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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 04/25/22.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 13 residents with one reviewed for positioning. Based on observation, record review, and interview, the facility failed to ensure staff provided the required positioning and offloading devices, and failed to ensure appropriate wheelchair positioning for Resident (R) 36. This placed R36 at increased risk for pain, contractures (fixed tightening of muscle, tendons, ligaments, or skin which prevents normal movement) and further skin breakdown. Findings included: - The electronic medical record (EMR) documented R36 had diagnoses of spastic hemiplegia affecting left dominant side (a neuromuscular condition of spasticity that	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/25/2022

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resulted in the muscles on one side of the body being in a constant state of contraction), traumatic brain injury (sudden trauma to the brain), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Quarterly Minimum Data Set," dated 03/30/22, documented R36 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, dressing, personal hygiene, and dependent upon two staff for transfers and toileting. R36 had upper functional impairment on one side, lower functional impairment on both sides, had one Stage 3 pressure ulcer (full thickness skin loss potentially extending into the subcutaneous (under the skin) tissue layer), one Stage 4 pressure ulcer (a deep wound that reaches the muscles, ligaments, or even bone), and one unstageable pressure ulcer (full thickness tissue loss in which the actual depth of the ulcer cannot be seen due to dead tissue). The resident had a turning and repositioning program, pressure relieving devices for bed and chair, nutrition and hydration interventions to manage skin problems, and pressure ulcer care.

The "Activity of Daily Living (ADL) Care Plan," dated 03/10/22, directed staff to turn and reposition R36 every two hours and as needed, and directed two staff for assistance with bed mobility. It directed staff to place a pillow behind the residents back and between his knees; utilize one to two positioning wedges in the bed to help with off loading and promote wound healing. It further directed R36 needed blue heel protector boots to lower legs and feet at all times but R36 often refused.

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On 04/07/22 at 12:28 PM, observation revealed R36 sat in a Broda chair (a positioning chair), leaned to the left, with no pillow under or between his legs. Further observation revealed R36's feet had nonskid socks on and they rested against the back of the foot rest.

On 04/11/22 at 12:00 PM, observation revealed R36 sat in his Broda chair and leaned to the left. R36's left arm was positioned at his side between his side and the foam cushion on the resident's left arm rest. There was no pillow behind his back or under his legs or feet. R36's knees were together, his left foot and ankle had an ace wrap and gripper socks, and the foot rest not elevated. Staff did not assist the resident with repositioning.

On 04/12/22 at 01:41 PM, observation revealed R36 sat in his Broda chair in the dining room. The resident leaned to his left and his head hung over the side of his head rest, making his face look straight down. R36 had on the heel protection boots but his right leg kept falling off the foot rest and hung down unsupported. R36 did not have a pillow between his legs or behind his back.

On 04/13/22 at 08:22 AM, Therapy Consultant GG stated they last saw R36 for therapy in February. The facility ordered a Broda chair for the resident when he was admitted. Therapy Consultant GG stated R36 did tend to lean to the left but if he was leaning more than he should, staff were educated to reposition him or lay him down in bed. Therapy Consultant GG stated she discussed with the facility using two to three wedge cushions to keep R36 off his left side to prevent further skin breakdown.

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F 684	Continued From page 3 On 04/11/22 at 03:31 PM, Certified Nurse Aide (CNA) M stated R36 was repositioned every two hours and he could be repositioned in the Broda chair. On 04/12/22 at 02:45 PM, Administrative Nurse D verified R36 should be positioned better in the Broda chair and should have a pillow between his knees. The facility's "Repositioning" policy, dated May 2021, documented the guidelines for the assessment of resident repositioning needs was to aid in the development of an individualized care plan for repositioning to promote comfort for all bed and chair bound residents and to prevent skin breakdown, promote circulation, and provide pressure relief for residents. The facility failed to provide the necessary cares and services to ensure appropriate wheelchair positioning, positioning devices, and off-loading for R36, placing the resident at risk for pain and further skin breakdown.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		

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with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 13 residents, with four reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to ensure staff implemented interventions placed to promote healing and prevent worsening of a Stage 3 pressure ulcer (full thickness skin loss potentially extending into the subcutaneous tissue layer), a Stage 4 pressure ulcer (a deep wound that reaches the muscles, ligaments, or even bone), and a suspected deep tissue injury (an injury to underlying tissue below the skin's surface that results from prolonged pressure in an area of the body) for Resident (R)36. This placed the resident at risk for further skin breakdown and delayed healing.

