourage the heel protectors, but to wear at all times was not a good idea.</p> <p>d. 7/8/14 staff documented the resident's right heel wound remained with necrotic tissue and measured 9.0 cm x 12.0 cm and the treatment was changed to a betadine pad, non-adhesive pad and a Kerlix wrap. A new intervention was started for a boot to be worn in bed.</p> <p>The quarterly MDS dated 9/18/14 documented the resident required extensive assistance for bed mobility and had one un-stageable pressure ulcer, suspected deep tissue injury that measured 11.5 cm x 7.0 cm of eschar</p> <p>Review of the Consultation Note from a physician at the hospital dated 9/23/14 documented the resident had a right heel decubitus ulcer with subcutaneous erythema and recommended beginning antibiotics intravenously and local wound care. Further review of the hospital records revealed the resident had gangrene and sepsis and a large decubitus ulcer of the right heel and adjacent abscess to the mid foot on the plantar surface which was malodorous.</p> <p>The discharge summary printed 10/1/14 from the hospital documented the resident had a two stage procedure leading to a below the knee</p> | F 279  |   |   |

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| F 279   | <p>Continued From page 9 amputation of the right leg.</p> <p>Nurse's notes documented the resident returned on 10/1/14 from a hospitalization with a stage 2 pressure ulcer on the coccyx which measured 4 cm x 2 cm and required a wound dressing.</p> <p>During an interview on 7/30/15 6:33 P.M., Licensed Nursing Staff #3 acknowledged the care plan for the prevention of pressure ulcers lacked pressure relief interventions for the heels while the resident was in bed and also lacked direction for staff to treat the left heel pressure ulcer after it developed. Staff failed to address the stage 2 pressure ulcer and treatment on the resident's coccyx on the residents care plan.</p> <p>The facility provided a policy which addressed wounds that lacked a title or date which instructed staff to use pillow boots, devices and protectors that were available as needed to provide support surfaces and pressure redistribution. The policy also directed staff to complete accurate measurement of a wound's length, width, depth and tunneling and note the wound location, color and description of the skin around the wound, wound surface and drainage. The facility policy did not direct staff on the frequency of wound measurements/assessments or care planning of interventions.</p> <p>The facility failed to develop a care plan to address pressure ulcers, treatments and pressure ulcer prevention measures for this resident.</p> <p>2. Resident #12, a resident at risk for diminished activity attendance, was re-admitted to the facility on 11/11/11 with the diagnoses of Profound</p> | F 279  |   |                      |   |

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| F 279   | <p>Continued From page 10</p> <p>intellectual disabilities, Palsy, Infantile cerebral, Convulsions, Psychosis, Anxiety and Persistent mental disorder.</p> <p>The annual MDS dated 11/4/14 documented the resident required extensive assistance to total assistance for activities of daily living such as bed mobility and transfers and had problems with short and long term memory and intellectual disabilities. It was very important for the resident to listen to music he/she liked, somewhat important to attend religious services and to get fresh air when the weather was good. The resident enjoyed favorite activities liked to do things in small groups, his/her interests included books, newspapers and magazines were all assessed as somewhat important to the resident.</p> <p>The Pre-Admission Screening and Resident Review (PASRR) for the resident dated 10/3/07 directed the resident's placement in a nursing facility was appropriate and the facility needed to provide psychotropic medication monitoring, assistance with activities of daily living and either group activities and or individual sensory stimulation for socialization.</p> <p>The CAA for activities did not trigger for this resident.</p> <p>Care plan for activities current and original dated 9/30/09 documented the resident had limited involvement in activities related to the diagnosis of Mental Retardation. The care plan directed staff to document the resident's participation in activities, provide materials for in room activities as needed/preferred and provide a monthly calendar in the resident's room to announce daily activities each morning. Staff were to continue to</p> | F 279  |   |                      |   |

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| F 279  | <p>Continued From page 11</p> <p>invite the resident to activities regardless of attendance. The staff failed to develop an individualized activity care plan for the resident's specific activity preferences that were assessed and reported by staff.</p> <p>The activity assessment dated 11/4/14 documented the resident liked all music and music was important to the resident, it was somewhat important to do things with groups of people, and participate in favorite activities and to go outside to get fresh air when the weather was good. Daily activity preferences were books, newspapers or magazines, listening to music, doing things in groups of people and spending time outdoors.</p> <p>The 7/21/15 activity progress note documented the resident was alert, needed cueing and supervision for all daily tasks. The resident enjoyed the entertainers and groups that sing and the resident pointed and laughed and listened to them sing. The resident went in and out of the dining room during group activities at times.</p> <p>Observation on 7/29/15 from 1:00 P.M. to 2:45 P.M., Resident #12 returned frequently to the Social Service doorway yelling and talking and again Staff #1 took the resident back into the hall and instructed the resident to stay out of the office and did not offer any activity for the resident. Staff did not offer for the resident to join in on the Bingo activity which was offered to other residents at that time. Staff also did not offer to provide an activity of less complexity to meet the interests of this residents cognitive abilities.</p> <p>During an interview on 7/29/15 at 4:15 P.M., Staff #11 reported the resident required assistance</p> | F 279   |   |                      |   |

