STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255164	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY NURSING HOME	910 MAIN STREET FAYETTE, MS 39069

(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 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 5/28/19 through 5/30/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid requirements for participation. The SA cited F656, F657, F686, and F693. The facility census was 46, and the facility was licensed for 60 beds at the time of survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		7/10/19

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

Electronically Signed | 06/28/2019

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

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement the comprehensive care plan for two (2) of 16 care plans reviewed. For Resident #9's pressure ulcer and Resident #37's Percutaneous Endoscopic Gastrostomy (PEG) tube site care. Findings include: A review of the facility's policy titled, "Comprehensive Care Plans", with a revision date of 02/2017, revealed qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Resident #9 Review of Resident #9's Comprehensive Care Plan revealed the following: Problem/Need, dated	F 656	1. Resident #9 had an Occupational Therapy evaluation completed on 6/5/19. The physician order was written on 6/5/2019 for Occupational Therapy to evaluate and treat as indicated along with clarification orders for Resident #9 to receive skilled Occupational Therapy intervention three times a week times two weeks for therapeutic activities, orthotic management, positioning and patient/caregiver education. The Resident's Representative was notified by the Registered Charge Nurse on 6/5/2019. The positioning equipment has been ordered for his Geri chair to ensure comfort and to help prevent pressure. Licensed Practical Nurse (LPN)#1 was re-educated by the Quality Assurance Nurse on 5/30/2019 on the policy and procedure of cleaning Percutaneous Endoscopic Gastrostomy tube(PEG).	

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F 656	Continued From page 2 09/13/14, for potential for Pressure Ulcer related to (R/T) immobility and incontinence of bowel and bladder, Hemiplegia following unspecified Cerebrovascular Disease affecting left nondominant side. Goal & Target Date: skin will remain intact with no red or broken areas, and will be kept clean and dry during next review. Interventions included: Turn and position resident every two hours as indicated by individual turning schedule posted in resident's room. Skin sweep every shift by CNA (Certified Nursing Assistant) staff and Weekly skin assessment by nursing staff. Problem/Need, dated, 04/29/19, for a Stage 2 decubitus to the left knee. Goal & Target Date: To show signs of healing by next review on 07/30/19. Interventions included: Cleanse Stage 2 decubitus to left knee with NS (Normal Saline), pat dry, apply hydrogen and powder collagen, non-stick Telfa, and secure with kerlix daily until healed. Problem/Need for use of geri chair for socialization and mobility, dated 07/01/15, revealed the Goal & Target Date stated: All safety measures will be maintained with use of geri chair by next review on 06/30/19. Interventions included: Staff will make sure all safety measures will be maintained. Staff will reposition resident every two hours and as needed. Pressure relief every two hours. A review of Residents #9's facility form titled, "Assessment of Pressure Sore Potential", dated 03/22/19, revealed a total score of 11, which indicated the facility should follow pressure sore protocol. An observation, on 05/28/19 at 3:14 PM, revealed Resident #9 was in a geri chair with a sheep skin covering the left arm rest. Resident #9's left leg was bent at the knee, and rested	F 656	2. The Interdisciplinary Team reviewed the care plan from 5/30/2019 through 6/4/2019 of residents that are at high risk for skin breakdown to ensure that the care plan addressed positioning interventions and that the positioning interventions were followed by the staff. All residents have the potential to be affected by this practice. The Registered Nurses assessed all residents for the potential for skin breakdown due to positioning from 6/4/2019 through 6/6/2019. Residents will be assessed upon admission, quarterly, annually and upon any significant change for the potential of skin breakdown due to positioning. Eleven facility residents with Percutaneous Endoscopic Gastrostomy tubes (PEG/GT) have the potential to be affected by this practice. Licensed Practical Nurse (LPN) #1 was re-educated by the Quality Assurance Nurse on 5/30/2019 on the policy and procedure of cleaning Percutaneous Endoscopic Gastrostomy tube(PEG/GT). Licensed Practical Nurse (LPN) #1 will be monitored weekly times four weeks beginning the week of 6/3/2019 and ending the week of 6/24/2019. Registered Nurses and Licensed Practical Nurses were re-educated beginning 6/5/2019 to be completed by 7/10/2019 on the policy and procedure of cleaning Percutaneous Endoscopic Gastrostomy tube (PEG/GT). Newly hired Registered Nurses and Licensed Practical Nurses will be educated upon hire and every six months by the Staff Development Nurse on the policy and procedure of cleaning Percutaneous Endoscopic Gastrostomy	

