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	175347	A. BUILDING _____ B. WING _____	C 11/23/2016

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GOOD SAMARITAN SOCIETY - CHEYENNE COUNTY	820 S DENISON STREET ST FRANCIS, KS 67756

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #108073 and partial extended survey.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, 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: The facility had a census of 26 residents. The sample included 3 residents. Based on observation, record review and interview the facility failed to update 1 of 3 sampled resident's care plan to include the placement of physician ordered blue pressure reducing boots on the resident's feet, bilaterally, the at all times.	F 280		

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

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Findings included:

- The quarterly (MDS) Minimum Data Set assessment, dated 9/20/16, revealed the resident had intact cognition, a functional limitation in range of motion of his/her lower extremities, needed total assistance of 2 staff for (ADLs) Activities of Daily Living, and used a urinary catheter. The MDS further revealed the resident had 5 stage 2 pressure ulcers, used a pressure reducing device for the bed and his/her wheelchair, received nutrition and hydration interventions for management of the ulcers, and had dressings applied to the ulcers.

The 9/26/16 care plan directed staff to monitor the location, size, and treatment of the skin injury, report any abnormalities, failure to heal, and signs of infection to the physician. The care plan further directed staff to place a pressure reducing cushion in the resident's wheelchair, reposition the resident every 2 hours, and provide the resident with a fortified diet (food that has essential nutrients (such as iron and vitamins) added). The care plan had no documentation regarding use of heel protectors as directed by the 9/11/16 physician orders or other interventions to float the resident's heels.

The 9/11/16 physician ordered hospital discharge instructions directed staff to use heel protectors at all times unless ambulating, and to provide the resident a regular diet with a protein supplement 3 times a day, with meals.

The 9/14/16 at 8:30 AM, Wound Data Collection form revealed the resident's right heel had a stage 2 pressure ulcer with a measurement of 0.6

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(cm) centimeters x 2 cm, and described the surrounding tissue as pink and intact.

The 9/14/16 at 4:18 PM, Wound Data Collection form revealed the resident's left heel had a stage 2 pressure ulcer with a measurement of 0.4 cm x 0.3 cm, with minimal drainage.

The 11/8/16 physician's order directed staff to apply heel protectors at all times while sitting in a chair or lying in bed and to follow the physician's routine pressure ulcer orders. (The 9/11/16 physician's order had directed the use of heel protectors)

The 11/8/16 Wound Data Collection form indicated the resident had a water filled blister to the left lateral foot, that measured 2 cm x 2 cm.

The 11/12/16 Wound Data Collection form indicated the resident's right heel, had a stage 1 (skin appears reddened and does not blanch (lose color briefly when you press your finger on it and then remove your finger)) wound that measured 2 cm x 2 cm, with no depth. The form directed staff to use a skin barrier wipe, have the resident rest in bed after lunch with heel protectors on, float the resident heels on a pillow, have the resident wear compression hose (stronger elastic stockings to create significant pressure on the legs, ankles and feet), and follow up with the physician as needed.

The 11/16/16 Wound Data Collection form indicated the resident's right heel had a stage 1 wound that measured 2.5 cm x 2.5 cm, with no depth. The form directed staff to use a skin barrier wipe, have the resident rest in bed after lunch with heel protectors on, have the resident

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wear compression hose, and to follow up with the physician as needed.

On 11/17/16 at 10:48 AM, observation revealed the resident lying on top of the bedspread, covered with a blanket over his/her middle torso, the head of the bed elevated 30 degrees, an alarm attached to the bed, and the call light within the resident's reach. Observation revealed the resident laid on his/her left side with a pillow tucked behind his/her back, and compression stockings, on his/her legs. Observation further revealed the resident's legs laid flat on the bed, at a left angle, and did not have a pillow placed underneath his/her legs to float his/her heels off the mattress. Continued observation revealed 2 padded blue heel protector boots, lying on the corner of the bed, by the footboard. Nurse Aide D approached the resident, to get the resident out of bed, explained the task, and placed the blue boots on the resident's feet.

On 11/17/16 at 11:00 AM, Nurse Aide D verified the resident did not have his/her lower legs elevated on a pillow, and did not place the pressure reducing blue boots on the resident's feet earlier.