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| F 279   | <p>Continued From page 12</p> <p>with transfers to get in and out of bed. The resident enjoyed Bingo, visiting, pet therapy, loved to listen to talking about animals or anything that had to do with animals, country music, and Atlanta Braves baseball.</p> <p>During an interview on 7/30/15 at 3:38 P.M., Staff #1 and Staff #2 reported the resident wanders in the wheelchair in the halls, in and out of offices. The resident tore the paper and boxes and that was the resident's activities which he/she was involved.</p> <p>During an interview on 7/30/15 at 4:37 P.M., Staff #4 acknowledged the care plan lacked the resident's specific activity interests.</p> <p>The facility did not provide an activity policy. The facility did provide a policy entitled Care Plan Goals and Objectives without a date. The policy directed staff to care plan goals and objectives as the desired outcome for a specific resident problem. The policy did not address the need to develop a care plan with resident specific interventions.</p> <p>3. Resident #10 was admitted to the facility on 4/28/15 with diagnoses that included dementia with depression, difficulty walking, muscle weakness, muscular atrophy, renal disease, diabetes mellitus, coronary atherosclerosis, chronic pain, dysphagia, and skin ulcer.</p> <p>The admission MDS dated 5/5/15 recorded the resident's BIMS score was 15/15, cognitively intact. The MDS recorded the resident admitted with a pressure ulcer on his/her coccyx measuring 11 cm x 11 cm. The resident required extensive assistance of 2 staff for bed mobility.</p> | F 279  |   |                      |   |

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| F 279  | <p>Continued From page 13</p> <p>Review of the medical record revealed a Braden Scale Skin Assessment was not completed for this resident with an existing pressure ulcer upon admission.</p> <p>Skin Ulcer documentation dated 4/28/15 recorded the resident's coccyx wound as 11 cm. x 11 cm. covered with eschar and slough. No other skin issues were recorded upon admission.</p> <p>Wound Care Note dated 5/6/15 at 8:31 P.M. recorded, "Reported by therapy staff this am that while resident having PT [Physical Therapy] noticed some drainage on [his/her] sock. Area was assessed R [right] heel with serous color drainage noted area measuring 2 x 4 [2 cm. x 4 cm.] appearance skin noted that blister had opened and was draining."</p> <p>The resident experienced a cognitive decline since admission, and was unable to be interviewed.</p> <p>During an interview on 7/29/15 at 11:51 A.M., the Director of Nursing (DON) stated the resident was admitted (4/28/15) with "boggy heels," and admitted there was no documentation in the medical record about the resident's heels until the 5/6/15 note when the blister opened. The DON stated he/she thought this blister's cause was the boots the resident wore caused pressure on the heel, but did not document it. The DON stated the facility changed the boots to another type after the opened blister was noted.</p> <p>During an interview on 7/30/15 at 4:09 P.M., Licensed Nurse #3 verified no Braden Assessment was completed for the resident, and</p> | F 279   |   |                      |   |

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| F 279   | Continued From page 14<br>stated usually this was done upon admit and agreed the resident's initial care plan did not include any interventions for the resident's heels until the right heel blister opened and was noted by PT on 5/5/15 (resident's admission 4/28/15). Licensed Nurse #3 agreed the resident's skin was fragile.<br><br>During a follow up interview with the DON on 7/30/15 at 5:31 P.M., the DON stated he/she did not know why staff failed to notice the resident's right heel blister until it opened. The DON expected staff to observe the resident's skin during care and report it, document, and put a treatment in place.<br><br>The facility failed to provide care plan interventions to prevent new pressure ulcers, and promote healing of current pressure ulcers for this dependent resident. | F 279  |   |                      |   |
| F 312<br>SS=D   | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and policy review, the facility failed to ensure timely activities of daily living (ADL) assistance to include transfer assistance, appropriate dressing and grooming was provided for 3 of 23 (Residents #12, 13 and 10) residents sampled.   | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 15</p> <p>The findings included:</p> <p>1. Resident #12 was re-admitted to the facility on 11/11/11 with the diagnoses of Profound intellectual disabilities, Palsy, Infantile cerebral, Convulsions, Psychosis, Anxiety and Persistent mental disorder.</p> <p>The annual Minimum Data Set (MDS) dated 11/4/14 documented the resident required extensive assistance to total assistance for activities of daily living such as bed mobility, transfers and dressing and supervision for eating. The resident was incontinent of bowel and bladder, had problems with short and long term memory and had intellectual disabilities.</p> <p>The quarterly MDS assessment dated 7/21/15 documented the resident with a short and long term memory problem and severely impaired daily decision making ability. The resident required assistance for bed mobility and transfers and total assistance for dressing and supervision for eating.</p> <p>The Pre-Admission Screening and Resident Review (PASRR) for the resident dated 10/3/07 directed the resident's placement in a nursing facility was appropriate and the facility needed to provide psychotropic medication monitoring, assistance with activities of daily living and either group activities and or individual sensory stimulation for socialization.</p> <p>The Care Area Assessment (CAA) for ADL's did not trigger for this resident.</p> <p>The current care plan for ADL's original date of</p> | F 312  | <p>F-312 ADL Care<br/>S/S= D</p> <p>I. Resident #10 is no longer in the facility. Resident #12 and #13 are receiving assistance with ADLs as per their care plan.</p> <p>II. Residents requiring assistance with ADLs are receiving assistance with ADLs as per their care plan.</p> <p>III. Nursing staff has been in-serviced on providing assistance with ADLs as per the care plan.</p> <p>IV. The Director of Nursing, and/or Designee will complete random observation audits of resident ADL completion, weekly for four weeks then monthly for two months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date: 8/28/15</p> |                      |   |