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F 656	Continued From page 3 against the arm rest. An observation, on 05/29/19 at 11:15 AM, revealed Resident #9 was in a geri chair. Resident #9 had his left leg bent at the knee, and was laying on the arm rest with a sheep skin over the arm rest. On 05/29/19 at 2:13 PM, an observation revealed Resident #9's wound care was performed by Licensed Practical Nurse (LPN) #1/Treatment Nurse. LPN #1 measured the wound bed at 0.6 centimeters by 0.6 centimeters. Resident #9's wound bed was pink with dark scars surrounding the wound located on the side of the left knee. The wound had no foul odors or discharge. An interview at this time with LPN #1 revealed she said Resident #9's wound on his left knee was found over a weekend, and treatment was started on 04/28/19. LPN #1 said she completed the weekly skin checks, and did not remember the wound on the resident the week before it was found on 04/28/19. LPN #1 said the left knee had several scars from previous wounds. LPN #1 said the sheep skin was not being used prior to the wound treatment that started on 04/28/19. LPN #1 confirmed Resident #9 had not been out to the hospital and said the pressure ulcer was acquired in the facility. An interview, on 05/29/19 at 11:36 AM, with Certified Nursing Assistant (CNA) #1 revealed she said she was Resident #9's CNA, and the resident needed assist to move his left side. She said the resident could move his right leg independently. An interview, on 05/30/19 at 10:21 AM, with LPN #2/Minimum Data Set Nurse, revealed she said	F 656	tube (PEG/GT). 3. Facility nurses and nursing assistants were re-educated by the Staff Development Nurse on 6/25/2019 on the importance of ensuring that residents that are at a high risk for skin breakdown have proper positioning interventions. Facility nurses were re-educated on the policy and procedure for cleaning Percutaneous Endoscopic Gastrostomy tubes (PEG) by the Staff Development Nurse on 5/30/2019. 4. The Quality Assurance Nurse will conduct observation rounds beginning the week of 6/3/2019 to ensure that residents that are at a high risk for skin breakdown have positioning interventions and that they are in place as indicated in the care plan weekly times four weeks then monthly. Staff Development Nurse will observe nurses providing Percutaneous Endoscopic Gastrostomy site care weekly times four weeks beginning the week of 6/3/2019 then monthly to ensure nurses are following the policy and procedure for cleaning. Findings of the rounds will be submitted to the facility Quality Assurance Performance Improvement Committee monthly by the Quality Assurance Nurse for further review and recommendations to ensure substantial compliance is maintained. Changes to the plan will be made as deemed necessary by the Quality Assurance Performance Improvement Committee.	

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F 656	Continued From page 4 she would expect staff to follow the care plan and carry out the interventions listed on the comprehensive care plan. An interview, on 05/30/19 11:18 AM, with the Director of Nursing (DON), revealed she said Resident #9 did have interventions for propping his left leg up with a pillow, but the resident would remove it. The DON said Resident #9 received a new chair about a year ago because the previous one was too short. The DON confirmed that she believed the pressure ulcer on Resident #9 was preventable, and was caused by the left leg leaning on the arm rest. The DON said she thought the sheep skin on the geri chair armrest would keep his skin from breaking down again. A review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date of 03/25/19, revealed Section M - Skin Conditions listed M0150 "is resident at risk of developing pressure ulcers/injuries" was marked Yes. Section M0210 "Resident has 1+ unhealed pressure ulcers/injuries" marked as No. Further review of the MDS revealed Resident #9 had a Basic Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Resident #9 was also coded for upper and lower extremity Range of Motion (ROM) impairment on one side. Resident #9 required extensive assistance with two person physical assist for bed mobility, and was totally dependent on two persons for transfers. Resident #9 was totally dependent on one person assist with locomotion on and off the unit Review of the Face Sheet revealed Resident #9 was admitted by the facility, on 05/29/08, and readmitted on 06/23/19, with the included	F 656		