On 11/17/16 at 5:15 PM, observation revealed the resident seated in his/her wheelchair with footrests in place, at a dining room table. Further observation revealed the resident wore compression stockings, with rubber soled slippers on his/her feet. (The 11/8/16 physician's order directed staff to place heel protectors on the resident's feet at all times)

On 11/17/16 at 5:31 PM, Administrative Nurse A stated staff should follow the physician's order to

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F 280	Continued From page 4 wear the blue pressure reducing boots at all times, and acknowledged the care plan did not include the physician's order to wear the blue pressure reducing boots. Upon request, the facility did not to provide a policy for updating care plans. The facility failed to update the resident's care plan with instructions to apply the pressure reducing boots to Resident #2's feet, bilaterally, as physician ordered, placing the resident at risk for new or worsening pressure ulcers.	F 280		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 3 residents. Based on observation, record review, and interview the facility failed to complete a thorough assessment and reassessment after a change of condition for 1 of 3 sampled residents. Resident #1 returned from the emergency room after he/she swallowed a metal washer and experienced respiratory problems. The facility failed to thoroughly assess/reassess the resident who displayed restlessness, coughing and a decreased oxygen	F 309		

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saturation of 87% for approximately 3 hours, and found the resident deceased on 11/11/16 at 10:05 PM. This deficient practice placed the resident in immediate jeopardy.

Findings included:

- Resident #1's significant change (MDS) Minimum Data Set assessment, dated 8/31/16, indicated the resident had adequate vision, a (BIMS) Brief Interview for Mental Status score of 3, indicating severe cognitive impairment, The MDS further indicated the resident required extensive assistance for bed mobility, transfers, walking in room, supervision for eating and had no swallowing problems. The MDS further indicated the resident had shortness of breath with exertion, sitting and lying flat.

The 8/31/16 Cognitive Loss/Dementia (CAA) Care Area Assessment revealed the resident had dementia (progressive mental disorder characterized by failing memory, confusion) which could contribute to him/her not remembering things. The CAA indicated the resident received continuous oxygen and if he/she was not getting enough oxygen, it would affect his/her cognitive thinking.

The 10/6/16 care plan indicated the resident had impaired cognitive function and thought process related to confusion, and he/she was not oriented to time or place. The care plan directed staff to cue, reorient and supervise the resident, and redirect/reassure as needed. The care plan

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further revealed the resident had an (ADL) Activities of Daily Living self-care performance deficit related to confusion, dementia, limited mobility and pain, and directed one staff to assist the resident with ADLs. The care plan further indicated the resident received antianxiety medications and directed staff to monitor/document side effects (drowsiness, clumsiness, confusion, disorientation, impaired thinking and judgement, blurred or double vision) and the medication's effectiveness. The care plan further indicated the resident had chronic pain and directed staff to notify the health care provider if interventions were unsuccessful or if current complaint was a significant change from the resident's past experience of pain. The care plan instructed staff to observe/record/report to the nurse any signs or symptoms of non verbal pain (changes in breathing, vocalizations, mood/behavior). The care plan directed staff to monitor/document for side effects of pain medication, observe for new onset of increased agitation, restlessness, confusion, hallucinations (sensations that appear real but are created by your mind), nausea, vomiting, and report to the resident's health care provider.

The 11/10/16 at 2:05 PM, nurse's note revealed the resident had received Zyprexa (a medication capable of affecting the mind, emotions, or behavior) for at least one week for dementia with behavioral disturbances, and he/she did not seem to be improving. The note revealed the resident's spouse became upset when the resident was agitated. The note further stated the resident benefited from 1:1 attention and the 2 PM-10 PM shift found it helpful to keep him/her by their side as they work. The note revealed the staff

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suggested sorting nuts and bolts as an activity, as the resident was a farmer and this may be helpful for him/her.

The 11/10/16 at 2:29 PM, nurse's note revealed an intervention (not clearly specified) was added to the care plan for the resident's anxiety and agitation, and directed staff to provide 1:1 interaction.