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| F 312   | <p>Continued From page 16</p> <p>8/7/08 documented the resident was at risk for self-care deficit related to Mental Retardation and the resident required assistance with all ADL's. Staff were to ensure the resident wore shoes, dress the resident appropriately daily and provide pivot turn assistance with transfers. Staff were to check the resident for incontinence and change the resident as needed. Incontinence care needed to be provided by staff after each episode of incontinence.</p> <p>Observations on 7/29/15 from 3:14 P.M. to 4:51 P.M. revealed Resident #12 laid in bed awake dressed in a hospital gown. At 4:45 P.M. the resident's call light went off. The resident laid awake on top of the bed in a hospital gown holding part of a piece of card board. Direct Care Staff #11 entered the resident's room and turned off the resident's call light without offering to assist the resident to get up and out of bed and exited the room. Approximately immediately after staff exited the resident's room, Resident #12 set off the call light again signaling staff for the need for assistance. Staff #11 again, entered the resident's room and turned off the call light, then exited the room without offering assistance with the resident's ADL's. Observation revealed the resident holding the call light in hand, dressed in the hospital gown and fidgeting in bed. The resident smelled of urine. Staff #11 said, "See he pushed it again, he just plays with that call light."</p> <p>Observations on 7/29/15 at 4:51 P.M., revealed Resident #12's call light went off. Office Staff #13 entered the room and turned off the call light. Staff exited the room and stated, "The resident has torn that card board box to shreds."</p> <p>Observations on 7/29/15 at 4:58 P.M. Resident</p> | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 17</p> <p>#12's call light went off. Office staff #13 again entered the room and turned off the call light then left the resident's room and did not offer any help with ADL's and did not send nursing staff to assist the resident.</p> <p>Observations on 7/29/15 at 5:00 P.M. Resident 312's call light went off. Direct Care Staff #14 entered the room and transferred the resident to a standard arm chair in the room where the resident sat wearing a hospital gown. The resident's left buttocks was exposed to the hallway. Staff left the resident's room and did not attempt to change the resident's brief, did not place shoes on the resident's bare feet and did not attempt to dress the resident in appropriate clothing.</p> <p>Observations on 7/29/15 at 5:19 P.M., the staff placed a room tray on the over bed table in front of the resident who sat in a standard chair in his/her room dressed in a hospital gown and who smelled of strong urine. The resident's hospital gown was open in the back and exposed the right hip and buttocks to the hallway. Staff left the room leaving the resident unassisted and unsupervised in the room alone to eat the dinner meal.</p> <p>Observations on 7/29/15 at 5:28 P.M., Resident #12 pushed the bed side table away and began trying to put a shoe on his/her foot unsuccessfully. Much of the resident's food on the dinner tray was left uneaten.</p> <p>Observations on 7/29/15 at 5:38 P.M., Staff #1 summoned Staff #14 and said, "Look, the resident wants to get dressed and get up, see what he is doing." While the resident sat in the</p> | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 18</p> <p>chair, Staff #14 provided total assistance to don the resident's shirt and also placed sweat pants up to the resident's knees. Staff assisted the resident to stand, then removed the urine saturated brief which was secured on the right side, but hung open on the left side of the resident. The staff acknowledged the resident's brief was wet and that there was a strong urine odor. The chair the resident sat in during the dinner meal was wet with urine. Staff #14 provided incomplete perineal care (staff did not clean the urine thoroughly from the resident's skin) and then exited the resident's room.</p> <p>During an interview on 7/29/15 at 5:38 P.M., Staff #14 reported staff get the residents up really early in the morning and so they are dressed in gowns at 2:00 P.M. and put back to bed and provided the evening meal in their rooms. The reason staff put gowns on the residents and put the residents back to bed at 2:00 P.M. is because "The nurse makes the schedule of assignments that way." Staff #14 reported this practice was based on the nursing schedule, not resident's preference or choices.</p> <p>During an interview on 7/30/15 3:28 P.M., Staff Nurse #2 reported staff should encourage the resident to eat and provide supervision during meals and did not know why the resident was not up, dressed and groomed and able to eat in the dining room. Residents should be dressed and use of a hospital gown would be due to the resident's preference. This resident was not able to voice a preference for a gown or to eat in bed due to the resident's current cognition.</p> <p>During an interview on 7/30/15 at 3:30 P.M., Administrative staff #1 reported nursing staff</p> | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 19</p> <p>should have responded to the resident's call light and assisted the resident out of bed, to get dressed and into the dining room for the dinner meal. Staff #1 did not know why there were eleven residents on the same hall as this resident, all dressed in hospital gowns who staff did not assist to the dining room and who ate their meal in their rooms. Staff #1 said, "It must have happened due to survey overkill."</p> <p>During an interview on 7/30/15 at 6:33 P.M., Staff Nurse #3 acknowledged the resident's care plan did not indicate the resident wore a hospital gown, went to bed at 2:00 P.M. or ate dinner in bed. Staff had no knowledge of why the nursing staff left the resident in bed awake in a hospital gown and did not know why the staff did not have the resident up, dressed and in the dining room for the dinner meal. Staff did not assess this practice as a resident preference as this resident was not able to verbalize a preference due to cognition. The resident did not have the ability to request staff leave a hospital gown on him/her or to request to remain in bed for the meal.</p> <p>The facility provided a policy without a date entitled dressing the resident which did not address the need to ensure residents were dressed in appropriate clothing during waking hours, nor did it address the need for staff to provide assistance to residents who used the call light or to ensure resident who required supervision with meals were assisted to the dining room.</p> <p>The facility failed to provide appropriate assistance with ADL's in the areas of responding to the use of the call light, dressing and supervision with a meal to meet the needs of this</p> | F 312  |   |                      |   |