Findings included:

- The electronic medical record (EMR) documented R36 had diagnoses of spastic hemiplegia affecting left dominant side (a neuromuscular condition of spasticity that resulted in the muscles on one side of the body being in a constant state of contraction), traumatic brain injury (sudden trauma to the brain), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and protein-calorie malnutrition (an imbalance of nutrients from your food and

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drinks that are needed to keep the body healthy and functioning properly).

The "Quarterly MDS," dated 03/30/22, documented R36 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, dressing, personal hygiene, and dependent upon two staff for transfers and toileting. R36 had upper functional impairment on one side, lower functional impairment on both sides, had one Stage 3 pressure ulcer, one Stage 4 pressure ulcer, and one unstageable pressure ulcer. The resident was provided a turning and repositioning program, pressure relieving devices for bed and chair, nutrition and hydration interventions to manage skin problems, and pressure ulcer care.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 11/24/21, documented R36 was at risk for pressure ulcers but did not have any skin breakdown at this time.

The "Pressure Ulcer Care Plan" initiated on 12/01/21, directed staff to assess skin weekly and as needed, apply a cushion to the wheelchair. It further directed a low loss air mattress and turn and reposition every two hours and as needed. It listed an intervention dated 12/01/21 to monitor R36's palm guard/splint areas for redness every day and night shift for contracture to the left hand.

R36's "Care Plan" recorded R36 had limited physical mobility and needed assistance due to his diagnoses of stroke, spastic hemiplegia of the left side an left upper and lower extremity contractures. It listed an intervention dated 12/01/21 which directed R36 required assistance of two staff members for bed mobility. It recorded

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an intervention dated 12/01/21 which directed R36 required use of a Hoyer lift (mechanical lift) and two staff member for transfers.

The "Care Plan" listed a new intervention dated 01/19/22 which directed staff to place a pillow to R36's back and between his knees and place pressure reducing boots to both feet when R36 was in bed.

The "Wound Clinic Report," dated 03/11/22, directed staff to pad the wheelchair arms with padding to promote healing.

The "Wound Clinic Report," dated 03/18/22, directed staff to pad both arms on R36's wheelchair with padding such as pool noodles and secure the padding to keep pressure off the resident's elbows; apply Prevalon (cushioned bottom boot that floats the heel off surfaces, helping to reduce pressure) blue heel protector boots to each lower leg/foot.

On 04/07/22 at 12:28 PM, observation revealed R36 seated in a Broda chair (a positioning chair), leaned to the left, no pillow under or between his legs, and a foam pad on the left arm of the Broda chair, which his left elbow rested on. Further observation revealed the resident's feet had nonskid socks on and they rested against the back of the footrest.

On 04/11/22 at 08:35 AM, observation revealed R36 laid in bed, eyes closed with no Prevalon boots on the resident's feet.

On 04/11/22 at 12:00 PM, observation revealed R36 in his Broda chair and he leaned to the left. R36's left arm was positioned at his side between

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his side and the foam cushion on the resident's left arm rest. No pillow behind his back or under his legs or feet. The resident's knees were together, and his left foot/ankle had an ace wrap on, gripper socks and footrest not elevated. Staff did not assist the resident with repositioning.