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F 656	Continued From page 5 diagnoses: Hemiplegia following unspecified Cerebrovascular Disease affecting the left nondominant side, Pressure Ulcer of other site, Stage 2, Gastrostomy Status, Vascular Dementia with behavior disturbance, and contracture of right hip. Resident #37 Review of the Comprehensive Care Plan revealed the Problem/Focus, dated 08/19/18, for a need for use of a Percutaneous Endoscopic Gastrostomy (PEG) tube related to disease process, NPO (Nothing by Mouth). Goal & Target Date revealed resident will remain free of complications related to use of the PEG tube as evidenced by no sign and symptoms (s/s) of aspiration, nausea, vomiting, diarrhea, and no abdominal distention through next review on 08/28/19. Interventions included: Provide skin care to insertion site. Absence or presence of drainage and or presence of distention and or s/s of infection to PEG tube. On 05/29/19 at 11:07 AM, an observation revealed, Resident #37 lying in bed with the head of bed (HOB) up at least 45 degrees. Resident #37 had a tube feeding of Jevity 1.5 at 45 cubic centimeter per hour (CC/HR) per a feeding pump. An observation of the gastric tube feeding site care revealed, Licensed Practical Nurse (LPN) #1 applied clean gloves and removed the resident's soiled dressing. She removed her gloves, applied clean gloves, moistened the 4x4 gauze with normal saline (NS), then wiped around the resident's tube feeding site underneath the tube in a half circular motion from right to left and backwards in a half circular motion from left to right. She then wiped around the tube feeding	F 656		

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F 656	Continued From page 6 site over the top of the resident's tube in a half circular motion from right to left and backwards from left to right and disposed of the 4x4 gauze. LPN #1 went out into the hallway to get another pair of gloves, returned to the resident's room, washed her hands, applied clean gloves, and placed a clean dressing to the resident's gastric tube site. On 05/30/19 at 10:34 AM, an interview with LPN #1, revealed she should not have wiped the tube feeding site backwards while she was cleaning the site, and she should have wiped once and then throw the gauze away. Record review of the May 2019 Physician Orders revealed an order, dated 03/14/19, for Jevity 1.5 at 45 milliliters per hour (ML/HR), and clean PEG site with NS, pat dry, and cover with 4x4 daily. On 5/30/19 at 10:52 AM, an interview with the Minimum Data Set (MDS) Nurse/LPN #2, revealed the staff should implement the interventions from the care plan. Review of the most recent Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/6/19, revealed Resident #37 was coded for tube feeding in the section K. Swallowing/Nutritional Status. Resident #9's BIMS score was 9, which indicated moderate cognitive impairment. Review of the Significant Change MDS, with an ARD of 08/26/18, revealed Resident #37 was coded to include tube feeding. Review of the Face Sheet revealed Resident #37 was admitted by the facility, on 10/27/12, and	F 656		

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F 656	Continued From page 7 readmitted on 03/06/15, with the included diagnoses: Hemiplegia following unspecified Cerebrovascular Disease affecting left nonodominant side, Malignant Neoplasm of unspecified site of unspecified female breast, Gastrostomy Status, Major Depression, and Vascular Dementia without behavior disturbance.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		7/10/19

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F 657	Continued From page 8 by: Based on staff interview, record review, and facility policy review, the facility failed to revise the Comprehensive Care Plan related to medication changes for one (1) of 16 care plan reviewed, Resident #23. Findings include: A review of the facility's policy titled, "Comprehensive Care Plans", with a revision date of 02/2017, revealed the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) assessment. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. A review of Resident #23's Comprehensive Care Plan revealed the Problem/Need for potential bleeding/bruising related to the use of blood thinner, dated 12/06/17. The Goal & Target Date revealed the resident would have no bleeding/bruising during next review period on 08/30/19. Interventions included: Warfarin Sodium (blood thinner) 5 milligrams (mg) by mouth (po) daily at 5 PM. A review of Resident #23's Physician's Orders revealed an order, dated 02/07/19, for Eliquis (blood thinner) 2.5 mg po BID (twice a day)resident had an order for Elequis on 2/7/19. An interview, on 05/30/19 at 10:21 AM, with	F 657	1. The care plan of Resident #23 was reviewed and updated to reflect the current physician order for Eliquis 2.5 milligrams by mouth twice daily on 5/30/2019 by the Minimum Data Set (MDS) Nurse. The entire care plan of Resident #23 was reviewed by the Minimum Data Set Nurses on 5/30/2019 for revisions and updates. The Minimum Data Set Nurses were re-educated by the Director of Nursing on 5/30/2019 on ensuring care plan revisions are made to reflect the current physician orders. 2. All facility residents have the potential to be affected by this practice. The facility residents care plans were reviewed by the Interdisciplinary Team from 5/30/2019 through 6/4/2019 to ensure that medications were care planned. Residents care plans will be reviewed upon admission, quarterly, annually and significant change of condition for medication updates. 3. The Interdisciplinary Team was re-educated by the Director of Nursing 5/30/2019 on the importance of updating care plans to reflect physician orders. The Interdisciplinary Team will be re-educated every six months on the importance of updating care plans to reflect physician orders. New physician orders will be reviewed in the daily clinical meeting by the Interdisciplinary Team and care plans will be updated accordingly.	