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| F 312  | <p>Continued From page 20</p> <p>cognitively impaired and dependent resident.</p> <p>2. Resident #13 was admitted to the facility on 9/10/09 with the diagnoses of contracture, dementia without behavior disturbances and epilepsy.</p> <p>The annual MDS dated 1/29/15 documented the resident with a Brief Interview for Mental Status Score (BIMS) of 5, which indicated the resident had severely impaired cognition. The resident did not have behaviors and did not refuse care. The resident required extensive assistance for most ADL's.</p> <p>The Care Area Assessment did not trigger for ADL's.</p> <p>The quarterly MDS dated 7/21/15 documented the resident with a BIMS of 3, which indicated the resident had severely impaired cognition. The resident required extensive assistance of one staff for bed mobility, dressing and transfers and total assistance for grooming. The resident did not refuse care. The resident's preference for customary routine and activities documented it was somewhat important for the resident to choose their own bedtime.</p> <p>The annual MDS CAA dated 2/6/15 for ADL's documented the resident required extensive to total assistance with most of the adl's.</p> <p>The current care plan for ADL's original date of 5/26/09 directed staff to assist with personal hygiene as needed, assist the resident with tying and buttoning, check and change the resident every two hours and assist with transfers as needed. The care plan did not direct staff on the</p> | F 312   |   |                      |   |

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| F 312              | <p>Continued From page 21</p> <p>amount of assistance to provide for dressing or address why the resident wore a hospital gown during the day and did not identify the resident's preference for bedtime.</p> <p>Observations on 7/29/15 at 3:05 P.M., revealed Resident #13 sat up on the side of the bed with legs dangling off the bed awake. The resident wore a hospital gown, had bare feet and his/her hair was dirty/greasy looking and ungroomed.</p> <p>During an attempt to interview the resident on 7/29/15 at 3:05 P.M. the resident voiced nonsensical talk and was not able to voice dressing or bedtime preferences.</p> <p>Frequent observations on 7/29/15 between the times of 4:15 P.M. to 5:45 P.M., the resident sat on top of the bed, wore a hospital gown and ate off of a room tray alone. Further observation on this hall revealed 9 other unsampled residents wore hospital gowns and ate off of room trays in their rooms. Staff did not offer for this resident to dress and eat in the dining room.</p> <p>Observations on 7/30/15 at 7:28 A.M., revealed the resident laid in bed and wore a hospital gown while he/she ate alone from a room tray.</p> <p>Observations on 7/30/15 at 2:57 P.M., revealed the resident laid in bed and wore hospital gown.</p> <p>During an interview on 7/29/15 at 4:15 P.M., Staff #14 reported the resident required assistance with meals, extensive assistance with transfers and limited assistance with dressing and grooming. The resident did not have any behaviors and did not refuse cares. Staff routinely woke the residents early, so the staff placed</p> | F 312         |   |                      |

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| F 312   | <p>Continued From page 22</p> <p>gowns on the residents and laid them in bed at 2:00 P.M. where staff served the resident's room trays.</p> <p>During an interview on 7/30/15 at 3:28 P.M., Staff #2 reported nursing staff should have encourage the resident to eat and did not know why the resident was not up, dressed and groomed and able to eat in the dining room. Residents should be dressed and use of a hospital gown would be due to the resident's preference. This resident was not able to voice a preference for a gown or request to eat in bed so staff should have dressed the resident and should have taken the resident to the dining room to eat with other residents.</p> <p>During an interview on 7/30/15 at 6:33 P.M., Staff #3 reported the resident was care planned to lay down after lunch, but acknowledged the care plan did not indicate the resident wore a hospital gown, went to bed at 2:00 P.M. or ate dinner in bed. She had no knowledge of why the resident was not dressed and ate in bed. Staff did not assess this routine as the resident's preference and thus, staff should have dressed the resident in appropriate clothing and fed the resident dinner in the dining room.</p> <p>The facility provided a policy without a date entitled dressing the resident which did not address the need to ensure residents were dressed in appropriate clothing during waking hours, nor did it address the need to ensure resident who required supervision with meals were assisted to the dining room.</p> <p>The facility failed to provide appropriate assistance with ADL's in the areas of dressing</p> | F 312  |   |   |