The 11/10/16 at 4:06 PM, nurse's note revealed the physician saw the resident today for an acute visit, as the medication Zyprexa, initiated last week, had not helped much to decrease the resident's symptoms. The resident continued to have confusion, due to his/her advanced dementia and became agitated at times, but was not typically violent. The resident had a PRN (as needed) physician order for Ativan (medication to treat a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) for his/her agitation. The note further indicated the resident's appetite was good, and lung sounds somewhat diminished at bases bilaterally, otherwise (CTAB) clear to auscultation (the action of listening to sounds from the heart, lungs, or other organs) bilaterally. The psychiatric evaluation stated: normal mood/affect, disoriented to place, time and situation - spoke to the physician about doing chores on his/her farm yesterday. Do not feel that Zyprexa helped, so will discontinue this. Increase PRN Ativan for times of agitation and feel that his/her symptoms are natural progression of Alzheimer dementia. Staff working on tasks to perform with resident to help keep him/her occupied - sorting nuts/bolts, reading, etc. which physician felt was a good

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idea. Orders as follows: Discontinue Zyprexa, Change Ativan to: Ativan 1 (mg) milligram every 6 hours PRN for agitation, Diagnosis: dementia with behavior disturbance.

The 11/11/16 at 7:56 AM, nurse's note revealed staff administered Ativan, 1 mg, to the resident for behavior. At 8:39 AM, documentation revealed the resident more calm and the medication was effective.

The 8/15/16 physician's order directed staff to administer DuoNeb Solution (medication to help make breathing easier) 0.5-2.5 (3) mg/(ml) milliliter inhale orally for congestion, shortness of breath and related to systolic (congestive) heart failure (QID) four times a day.

The 11/11/16 at 1:38 PM, nurse's note revealed staff administered a DuoNeb Solution 0.5-2.5 mg/3 ml for increased phlegm (thick, sticky, stringy mucus secreted by the mucous membrane of the respiratory tract) and shortness of breath.

The 11/11/16 at 1:41 PM, nurse's note revealed the resident spitting out a large amount of phlegm, exhibited shortness of breath, and O2 (oxygen) on at 2.5 (L) liters per (N/C) nasal cannula (nose piece). The note further indicated staff administered a DuoNeb treatment and obtained the resident's vital signs.

The 11/11/16 at 2:17 PM, nurse's note revealed the resident had shortness of breath, expectorating (coughing up) large amounts of phlegm today, with poor food and fluid intake. The change in condition started on 11/11/16. The

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note revealed the resident's blood pressure 123/85, pulse 73, respirations 20, temperature 97.8, oxygen saturation 91% with oxygen per N/C (normal range greater than 90%). The note indicated food and drink worsened the resident's symptoms and nebulizer treatment, and oxygen improved the symptoms. The note stated the resident was spitting up a large amount of phlegm today, and had a poor intake of food/drink. The note further stated that staff administered oxygen via N/C to the resident, due to shortness of breath, and administered a DuoNeb treatment for crackles noted in his/her lungs.

The 11/11/16 at 2:50 PM, nurse's note revealed the resident coughing up phlegm, respirations sound very congested in the right lung, oxygen saturations not staying above 90%, with oxygen at 2.5 L. The note revealed staff increased the resident's oxygen to 4.5 L which improved his/her oxygen saturation to 90%. The note revealed the nurse contacted the physician's office at 2:40 PM and was advised to transfer the resident to the (ER) Emergency Room.

The 11/11/16 at 2:56 PM, nurse's note revealed staff sent the resident to the hospital for a respiratory infection.

The medical record lacked evidence of documentation of when the resident returned to the facility from the hospital.

The 11/11/16 at 6:48 PM, nurse's note revealed staff administered a DuoNeb Solution 0.5-2.5 mg/3 ml to the resident, which was ineffective. The medical record lacked documentation of the resident's vital signs including his/her respiratory status.

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The 11/11/16 at 6:49 PM nurse's note revealed staff administered Ativan 1 mg to the resident. The note had no documentation for the reason.

The 11/11/16 at 7:43 PM, nurse's note revealed the Ativan 1 mg PRN administration was effective.

The Emergency Room report, dated 11/11/16, revealed the ER staff evaluated the resident 3:30 PM with a chief complaint of cough. The resident presented from the (NH) nursing home with dementia, oxygen on, with a saturation reading of 90% on 4 L per N/C, a loose productive cough with a large amount of clear return, and was receiving breathing treatments with DuoNeb PRN only, with no other PRN treatments. The note further indicated the resident had been sorting metal bolts, screws, and washers at the NH. The note further revealed the facility administered an albuterol breathing treatment, and Pulmicort (steroid medication) 0.5 mg with no improvement.