On 04/11/22 at 03:05 PM, observation revealed R36 in his Broda chair, in the living room area watching television. The resident yelled for assistance and staff did not check on the resident. At 03:23 PM, R36 hollered for help and was getting anxious and continued to holler for assistance. At 03:31 PM, Certified Nurse Aide (CNA) N and CNA M took the resident to his room to lay him down in his bed. CNA M placed a lift sling under R36's right knee, CNA M lifted R36's knee up to adjust the sling and the resident said "ouch, my knee popped, can I get a pain pill?" CNA M told R36 she would check to see if he could get a pain pill. CNA M and CNA N had trouble adjusting the sling to be able to hook the sling to the lift. CNA M continued to pull on the sling underneath the resident which caused the resident to yell "Ouch!". CNA N asked the resident if he was ok. R36 stated, "No, I'm just suffering!" CNA M and CNA N continued to adjust the sling until they were able to hook the sling to the lift. R36 was transferred to his bed and staff positioned the resident on his back, with his feet lying directly on the mattress, did not place the wedge cushion, nor offer the Prevalon boots before leaving R36's room.

On 04/12/22 at 01:41 PM, observation revealed R36 seated in his Broda chair in the dining room. The resident leaned to his left and his head hung over the side of his head rest, making his face look straight down. R36 had on the Prevalon

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boots, his right leg kept falling off the footrest and would just hang down. R36 did not have a pillow between his legs or behind his back.

On 04/11/22 at 03:31 PM, CNA M stated staff reposition R36 frequently and stated she did not offer the boots or the pillow under his legs because he would be getting up for supper. CNA M further stated prior to his skin breakdown, staff just repositioned him every two hours.
On 04/13/22 at 08:22 AM, Therapy Consultant GG stated they had last seen R36 for therapy in February. The facility had ordered a Broda chair for the resident when he was admitted. Consultant GG stated R36 did tend to lean to the left but if he was leaning more that he should, staff were educated to reposition him or lay him down in bed. Consultant GG stated she had discussed with the facility to use 2-3 wedge cushions to keep him off the left side to prevent further breakdown.
On 04/12/22 at 02:54 PM, Administrative Nurse D stated staff should offer the Prevalon boots to R36 when he was in bed and should follow the care plan to prevent further breakdown.
On 04/12/22 at 03:00 PM, Wound Consultant HH stated the physician would expect the facility to follow all recommendations that were given to them from the wound clinic to prevent further breakdown.

The facility's "Prevention of Pressure Injuries" policy, dated May 2021, documented staff identify specific risk factors, establish goals and prevention interventions with the resident, representatives and physician s input to establish goals and approaches to identify co-morbities, risk factors associated with pressure injuries. The risk factors increase with impaired mobility and

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F 686	Continued From page 9 decreased functional ability. The resident should be repositioned at least every two hours and more frequently as needed, use special mattress that contained foam, air, gel, or water as indication. Consider offloading pressure hourly if the head of the bed was greater than 30 degrees. The policy documented to utilize pillows or wedges to keep body prominences from touching each other, float heels when in bed and place a pillow from knee to ankle. The facility failed to provide the care planned pressure ulcer interventions for R36 to prevent skin breakdown, placing the resident at risk for further skin breakdown and delayed wound healing.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 13 residents, with one reviewed for pain. Based on observation, record review, and interview, the facility failed to administer pain medication in a timely manner to Resident (R) 36, who had a Stage 3 pressure ulcer (full thickness skin loss potentially extending into the subcutaneous tissue layer), a Stage 4 pressure ulcer (a deep wound that reaches the muscles, ligaments, or even bone), and a suspected deep tissue injury (an injury to underlying tissue below	F 697		

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the skin's surface that results from prolonged pressure in an area of the body). This placed R36 at risk for further pain and discomfort.

Findings included:

- The electronic medical record (EMR) documented R36 had diagnoses of spastic hemiplegia affecting left dominant side (a neuromuscular condition of spasticity that resulted in the muscles on one side of the body being in a constant state of contraction), traumatic brain injury (sudden trauma to the brain), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Quarterly Minimum Data Set," dated 03/30/22, documented R36 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, dressing, personal hygiene, and dependent upon two staff for transfers and toileting. The resident had moderate pain and received scheduled pain medication.

The "Pain Care Area Assessment" did not trigger.

The "Pain Care Plan," dated 03/10/22, directed staff to administer as needed analgesics (medication that relieve different types of pain) as ordered by the physician, assess for pain every shift and as needed, and anticipate and meet R36's needs. Reposition the resident, distract with television or talking about topics of R36's choice, hold his hand, offer food and/or drinks, and rotate sites when changing the Fentanyl patch (a patch that is used to treat severe pain).