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| F 312   | <p>Continued From page 23 and supervision with a meal to meet the needs of this cognitively impaired and dependent resident.</p> <p>3. Resident #10 was admitted to the facility on 4/28/15 with diagnoses of dementia with depression, difficulty walking, muscle weakness, muscular atrophy, renal disease, diabetes mellitus, coronary atherosclerosis, chronic pain, dysphagia, and skin ulcer.</p> <p>The admission MDS dated 5/5/15 recorded the resident's BIMS score was 15/15, cognitively intact. The MDS recorded the resident required total staff assistance for bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing. The resident had a Percutaneous Endoscopy Gastrostomy (PEG) Tube for eating, and received at least 51 percent (%) of his/her nutrition from the PEG tube.</p> <p>The Activities of Daily Living (ADL) care plan dated 5/5/15 directed staff: assist to select and dress in clean/season appropriate clothing daily and as needed, assist with oral care, personal hygiene, perineal care after toileting as needed, check and change every 2-3 hours and provide incontinence care as needed, encourage cooperation with rehabilitation therapy to increase independence and safety, provide bath/shower on scheduled days and as needed, use geri-chair when out of bed for comfort and support and uses ¼ side rails to assist with bed mobility and transfers.</p> <p>The dietary note dated 5/19/15 recorded the resident now had pleasure meals with 0 to (-) 20% intake, and nectar thickened fluids.</p> <p>Observation on 7/27/15 at 3:50 P.M. revealed</p> | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 24</p> <p>Resident #10 in bed with very dry chapped lips and a lump of grayish colored substance stuck to the side of the resident's tongue.</p> <p>Observations of Resident #10 during medication administration on 7/28/15 at 2:42 P.M., revealed the resident's lips were chapped and tongue was grooved and dry. The resident's tongue was noted to stick to his/her teeth and roof of mouth when speaking. Licensed Nurse #7 did not offer the resident oral care or a drink.</p> <p>Observations of Resident #10 in bed on 7/29/15 at 12:26 P.M., revealed the resident yelled help. The resident's lips were dry and chapped, and the resident's tongue was grooved and dry. Licensed Nurse #15 was notified, and the nurse stated they were just in the resident's room, but failed to go and re-check what the resident wanted or offer oral care and a drink.</p> <p>Observations on 7/29/15 at 6:09 P.M. revealed the resident lay in bed asleep with dry, chapped lips.</p> <p>Observations on 7/30/15 at 7:25 A.M. and 8:43 A.M., revealed Resident #10 lay in bed asleep with dry chapped lips, and dried crusted white matter on his/her lips and chin. At 9:35 A.M., the resident was observed in bed with eyes closed and yelling, "Water, water, water." The resident's tongue appeared dry and grooved, with thick yellow matter on the tongue, lips chapped. Upon interview, Licensed Nurse #7 stated one of the CNAs was just in the resident's room to adjust his/her body and straighten his/her torso. Staff failed to re-enter the resident's room to provide oral care and water.</p> | F 312  |   |                      |   |

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| F 312   | <p>Continued From page 25</p> <p>Observations of wound care dressing change on 7/30/15 at 10:58 A.M. with Licensed Nurse #7 and Certified Nursing Assistant (CNA) #12, Resident #10 stated, "My mouth is so dry." Licensed Nurse #7 explained the wound care to the resident and stated he/she would give the resident a drink after wound care. Staff failed to give the resident a drink or provide oral care.</p> <p>During an interview on 7/29/15 at 2:22 P.M., Licensed Nurse #15 stated the resident's mouth care was done 2 times per day by staff.</p> <p>During interview on 7/29/15 at 2:32 P.M., CNA #10 stated the resident received mouth care that morning and after lunch. CNA #10 stated he/she was not allowed to use toothettes with water for the resident's oral care, only dry toothettes, and displayed the regular dry sponge-type toothettes staff used for the resident's oral care, in a drawer in the bedside table.</p> <p>During an interview on 7/30/15 at 5:23 P.M., the Director of Nursing (DON) stated every nursing staff member could give the resident a drink and provide oral care, and he/she expected the nurses to do mouth care for the resident. The resident used to be "Nothing by mouth", but now all nursing staff could use the toothettes with water for oral care. The DON further stated glycerin swabs were ordered and should have been used for the resident's oral care.</p> <p>The policy provided by the facility did not address oral care for a dependent resident.</p> <p>The facility failed to provide assistance with this dependent resident's oral care and fluids.</p> | F 312  |   |   |

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| F 314<br>F 314<br>SS=G  | Continued From page 26<br>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and policy review, the facility failed to promote the healing of pressure ulcers that were present and failed to prevent the development of new pressure ulcers for 2 of 5 (Residents #35 and 10) residents with a pressure ulcer. Resident #10 developed new pressure/shearing ulcers after being repositioned using a draw sheet to pull the resident's body. Resident #10 developed a new right heel pressure ulcer without interventions in place to prevent pressure ulcers. The facility failed to accurately and comprehensively assess Resident #35's skin timely to identify skin breakdown prior to the development of a deep tissue injury, failed to effectively relieve pressure to the resident's heels by floating them in accordance with nursing standards and facility policy and failed to thoroughly assess and measure the pressure ulcer's worsening condition timely. Therefore, it was determined the findings caused serious injury, harm and impairment to Residents #10 and #35. | F 314<br>F 314   | F-314 Pressure Wounds<br>S/S=G<br>1. Resident #35 was a closed record review. Resident #10 is no longer in the facility.<br>II. The residents upon admission will have skin assessments performed, documented and care planned accordingly. Residents with pressure wounds have been assessed, measured and documented. Residents with pressure wounds have preventive skin measures in place as per care plan.<br>III. Licensed nurses have been in-serviced by the Director of Nursing on 8/7/15, NP (Nurse Practitioner) on wound management on 8/11 /15. Licensed nurses were in-serviced on a Wound Care presentation prepared by a physician from a wound care practice and a Wound Assessment presentation prepared by a Wound Ostomy Certified Nurse/NP, both on 8/17/15 and 8/18/15.<br>IV. The Director of Nursing will complete audits on wound care assessment/measurements, documentation and preventive care plan interventions weekly for 3 months, monthly for 3 months, then quarterly for two quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.<br>V. Completion Date: 8/21/15 |   |