The 11/11/16 (KUB) kidney, ureter, bladder x-ray report revealed there was a centrally lucent (glowing with or giving off light) round metallic (resembling metal) foreign body located at the level the gastroesophageal junction (the place where the esophagus connects to the stomach) just above the diaphragm (the muscle that separates the chest cavity from the abdomen), measuring 3 (cm) centimeters in diameter (larger than a quarter).

The 11/11/16 Emergency Room discharge directed staff to obtain a follow up KUB Monday morning (11/14/16) or sooner if symptoms

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worsen. The note further revealed the physician spoke with the surgeon on call, who recommended serial KUB films to see if the washer in the resident's distal esophagus will pass. The note further revealed a repeat KUB was ordered for Monday (11/14/16), as there was a foreign body, in the distal esophagus. The discharge instructions directed staff to encourage intake, for the resident, which may allow the washer to pass through his/her gut, continue current treatment but change DuoNeb breathing treatments to (TID) three times a day routinely, elevate the resident's (HOB) head of bed for sleep, return to the hospital on Monday morning (11/14/16) for repeat KUB, to see if the foreign body would pass. The note further revealed a nursing order to have the resident wear oxygen 2-4 L per N/C, and adjust to keep O2 saturation greater than 90%.

The medical record revealed no further documented nurse's notes until 11/11/16 at 10:05 PM, (over 3 hours since the documentation revealed the staff administered a breathing treatment that was ineffective per the staff) revealing the resident's VS's were absent, with no spontaneous respirations, skin white in color, warm to touch, pupils fixed and dilated, and unresponsive to voice and touch. The note further revealed staff notified the Emergency Room physician at 10:15 PM.

Review of the medical record lacked documentation of an assessment of the resident following his/her return from the hospital, some time after 2:56 PM, or an assessment after the staff administered a breathing treatment

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documented as ineffective at 6:48 PM. The documentation lacked a thorough assessment, including breath sounds, from the 2:50 PM nurse's notes of the resident's oxygen saturation levels which declined and staff transferred him/her to ER . The medical record lacked documentation of the resident's return from ER and staff finding him/her unresponsive without vital signs present at 10:05 PM (approximately 7 hours).

On 11/15/16 at 1:39 PM, Licensed Nursing Staff C stated when he/she checked the resident's vital signs on 11/11//16 at approximately 2:15 PM, oxygen was on at 2.5 Liters via nasal cannula, the resident's oxygen saturation was below 90% at that time, so Licensed Nursing Staff C increased the oxygen to 4 Liters to keep his/her oxygen saturation above 90%. Licensed Nursing Staff C further stated the Administrative Staff K told him/her that the resident was coughing up phlegm, so Licensed Nursing Staff C listened to the resident's lungs, and heard crackles (abnormal breath sounds caused by excessive fluid within the airways) in the right lung. Licensed Nursing Staff C reported he/she called Physician B, who responded with orders to send the resident to the (ER) Emergency Room. Licensed Nursing Staff C stated that he/she called the ER at 5:30 PM to see if the resident was returning to the NH, and was told that the resident had swallowed a foreign object, but would be returning to the facility with orders for repeat x-rays. Licensed Nursing Staff C further stated that Administrative Staff K went to the hospital to pick up the resident at 6:40 PM. Licensed Nursing Staff C further stated the ER had sent an order to administer DuoNeb breathing treatments TID and

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encourage food and fluids to help the object pass. Licensed Nursing Staff C stated the resident didn't want to eat so he/she gave the resident some water but after taking a drink, the resident started coughing, so Licensed Nursing Staff C took the water away from the resident. The resident then became restless and agitated, so Licensed Nursing Staff C tried to talk to the resident to calm him/her, but he/she wouldn't calm down, so Licensed Nursing Staff C administered an Ativan to the resident around 6:50 PM. Around 8:30-9:00 PM, the resident went to his/her room, where Licensed Nursing Staff C stated he/she directed the direct care staff to elevate the HOB when he/she helped the resident to bed and to turn the resident on his/her side slightly. Licensed Nursing Staff C further stated that when he/she was finished with medication pass, he/she checked on the resident, around 8:45 PM, and then after finishing charting, went back to the resident's room, around 9:40 PM and listened to the resident's breathing audibly, but did not listen to his/her lungs with a stethoscope (a medical instrument for listening to the action of someone's heart or breathing) or complete a thorough assessment. Nurse C stated the resident was a little wheezy (to breathe with a hissing sound and with difficulty) and flinched to touch, but did not appear to be having a hard time breathing. Licensed Nursing Staff C stated the resident's oxygen saturation was 87% on 4 Liters, so Licensed Nursing Staff C increased the oxygen to 4.5 Liters to get his/her saturation to 90%. Licensed Nursing Staff C further stated that was the last time he/she checked on the resident.