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F 657	Continued From page 9 Licensed Practical Nurse (LPN) #2/Minimum Data Set (MDS) Nurse revealed she was notified of changes in the resident's medications by the physician's orders or by verbal notification through the nurses. LPN #2 also confirmed she was responsible for most of the additions and changes on the care plan in the computer. An interview, on 05/30/19 at 10:45 AM, revealed the Director of Nursing (DON) said all updates to the care plan were made in the computer. An interview, on 05/30/19 at 11:53 AM, revealed the DON said Resident #23 had not been on Coumadin since a hospital return, and the MDS nurse should have updated the care plan at the time of the medication change .	F 657	4. The Quality Assurance Nurse will review care plans weekly times four weeks beginning the week of 6/10/2019 then monthly to ensure that care plans have been updated to reflect current physician orders for medications. Findings of the reviews will be submitted to the Quality Assurance Performance Improvement Committee monthly by the Quality Assurance Nurse for changes or recommendations as deemed necessary.	
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 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed	F 686	1. Resident #9 had an Occupational Therapy evaluation completed on 6/05/19.	7/10/19

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F 686	Continued From page 10 to prevent a pressure ulcer for one (1) of one (1) residents reviewed for pressure ulcers, Resident #9. Findings include: Review of a facility's policy titled, "Pressure Injury Prevention Guidelines", dated 04/2017, revealed to avoid positioning the resident directly onto medical devices and utilize pillows and wedges to maintain proper positioning. On 05/29/19 at 2:13 PM, an observation revealed Resident #9's wound care was provided by Licensed Practical Nurse (LPN) #1/Treatment Nurse. LPN #1 measured the wound bed at 0.6 (centimeters) cm length and 0.6 cm width. Resident #9's wound bed was pink with dark scars surrounding the wound located on the side of the left knee. The wound had no foul odors or discharge. A review of Resident #9's Physician Orders, dated 04/28/19, revealed an order to clean the wound on the left leg with Normal Saline or wound cleanser. Pat dry, Apply triple antibiotic ointment daily until healed. Further review of the the Physician's Orders revealed an order, dated 04/29/19, to treat the Stage 2 decubitus to knee with ns (Normal Saline), pat dry, apply Hydrogel and Collagen powder, nonstick tefla, and wrap with kerlix daily. Review of the May 2019 Physician's Orders revealed an order, dated 11/03/14, to use a wedge for positioning of lower extremities. Review of Resident #9's Treatment Record for May 2019, revealed staff documentation for the wound care to the left knee per the Physician's	F 686	The physician order was written on 6/5/2019 for Occupational Therapy to evaluate and treat as indicated along with clarification orders for Resident #9 to receive skilled Occupational Therapy intervention three times a week times two weeks for therapeutic activities, orthotic management, positioning and patient/caregiver education. The Resident's Representative was notified by the Registered Charge Nurse on 6/5/2019. The positioning equipment has been ordered for his Geri chair to ensure comfort and to help prevent pressure. 2. All residents have the potential to be affected by this practice. The Interdisciplinary Team reviewed the care plans of residents that are at high risk for skin breakdown from 5/30/2019 through 6/4/2019 to ensure that the care plan addressed positioning interventions and that the positioning interventions were followed by the staff. The Registered Nurses assessed all residents for the potential for skin breakdown due to positioning from 6/4/2019 through 6/6/2019. Residents will be assessed upon admission, quarterly, annually and upon any significant change for the potential of skin breakdown due to positioning. 3. Facility nurses and nursing assistants were re-educated by the Staff Development Nurse on 6/25/19 on the importance of ensuring that residents that are at a high risk for skin breakdown have proper positioning interventions. Staff	