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| F 314  | <p>Continued From page 27</p> <p>The findings included:</p> <p>1. Resident #35 was admitted to the facility on 6/13/14 and the closed electronic record documented the resident with the diagnoses of End Stage Renal Disease, Hypertension, Diabetes, Ischemic heart disease, Peripheral vascular disease, Diarrhea and a Below the knee amputation.</p> <p>The admission Minimum Data Set (MDS) dated 6/20/14 documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The resident required extensive assistance for bed mobility. Staff assessed the resident to be at risk for the development of pressure ulcers, but the resident did not have any pressure ulcers.</p> <p>The quarterly MDS dated 9/18/14 documented the resident required extensive assistance for bed mobility and had one unstageable pressure ulcer, suspected deep tissue injury that measured 11.5 centimeters (cm) by (x) 7.0cm of eschar.</p> <p>The Care Area Assessment (CAA) for pressure ulcers dated from the 6/20/14 admission MDS documented the resident was at risk for pressure ulcers.</p> <p>The care plan for Pressure Ulcers dated 6/13/14 documented the resident was at risk for pressure ulcers and directed staff as follows: encourage mobility and or assist with turning and repositioning as resident will comply, monitor nutrition/hydration and assist as needed as resident will comply, observe skin with daily cares and notify nurse / doctor of any changes or resident complaints, pressure reduction mattress</p> | F 314   |   |                      |   |

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| F 314 | <p>Continued From page 28</p> <p>to bed if needed and as resident will comply, boots when out of bed, assist resident to keep skin clean and dry as resident will allow and staff added a new intervention on 10/1/14 to monitor the right below the knee amputation site daily for any signs of infection. The care plan lacked interventions to prevent heel pressure while in bed for this resident (who in the nurse's notes staff identified as daily refused to get out of bed) such as padded boots, heel lift boots or floating of the heels and also lacked interventions to address the pressure ulcer which developed on the right heel identified on 7/2/14.</p> <p>The electronic record revealed on 6/13/14 staff documented a skin risk assessment and indicated the resident had no skin issues and a BRADEN (assessment to determine a resident's risk for the development of pressure ulcers) score of 16, which indicated the resident was at risk for pressure ulcer development.</p> <p>Review of the nurse's notes revealed the following:</p> <p>a. 6/29/14 - staff documented the resident refused therapy and refused to get up from bed daily and the family had concerns.</p> <p>b. 7/2/14 at 1:14 A.M. - staff documented the resident's heels were black with a chronic peeling of the skin and both heels were rough, but had no open areas. Heel protectors were applied and the physician was made aware.</p> <p>c. 7/3/14 at 1:34 P.M. - staff documented the resident had a necrotic (dead tissue) area to the right heel that measured 9.0 cm x 12.0 cm with no odor and no drainage. A treatment was started of skin prep to the right heel twice daily. The family was notified and the family wanted the resident to wear heel protectors at all times. Staff</p> | F 314 |  |  |
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| F 314   | <p>Continued From page 29</p> <p>informed the family they would encourage the heel protectors, but to wear at all times was not a good idea.</p> <p>d. 7/8/14 - staff documented the resident's right heel wound remained with necrotic tissue and measured 9.0 cm x 12.0 cm and the treatment was changed to a betadine pad, non-adhesive pad and a Kerlix wrap. A new intervention was started for a boot to be worn in bed.</p> <p>e. Continued review revealed the clinical record lacked further weekly wound measurements which indicated staff failed to adequately assess the resident's right heel ulcer progression.</p> <p>f. 9/20/14 - staff documented the family was notified of staff concerns with wound and doctor was also notified the right heel pressure ulcer had a brownish drainage and a slight odor under the heel. Staff did not measure the pressure ulcer and there were no treatment changes ordered for the resident.</p> <p>g. 9/22/14 - staff documented the resident was lethargic and at 6:30 A.M. staff sent the resident out by ambulance to a hospital.</p> <p>Review of the consultation note from a physician at the hospital dated 9/23/14 documented the resident had a right heel decubitus ulcer with subcutaneous erythema and recommended beginning antibiotics intravenously and local wound care. Further review of the hospital records revealed the resident had gangrene and sepsis and a large decubitus ulcer of the right heel and adjacent abscess to the mid foot on the plantar surface which was malodorous.</p> <p>The discharge summary printed 10/1/14 from the hospital documented the resident had a two stage procedure leading to a below the knee amputation of the right leg.</p> | F 314  |   |   |

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| F 314   | <p>Continued From page 30</p> <p>During an interview on 7/30/15 at 3:48 P.M., Licensed Nursing Staff #2 reported no knowledge of how often staff needed to measure a pressure ulcer to assess the progression of the ulcer and had no knowledge of staff having pressure ulcer prevention interventions in place for this resident. Staff #2 did say they try to make weekly rounds to assess pressure ulcers and tried to measure them weekly. He/She was not sure what the expectation would be for timely assessing and measuring wounds they would need to check the facility policy.</p> <p>During an interview on 7/30/15 6:33 P.M., Licensed Nursing Staff #3 reported he/she was not able to find any further measurements after 7/8/15 for the wound on the right heel. Staff #3 reported, "The pressure ulcer resulted in amputation of the right foot. I don't know if the wound was measured anymore than those few times because that DON [director of Nursing] is no longer employed here." Licensed Nursing Staff #3 acknowledged the care plan lacked pressure relief interventions for the heels while the resident was in bed to prevent the development of the pressure ulcer to the right heel and also lacked direction for staff to treat the left heel pressure ulcer after it developed.</p> <p>The facility provided a policy which addressed wounds that lacked a title or date which instructed staff to use pillow boots, devices and protectors that were available as needed to provide support surfaces and pressure redistribution. The policy also directed staff to complete accurate measurement of a wound's length, width, depth and tunneling and note the wound location, color and description of the skin around the wound,</p> | F 314  |   |                      |   |