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The "Pain Assessment,"dated 02/19/22, documented R36 was at risk for pain and had severe, constant pain all over.

The "Physician's Order," dated 11/19/21, directed staff to administer Tylenol Extra Strength, 600 milligrams (mg) by mouth every six hours, as needed, for discomfort.

The "Physician's Order," dated 12/24/21, directed staff to administer tramadol, 50 mg by mouth, every 12 hours, for the diagnosis of pain.

The "Physician's Order," dated 01/19/22, directed staff to administer tramadol (used to treat moderate to severe pain), 50 mg by mouth, three times a day, for the diagnosis of pain.

The "Physician's Order," dated 01/21/22, directed staff to apply a Lidoderm patch (used to relieve nerve pain), 5%, to R36's left hip, daily, for the diagnosis of pain.

The "Physician's Order," dated 03/25/22, directed staff to apply a Fentanyl patch 72 hours, 25 micrograms (mcg) per hour, apply trans dermally (absorbs through the skin) every 72 hours for the diagnosis of pain

The "Physician's Order," dated 04/08/22, directed staff to administer cyclobenzaprine (used to treat pain and stiffness), 10 mg, one tablet three times a day, for the diagnosis of muscle spasms (involuntary contractions of a muscle).

The "Medication Administration Record," dated April 2022, lacked documentation R36 received the requested as needed pain medication and lacked an assessment by the nurse for pain on

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04/12/22 at 03:30 PM.

On 04/11/22 at 03:31 PM, observation revealed R36 sat in his Broda chair (a positioning chair). Certified Nurse Aide (CNA) M placed a lift sling under R36's right knee, CNA M lifted R36's knee up to adjust the sling and the resident said "ouch, my knee popped, can I get a pain pill?" CNA M told R36 she would check to see if he could get a pain pill. CNA M and CNA N had trouble adjusting the sling to be able to hook the sling to the lift. CNA M continued to pull on the sling underneath the resident which caused the resident to yell "Ouch!". CNA N asked the resident if he was ok. R36 stated, "No, I'm just suffering!" CNA M and CNA N continued to adjust the sling until they were able to hook the sling to the lift.

On 04/12/22 at 10:15 AM, observation revealed R36 lying in bed. Licensed Nurse (LN) G and Administrative Nurse E explained to R36 that they were going to do his wound care and began to position R36 for wound care. LN G started to lift R36's left arm and he hollered "OW, that hurts, can I get a pain pill?" Administrative Nurse E asked him if he had been given his morning medications, and he stated "No!" Administrative Nurse E stated the resident had pain medication available but she did not know what exact medication nor when R1 was ordered to receive it. LN G asked R36 to roll to the left and grab the positioning rail with his right hand. R36 hollered "Ouch, that hurts my ankle!" Administrative Nurse E asked CNA O to tell Certified Medication Aide (CMA) R that R36 requested pain medication and his water pitcher. CMA R brought in a water pitcher, pills in a small plastic cup, and a Lidoderm patch. CMA R told Administrative Nurse E where to place the patch and left the room.

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(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
F 697	Continued From page 13	F 697		

Administrative Nurse E asked the resident his level of pain and started to administer the medication to the resident. Administrative Nurse E stated she did not know what the medications in the cup were except that they were the resident's "morning medications." R36 took the medications and LN G continued with wound care. LN G looked at R36's foot, checked capillary refill (time taken for color to return after presser was applied) and began to unwrap the ace bandage to rewrap it looser. R36 hollered "ouch, your hurting me!" After LN G rewrapped the resident's foot, she took a slipper sock and started to put in on the resident's foot. LN G noticed it was too small to fit over his wrapped foot; R36 again yelled "Ow, Ow" and stated it was hurting all the way up to his knee. LN G continued to try to put the sock on R36's foot. Administrative Nurse E removed the resident's shirt to look at a healed area on R36's rear left shoulder. LN G used wound cleanser on the resident's shoulder and applied skin prep (liquid protective film or barrier) to the area. R36 laid in bed with his left leg bent and the left knee underneath his right knee. Administrative Nurse E directed LN G to apply the resident's prevalon boots (pressure relieving boots) while he was in bed. LN G applied R36's right boot, then attempted to put on the left boot while the left leg was still under the right leg. R36 yelled "Ow Ow, Ow!" LN G was able to reposition the resident's left leg to put on his left boot .