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	255164	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 11 Orders, and the application of the wedge for positioning the lower extremities from May 1st to May 29th. A review of Resident #9's, "Wound Assessment Report", dated 04/29/19, revealed the wound was identified, on 04/28/19, on the left knee that was not present upon admission, and indicated the wound was a Stage 2 that measured 2.0 centimeters (cm) length, 1.7 cm width and 0.10 cm depth. An observation, on 05/28/19 at 3:14 PM, revealed Resident #9 was in a geri chair with a sheep skin covering the left arm rest. Resident #9's left leg was bent at the knee and rested against the arm rest. An observation, on 05/29/19 at 11:15 AM, revealed Resident #9 was in a geri chair. Resident #9 had his left leg bent at the knee, and was rested on the arm rest with a sheep skin over the arm rest. On 05/30/19 at 11:07 AM, Resident #9 was observed up in a geri-chair with his left leg bent towards, but not resting on the arm rest. Resident #9's left leg was not propped up on anything. A sheep skin covered the arm rest. A review of Residents #9's facility form titled, "Assessment of Pressure Sore Potential", dated 03/22/19, revealed a total score of 11, which indicated the facility should follow pressure sore protocol. A review of Resident #9's, "Activity of Daily Living (ADL) Assistant and Support", revealed Resident #9 was coded 4/2 in bed mobility and locomotion	F 686	nurses and nursing assistants will be re-educated on the importance of ensuring that residents that are at a high risk for skin breakdown have proper positioning interventions every six months. Newly hired staff nurses and nursing assistants will be educated on proper positioning interventions for all residents upon hire and every six months. A weekly risk meeting will be conducted by the Interdisciplinary Team beginning 6/27/2019 to discuss residents that are at high risk for breakdown to ensure that the care plan is updated and revised of any new interventions to assist with preventing pressure. 4. Residents identified as having high risk for skin breakdown due to positioning will be monitored every shift by the staff nurses and documented in the clinical record beginning 7/9/2019. The Quality Assurance Nurse will conduct observation rounds to ensure that residents that are at a high risk for skin breakdown have positioning interventions and that they are in place as indicated in the care plan weekly times four weeks beginning 7/3/2019 then monthly. Results of the rounds will be submitted to the facility Quality Assurance Performance Improvement Committee for further review and recommendations to ensure substantial compliance is maintained by the Quality Assurance Nurse monthly. Changes to the plan will be made as deemed necessary by the Quality Assurance Performance Improvement Committee.	

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F 686	Continued From page 12 on the unit, which indicated he was totally dependent on one person for the Activities of Daily Living (ADLs). A review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date of 03/25/19, revealed Section M - Skin Conditions listed M0150 "is resident at risk of developing pressure ulcers/injuries" was marked Yes. Section M0210 "Resident has 1+ unhealed pressure ulcers/injuries" marked as No. Resident #9's Comprehensive Care Plan revealed Resident #9 had a Stage 2 decubitus to the left knee with an onset date of 04/28/19. The care plan also listed Resident #9 used a geri chair for socialization and mobility with an onset date of 07/1/15. The interventions listed for the geri chair included staff to reposition the resident every two hours, and as needed with pressure release every two hours. An interview, on 05/29/19 at 11:36 AM, with Certified Nursing Assistant (CNA) #1 revealed she said she was Resident #9's CNA, and the resident needed assist to move his left side. She said the resident could move his right leg independently. An interview, on 05/29/19 at 2:13 PM, revealed LPN #1/Treatment Nurse said Resident #9's wound on his left knee was found over a weekend, and treatment was started on 04/28/19. LPN #1 said she completed the weekly skin checks, and did not remember the wound on the resident the week before. LPN #1 said the left knee had several scars from previous wounds. LPN #1 said the sheep skin was not being used prior to the wound treatment that was started on	F 686		