On 11/16/16 at 10:44 AM, direct care staff D stated that on 11/10/16 the resident was fine, and had no coughing. direct care staff D further stated

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that on 11/11/16, around 1:30 PM, the resident's spouse turned on the resident's call light because the resident had vomited. direct care staff D further stated he/she had been told the resident had been vomiting earlier that day, and was spitting up a lot of clear mucous. Staff D stated that while he/she was assisting the resident, the resident's spouse pointed at a bolt on the floor. Direct care staff D stated that he/she asked the resident's spouse if it was from his/her walker and the spouse replied that it was not, so Staff D put the bolt in his/her pocket and gave it to the nurse after assisting the resident. Direct care staff D stated the Licensed Nursing Staff C reported he/she would check vital signs on the resident because he/she had vomited, and administer him/her a breathing treatment. Direct care staff D stated that when the breathing treatment was finished, he/she went into the resident's room to put the resident's oxygen back on him/her and remove the breathing treatment. Direct care staff D further stated the resident was lying down in his/her chair, and exhibiting more confusion. The resident then asked for a drink of water, after taking a drink, he/she started coughing up a lot of clear phlegm again. Staff D stated that coughing up the phlegm, was not normal for the resident, that it started on 11/11/16. Direct care staff D further stated that he/she informed the nurse of the resident coughing/spitting up the phlegm.

On 11/16/16 at 4:47 PM, Administrative Nurse A stated when the resident came back from the hospital, he/she would have expected staff to do an assessment with a progress note documented in the medical record, and any nursing interventions to be put in writing. He/she further stated staff should have documented the follow up assessments that were done. Administrative

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Nurse A stated that Licensed Nursing Staff C failed to follow the documentation policy after the resident returned from the hospital, as far as doing an assessment and documenting it. Administrative Nursing staff A further stated that the nurse should have checked the resident every 15 minutes as he/she directed staff to do and document it. Administrative Nurse A verified there was no documentation for approximately 3 hours from when the resident came back from the hospital to when staff found the resident deceased. Administrative Nurse A further stated that when the resident went to the ER the facility was not aware that he/she had swallowed something, staff thought that his/her (CHF) congestive heart failure was just acting up or that he/she had a respiratory infection.

On 11/17/16 at 7:05 AM, Licensed Nursing Staff E stated that on 11/10/16 the resident was fine, had no coughing, and was not in any respiratory distress. The resident wore oxygen continuously at night at 2 Liters via N/C, slept flat in his/her bed. Licensed Nursing Staff E stated that on 11/11/16, he/she came to work at 9:40 PM, and saw the evening shift nurse running down the hall into resident #1's room and then come back out. Licensed Nursing Staff E further stated that at 9:45 PM, he/she received report from Licensed Nursing Staff C, that the resident had gone to the ER, and had apparently swallowed a washer, which the physician felt would pass on its own. Licensed Nursing Staff C reported the hospital was going to do more tests on Monday (11/14/16) if the washer had not passed on its own, and instructed Licensed Nursing Staff E to do 15 minute checks, check VS, do assessments, and document his/her findings in the medical record. Licensed Nursing Staff E further stated that

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he/she instructed his/her direct care staff that nursing staff were going to check the resident frequently, and to let Licensed Nursing Staff E know if they saw anything abnormal. Licensed Nursing Staff E further reported that when he/she walked into the resident's room, around 10:05 PM, the resident had passed away, his/her skin was pale white, still warm, and the resident had no VS. Licensed Nursing Staff E further stated that when he/she entered the resident's room, the resident was wearing oxygen at 4.5 Liters via N/C, he/she was lying on his/her back, and the HOB was not elevated. Licensed Nursing Staff E further stated that when he/she notified the primary physician, the physician wanted to know what the resident's VS had been, how he/she ate, and what the assessments had been like since the resident's return from the ER. Licensed Nursing Staff E further stated he/she was unable to provide the physician the requested information, because there was no documentation of these assessments or vital signs. Licensed Nursing Staff E further stated the primary physician asked if the resident had been sent back to the ER, and he/she informed the physician that the last documentation charted on the resident was the transfer to the hospital, with the last VS's documented at 2:30 PM.