On 04/12/22 at 10:45 AM, Administrative Nurse E stated R36 had neuropathy (dysfunction of one or more peripheral nerves, typically causing numbness or weakness) and often hollered out and they tried to be extra careful when moving him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175272	A. BUILDING _____ B. WING _____	04/13/2022

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F 697	Continued From page 14 On 04/12/22 at 11:00 AM, CMA R stated R36 received his tramadol, muscle spasm, and anxiety medications. CMA R stated she was behind on her medication administration and R36 should have received his pain medication two hours earlier. She stated she should have administered the resident's pain medication that she had prepared, and it was not standard practice to allow another staff member to administer the medications. On 04/12/22 at 02:54 PM, Administrative Nurse D stated R36 should have received his medications on time and CMA R should have administered the medications she had prepared. The facility's "Pain Assessment and Management" policy, dated May 2021, documented staff identify and develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain. The staff review the medication administration record to determine how often the resident received pain medication, and to what extent the administered medications relieve the resident's pain. The staff review the resident's treatment record or recent nurse's notes to identify any situations or interventions when an increase in the resident's pain may be anticipated, for example treatments such as wound care or dressing changes, turning and repositioning. The facility failed to administer pain medication in a timely to R36, who had pain during repositioning and wound care. This placed the resident at risk for further pain and discomfort.	F 697		

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F 726	Continued From page 15	F 726		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure staff possessed the	F 726		

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F 726	Continued From page 16	F 726		

appropriate competencies to safely administer medications per the standards of practice when a licensed nurse administered Resident (R)36 medications without verifying the medication, route, and/or dosage. This placed the resident at risk for medication errors.

Findings Included:

- On 04/12/22 at 10:20 AM, observation revealed Administrative Nurse E asked Certified Nurse Aide (CNA) O to tell Certified Medication Aide (CMA) R that R36 requested pain medication and his water pitcher. CMA R brought in a water pitcher, pills in a small plastic cup, and a Lidoderm patch. CMA R told Administrative Nurse E where to place the patch and left the room. Administrative Nurse E asked the resident his level of pain and started to administer the medication to R36. Administrative Nurse E stated she did not know what the medications in the cup were except that they were the resident's "morning medications." Administrative Nurse E administered the medications to R36.

On 04/12/22 at 11:00 AM, CMA R stated R36 received his tramadol, muscle spasm, and anxiety medications. CMA R stated she was behind on her medication administration and R36 should have received his pain medication two hours earlier. She stated she should have administered the resident's pain medication that she had prepared, and it was not standard practice to allow another staff member to administer the medications she had prepared.

On 04/12/22 at 02:54 PM, Administrative Nurse D stated R36 should have received his medications on time and CMA R should have administered the

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medications she had prepared. Administrative Nurse D stated Administrative Nurse E and CMA R had taken the medication administration competency test in December of 2021 and would take it again in July of 2022.

On 04/13/22 at 11:15 AM, Administrative Nurse E stated she knew that she should not have administered the medications to R36 since she had not prepared the medications.

On 04/13/22 at 01:00 PM, CMA S stated it was not standard practice to prepare medications and then another staff member administer the medications.

On 04/13/22 at 01:05 PM, CMA T stated if she prepared the medication, she would administer the medication.

On 04/13/22 at 01:15 PM, LN H stated staff are not to administer medications someone else prepared.

The facility's "Administering Medications" policy, dated May 2021, documented the individual administering the medication must check the label three times to assure the right medication, right dosage, right time, and right route of administration before giving the medication.

The facility failed to ensure staff possessed the appropriate competencies to safely administer medications per the standards of practice when a licensed nurse administered R36 medications without verifying the medication, route, and/or dosage. This placed the resident at risk for medication errors.