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| F 314   | <p>Continued From page 31</p> <p>wound surface and drainage. The policy did not direct staff on the frequency of wound measurements and assessments.</p> <p>The facility failed to accurately and comprehensively assess Resident #35's skin timely to identify skin breakdown prior to the development of a deep tissue injury, failed to effectively relieve pressure to the resident's heels by floating them in accordance with nursing standards and facility policy and failed to thoroughly assess and measure the pressure ulcer's worsening condition timely resulted in actual harm.</p> <p>2. Resident #10 was admitted to the facility on 4/28/15 with diagnoses of dementia with depression, difficulty walking, muscle weakness, muscular atrophy, renal disease, diabetes mellitus, coronary atherosclerosis, chronic pain, dysphagia, and skin ulcer.</p> <p>The admission MDS dated 5/5/15 recorded the resident's BIMS score was 15, indicating the resident was cognitively intact. The MDS recorded the resident admitted with a pressure ulcer on his/her coccyx measuring 11 cm x 11 cm. The resident required extensive assistance of 2 staff for bed mobility.</p> <p>The facility was unable to provide a Braden Scale Skin Assessment for this resident with an existing pressure ulcer upon admission.</p> <p>Skin Ulcer Documentation dated 4/28/15 recorded the resident's coccyx wound as 11 cm x 11 cm covered with eschar and slough. No other skin issues were recorded upon admission.</p> | F 314  |   |                      |   |

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| F 314  | <p>Continued From page 32</p> <p>Wound Care Note dated 5/6/15 at 8:31 P.M. recorded, "Reported by therapy staff this am that while resident having PT [Physical Therapy] noticed some drainage on [his/her] sock. Area was assessed R [right] heel with serous color drainage noted area measuring 2 x 4 [2 cm. x 4 cm.] appearance skin noted that blister had opened and was draining."</p> <p>Record review on 7/30/15 revealed no documentation of the area on the resident's left tailor bunion.</p> <p>Observation of perineal care on 7/29/15 at 2:46 P.M., Certified Nursing Assistants (CNA) #10 and #11 finished perineal care. During the observation there was an open red area noted on the resident's left tailor bunion. The staff placed the resident's feet in foam boots, but the boots did not cover the affected area.</p> <p>Observation of dressing change for a large coccyx wound open to the bone, on 7/30/15 at 10:58 A.M. revealed Licensed Nurse #7 began by pulling the resident him/herself using the draw sheet, dragging the resident's body with the draw sheet on the air mattress. During care, 1 open area observed on the right buttocks, and 3 open areas noted on the left buttock below the current coccyx wound. Further observation revealed the nurse's dressing fell out, and while out of the room, the coccyx wound was left open to the air, and CNA #12 pulled the soiled draw sheet with wound exudate against the cleaned wound until the nurse returned. Licensed Nurse #7 then applied the dressing without re-cleaning the wound.</p> <p>After the wound care on 7/30/15 at 12:03 P.M.,</p> | F 314  |   |   |

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| F 314 | <p>Continued From page 33</p> <p>Licensed Nurse #7 stated he/she did not know what wounds the resident had, and would have to look it up. He/she looked it up and stated the resident had a sacral wound, right heel wound, and healed upper back wound. Licensed Nurse #7 failed to disclose the 4 new open areas on the resident's buttocks or the left tailor bunion area.</p> <p>Upon request, the Director of Nursing (DON) completed a skin check on the resident. The DON stated the 4 areas on the buttocks were new areas, and were from pressure or rubbing. The DON stated the left tailor bunion wound appeared to be a resolving blister, and admitted none of the wounds were noted or documented in the record. The DON expected Licensed Nurse #7 to record and put a treatment in place for new wounds, and expected the nurses to know which wounds a resident had.</p> <p>During an interview on 7/29/15 at 11:51 A.M., the DON stated the resident was admitted (4/28/15) with "boggy heels," and admitted there was no documentation in the medical record about the resident's heels until the 5/6/15 note when the blister opened. The DON stated he/she thought this blister's cause was the boots the resident wore caused pressure on the heel, but did not document it. The DON stated the facility changed the boots to another type after the opened blister was noted.</p> <p>During interview on 7/30/15 at 4:09 P.M., Licensed Nurse #3 verified no Braden Assessment was completed for Resident #10. Licensed Nursing Staff #3 stated, "Usually this [Braden] was done upon admit. Licensed Nursing Staff #3 agreed the resident's initial care plan did not include any interventions for the resident's</p> | F 314 |  |  |
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| F 314   | Continued From page 34<br>heels until the right heel blister opened and was noted by PT and the resident's skin was fragile.<br><br>During a follow up interview on 7/30/15 at 5:31 P.M., the DON stated he/she did not know why staff failed to notice the resident's right heel blister until it opened. The DON expected staff to observe the resident's skin during care and report it, document, and put a treatment in place. The DON stated a Braden Scale should be completed upon admission and interventions put in place. The DON stated the CNAs should note and report any new skin problems to the nurse. The DON stated it was not appropriate for the nurse to pull the resident with a draw sheet and it could cause skin problems for a resident with frail skin; 2 staff should lift the resident off the sheet during repositioning. The DON stated the licensed nurse should have re-cleaned the wound before applying a dressing, and the CNA should not have held a soiled sheet to an open wound. The DON acknowledged harm to the resident for these practices.<br><br>The facility provided a document titled Section M5. Skin Treatments, related to filling out the MDS. The document was undated and no other skin care or wound care policy was provided for identifying, reporting, measuring wounds or putting treatments in place.<br><br>The facility failed to prevent new pressure ulcers, and failed to identify, report and treat existing pressure ulcers for this dependent resident which resulted in actual harm. | F 314  |   |   |
| F 441<br>SS=E   | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  | F 441  |   |   |