The facility's September, 2012, Documentation Policy stated documentation of all nursing care and observations, assessments and treatments, and effects will be written by an authorized professional using the Point Click Care System and resident services system of forms. The frequency of documentation was determined depending on the condition of the resident. Staff would clearly document all of the following according to the respective policies and

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F 309	Continued From page 17 procedures: 1. Physical health observations 2. Assessments 3. Reassessments (such as change in resident status or condition) 4 Physician's orders/medications and completion of orders 5. Transfers and discharges The facility failed to thoroughly assess and reassess cognitively impaired resident #1, who returned to the facility from the ER, with a report of swallowing a foreign object. The clinical record lacked evidence of documentation of nurse's assessment following the resident's return from the ER for approximately 3 hours, even when the resident displayed coughing, restlessness and decreased oxygen saturation of 87% (signs of respiratory distress), and staff found the resident had passed away on 11/11/16 at 10:05 PM. This deficient practice placed the resident in immediate jeopardy. The facility abated the immediate jeopardy on 11/23/16, when they completed the following: Developed a policy and procedure for nursing assessment/reassessment of residents with a change of condition and/or ER visit. In-serviced and educated all staff by administrative staff/designee of the facility's September 2012 Documentation Policy, to ensure all residents were assessed and reassessed in a timely manner, as physician ordered. The deficient practice remained at a scope and severity of G.	F 309		

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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.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 26 residents. The sample included 3 residents, 1 of which was reviewed for pressure ulcers. Based on observation, record review and interview, the facility failed to follow a physician's order to provide necessary treatment and services for the prevention of pressure ulcers for 1 of 1 sampled residents. (#2)

Findings included:

- Resident #2's physician order sheet, dated 9/11/16, included the following diagnoses: pressure ulcer (injury to the skin and/or underlying tissue usually over a bony prominence) of his/her left heel with a stage 2 wound (presents as an abrasion, blister, or shallow crater), pressure ulcer of his/her right heel with a stage 2 wound, lymphedema (swelling that usually occurs in the arms or legs), neuropathy (damage to the peripheral nerves that causes weakness, numbness, and pain), and an

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acquired foot deformity (distortion of the foot).

The quarterly (MDS) Minimum Data Set assessment, dated 9/20/16, revealed the resident had intact cognition, a functional limitation in range of motion of his/her lower extremities, needed total assistance of 2 staff for (ADLs) Activities of Daily Living, and had an indwelling urinary catheter. The MDS further revealed the resident had 5 stage 2 pressure ulcers, used a pressure reducing device for the bed and his/her wheelchair, received nutrition and hydration interventions for management of the pressure ulcers, and had dressings applied to the ulcers.

The 9/26/16 care plan directed staff to monitor the location, size, and treatment of the skin injury, report any abnormalities, failure to heal, and signs of infection to the physician. The care plan further directed staff to place a pressure reducing cushion in the resident's wheelchair, reposition the resident every 2 hours, and provide the resident with a fortified diet (food that has essential nutrients (such as iron and vitamins) added). The care plan had no documentation regarding use of heel protectors as directed by the 9/11/16 physician orders or other interventions to float the resident's heels.

The 9/11/16 physician ordered hospital discharge instructions directed staff to use heel protectors at all times unless ambulating, and to provide the resident a regular diet with a protein supplement 3 times a day, with meals.

The 9/14/16 at 8:30 AM, Wound Data Collection form revealed the resident's right heel had a stage 2 pressure ulcer with a measurement of 0.6 (cm) centimeters x 2 cm, and described the

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surrounding tissue as pink and intact.

The 9/14/16 at 4:18 PM, Wound Data Collection form revealed the resident's left heel had a stage 2 pressure ulcer with a measurement of 0.4 cm x 0.3 cm, with minimal drainage.

The 11/8/16 physician order directed staff to apply heel protectors at all times while sitting in a chair or lying in bed and to follow the physician's routine pressure ulcer orders. (The 9/11/16 physician order had directed the use of heel protectors)

The 11/8/16 Wound Data Collection form indicated the resident had a water filled blister to the left lateral foot, that measured 2 cm x 2 cm.

The 11/12/16 Wound Data Collection form indicated the resident's right heel, had a stage 1 (skin appears reddened and does not blanch (lose color briefly when you press your finger on it and then remove your finger)) wound that measured 2 cm x 2 cm, with no depth. The form directed staff to use a skin barrier wipe, have the resident rest in bed after lunch with heel protectors on, float the resident heels on a pillow, have the resident wear compression hose (stronger elastic stockings to create significant pressure on the legs, ankles and feet), and follow up with the physician as needed.

The 11/16/16 Wound Data Collection form indicated the resident's right heel had a stage 1 wound that measured 2.5 cm x 2.5 cm, with no depth. The form directed staff to use a skin barrier wipe, have the resident rest in bed after lunch with heel protectors on, have the resident wear compression hose, and to follow up with the

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physician as needed.

On 11/17/16 at 10:48 AM, observation revealed the resident lying on top of the bedspread, covered with a blanket over his/her middle torso, the head of the bed elevated 30 degrees, an alarm attached to the bed, and the call light within the resident's reach. Observation revealed the resident laid on his/her left side with a pillow tucked behind his/her back, and compression stockings, on his/her legs. Observation further revealed the resident's legs laid flat on the bed, at a left angle, and did not have a pillow placed underneath his/her legs to float his/her heels off the mattress. Continued observation revealed 2 padded blue heel protector boots, lying on the corner of the bed, by the footboard. Nurse Aide D approached the resident, to get the resident out of bed, explained the task, and placed the blue boots on the resident's feet.

On 11/17/16 at 11:00 AM, Nurse Aide D verified the resident did not have his/her lower legs elevated on a pillow, and did not place the pressure reducing blue boots on the resident's feet earlier.

On 11/17/16 at 5:15 PM, observation revealed the resident seated in his/her wheelchair with footrests in place, at a dining room table. Further observation revealed the resident wore compression stockings, with rubber soled slippers on his/her feet. (The 11/8/16 Physician's order directed staff to place heel protectors on the resident's feet at al times)

On 11/17/16 at 5:31 PM, Administrative Nurse A stated staff should follow the physician's order to wear the blue pressure reducing boots at all

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F 314	Continued From page 22 times, and acknowledged the care plan did not include the physician's order to wear the blue pressure reducing boots. The facility's September 2012 Wound and Pressure Ulcer Prevention and Documentation Requirements policy and procedure directed staff to notify the physician of the resident's ulcer and the resident's condition to obtain orders for a treatment. The policy further directed the staff to notify the resident and /or the family of the pressure ulcer, orders and planned interventions. The facility failed to follow a physician's order to place blue pressure reducing boots on Resident #2's feet, when lying in bed or up in a wheelchair, which placed the resident at risk for an increase in the wound size and development of new pressure ulcers.	F 314		
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every	F 496		

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State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 26 residents. Based on record review and interview, the facility failed to have a system in place to follow-up back ground check results for 4 of the 5 employees reviewed.

Findings included:

- On 11/17/16, record review revealed the facility submitted a request for a background check, dated 7/25/16, for Nurse Aide G, hired on 8/9/16. The record lacked evidence the facility reviewed and printed verification for the completed background check.

On 11/17/16, record review revealed the facility submitted a request for a background check, dated 7/30/16, for Nurse Aide H, hired on 8/9/16. The record lacked evidence the facility reviewed and printed verification for the completed

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background check.

On 11/17/16, record review revealed the facility submitted a request for a background check, dated 8/12/16, for Nurse Aide I, hired on 8/22/16. The record lacked evidence the facility reviewed and printed verification for the completed background check.

On 11/17/16, record review revealed the facility submitted a request for a background check, dated 9/8/16, for Dietary Aide J, hired on 9/29/16. The record lacked evidence the facility reviewed and printed verification for the completed background check.

On 11/17/16 at 2:15 PM, Administrative Staff F verified he/she did not obtain the background check results for the above employees' personnel record.

On 11/17/16 at 5:31 PM, Administrative Nursing Staff A stated the facility did not obtain the background check verification for each employee's personnel record.

The facility's September, 2013 Abuse and Neglect Policy states that the facility will not knowingly 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.

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F 496	Continued From page 25 The facility failed to follow-up on the back ground check results for 4 of the 5 employees reviewed, placing the residents at risk for possible abuse.	F 496		