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| F 441  | <p>Continued From page 35</p> <p>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.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br/>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 441   | <p>I. Resident #10 is no longer in the facility. Resident #12 is receiving incontinent care.</p> <p>II. Residents are receiving assistance with dining, perineal care, wound dressing changes, medication administration and with Foley catheter placement in a manner to prevent transmission of infection.</p> <p>III. Nursing staff has been in-serviced on infection control practices for dining service, perineal care, wound dressing changes, medication administration and Foley catheter placement.</p> <p>IV. The Director of Nursing, Charge nurse and/or Designee will complete random observation audits of infection control practices for dining service, perineal care, wound dressing changes, medication administration and Foley catheter placement, weekly for four weeks, then monthly for two months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>Completion Date: 8/28/15</p> |   |

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| F 441   | <p>Continued From page 36</p> <p>Based on observation and interview, the facility failed to provide a safe and sanitary environment to help prevent the development and/or transmission of infection during dining, perineal care, a dressing change and medication administration. The facility failed to ensure 2 of 6 (Resident #10 and a random resident) residents' with a indwelling foley catheter bag did not touch the floor. The facility failed to ensure Resident #12's pressure sore was not contaminated during a dressing change.</p> <p>The findings included:</p> <p>1. Observations in the dining room on 7/27/15 at 12:34 P.M., Staff #16 touched straws with his/her bare hand, covering the area where the resident would place his/her mouth, thus contaminated the straw for several unsampled residents. The same staff removed a resident's bread from the wrapper and touched the bread with his/her bare hands. Staff #16 sat at a table and fed two unsampled residents, but also stood and assisted several other residents in the area with their meals. After touching a resident's clothing, staff then assisted another resident with their plate set up and did not use hand sanitizer prior to assisting other residents with their meals.</p> <p>During an interview on 7/27/15 at 1:10 P.M. Staff #16 said, "You have to touch the bread to remove it from the package so the resident can eat." Staff #16 stated, "Was not aware the end of the straw should not be touched."</p> <p>2. Observations on 7/29/15 at 5:38 P.M., revealed Staff #14 assisted Resident #12 who sat in a wheelchair to stand. Staff then removed the resident's urine saturated brief which was</p> | F 441  |   |                      |   |

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| F 441   | <p>Continued From page 37</p> <p>secured on the right side of the resident and hung open on the left side of the resident. The staff acknowledged the resident's brief was wet and that there was a strong urine odor. The chair the resident sat in during the dinner meal was wet with urine. Staff then stood behind the resident and assisted the resident to stand. Staff steadied the resident with one hand while staff held a bath size towel with the other hand and wiped the resident's buttocks. Staff did not clean the resident's front perineal area. Staff then placed a new brief on the resident and pulled up the pants and pulled down the shirt. Staff assisted the resident to sit in the wheelchair touching the clothing, wheelchair arm and released the wheelchair brake all with the same contaminated gloved hand. Staff failed to change gloves or sanitize hands after touching the areas that were contaminated with urine, prior to touching the clean surface areas of the clothing and wheelchair.</p> <p>3. Observations of Resident #10 revealed the urinary catheter bag was touching the floor on the following dates and times: 7/29/15 at 11:33 A.M., at 12:26 P.M., at 2:20 P.M. and at 6:09 P.M. and on 7/30/15 at 7:25 A.M., at 8:43 A.M. and at 9:35 A.M.</p> <p>Observation of a dressing change on 7/30/15 at 10:58 A.M., for Resident #10 revealed a large coccyx wound open to the bone, revealed Licensed Nurse #7 left the resident's room and the coccyx wound was left open to the air. certified Nursing Assistant (CNA) #12 pulled the soiled draw sheet with wound exudate against the cleaned wound until the nurse returned. Licensed Nurse #7 then applied the dressing without re-cleaning the wound.</p> | F 441  |   |   |

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| F 441   | <p>Continued From page 38</p> <p>During an interview on 7/30/15 at 5:31 P.M., the Director of Nursing (DON) stated, it was not acceptable for staff to let any part of the resident's catheter bag touch the floor and the licensed nurse should have re-cleaned the wound before applying a dressing, and the CNA should not have held a soiled sheet to an open wound.</p> <p>4. Observations during medication administration on 7/29/15 at 11:56 A.M., an unsampled resident's catheter bag lay on the floor. Licensed Nurse #6 did not adjust the bag to remove it from the floor.</p> <p>During an interview on 7/30/15 at 5:31 P.M., the DON stated it was not acceptable for staff to let any part of the resident's catheter bag touch the floor.</p> <p>5. Observations during medication administration on 7/29/15 at 9:31 A.M., Licensed Nurse #15 dropped an unsampled resident's Levothyroxine tablet on the top of the medication cart, donned gloves and picked up the contaminated tablet, placed it in a medication cup and gave it to the resident.</p> <p>During an interview on 7/30/15 at 5:31 P.M., the DON stated the nurse should have disposed of the soiled tablet and administered another to the resident.</p> <p>6. Observations during medication administration on 7/30/15 at 8:03 A.M., Licensed Nurse #7 placed the entire medication cup in his/her bare hand, covering the area where the resident would place his/her mouth. Nurse #7 administered the medications to Resident #14 by placing the</p> | F 441  |   |   |

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| F 441   | <p>Continued From page 39</p> <p>contaminated cup against the resident's mouth.</p> <p>During an interview on 7/30/15 at 5:31 P.M., the DON stated the nurse should have placed his/her fingers below the lip area of the medication cup to prevent contamination.</p> <p>The facility did not provide a policy regarding medication administration, wound care or infection control.</p> | F 441  |   |   |

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