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F 686	Continued From page 13 04/29/19. LPN #1 confirmed Resident #9 had not been out to the hospital, and the pressure ulcer was acquired in the facility. An interview, on 05/29/19 at 3:55 PM, with the Director of Nursing (DON) revealed the nurses on admission do the assessments for needs for mobility, and therapy will screen to see if the resident needs therapy. An interview, on 05/30/19 at 11:14 AM, with the Certified Occupational Therapist Assistant (COTA) revealed she said she had assisted nursing with putting the sheep skin on the geri chair arm rest for Resident #9. The COTA said that nursing staff had to request an evaluation for appropriate chair use, but had not done one for Resident #9. An interview, on 05/30/19 11:18 AM, revealed the DON said Resident #9 did have interventions for propping his left leg up with a pillow, but the resident would remove it. The DON said Resident #9 received a new chair about a year ago because the previous one was too short. The DON confirmed she believed the pressure ulcer on Resident #9 was caused by the left leg leaning on the arm rest. The DON said with the sheep skin on the geri chair armrest she thought that would keep his skin from breaking down again. Review of Resident #9's Comprehensive Care Plan revealed the Problem/Need, dated 07/11/18, for the potential for exhibiting moods/ behaviors such as cursing and refusing care.	F 686		

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F 686	Continued From page 14 A review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date of 03/25/19, revealed Resident #9 had a Basic Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Resident #9 was also coded for upper and lower extremity Range of Motion (ROM) impairment on one side. Resident #9 required extensive assistance with two person physical assist for bed mobility, and was totally dependent on two persons for transfers. Resident #9 was totally dependent on one person assist with locomotion on and off the unit Review of the Face Sheet revealed Resident #9 was admitted by the facility, on 05/29/08, and readmitted on 06/23/19, with the included diagnoses: Hemiplegia following unspecified Cerebrovascular Disease affecting the left nondominant side, Pressure Ulcer of other site, Stage 2, Gastrostomy Status, Vascular Dementia with behavior disturbance, and contracture of right hip.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		7/10/19

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F 693	Continued From page 15 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, facility policy review, the facility failed to provide gastric tube site care in a manner to prevent the possibility of an infection and/or cross contamination for one (1) of three (3) resident reviewed with gastric tubes, Resident #37. Findings include: A review of the facility's policy titled, "Gastrostomy Status", dated 4/2017, revealed maintain a clean technique, and gently clean the area around the tube and continue in an outward circular fashion, ensuring that under the bolster is cleaned. On 5/29/19 at 11:07 AM, an observation revealed, Resident #37 lying in bed with the head of bed (HOB) up at least 45 degrees. Resident #37 had a tube feeding of Jevity 1.5 at 45 cubic centimeter per hour (CC/HR) per a feeding pump. An observation of gastric tube feeding site care revealed, Licensed Practical Nurse (LPN) #1 applied clean gloves and removed the resident's soiled dressing. She removed her gloves, applied clean gloves, moistened the 4x4 gauze with normal saline (NS), then wiped around the resident's tube feeding site underneath the tube	F 693	1. Licensed Practical Nurse (LPN) #1 was re-educated by the Quality Assurance Nurse on 5/30/2019 on the policy and procedure of cleaning Percutaneous Endoscopic Gastrostomy tube (PEG). Resident #37 was assessed for any adverse affects on 5/30/2019 by Licensed Practical Nurse (LPN) #1 and the Staff Development Nurse according to the policy and procedure of cleaning Percutaneous Endoscopic Gastrostomy tube (PEG). Resident #37 will be assessed on a daily basis for any adverse affects by staff nurses beginning 5/30/2019. 2. Eleven residents with Percutaneous Endoscopic Gastrostomy tubes (PEG/GT) have the potential to be affected by this practice. Each resident with Percutaneous Endoscopic Gastrostomy tube will be assessed daily by staff nurses for any adverse affects beginning 5/30/2019. 3. Facility nurses were re-educated on the policy and procedure for cleaning Percutaneous Endoscopic Gastrostomy	

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F 693	Continued From page 16 in a half circular motion from right to left and backwards in a half circular motion from left to right. She then wiped around the tube feeding site over the top of the resident's tube in a half circular motion from right to left and backwards from left to right and disposed of the 4x4 gauze. LPN #1 went out into the hallway to get another pair of gloves, returned to the resident's room, washed her hands, applied clean gloves, and placed a clean dressing to the resident's gastric tube site. On 5/30/19 at 10:34 AM, an interview with LPN #1, revealed she should not have wiped the tube feeding site backwards while cleaning the area. LPN #1 stated she should have wiped once and thrown the gauze away. A record review of the May 2019 Physician Orders revealed an order, dated 03/14/19, for Jevity 1.5 at 45 milliliters per hour (ML/HR), flush with 150 ML of water every 6 hours. Jevity 1.5 at 45 ML/HR, flush with 150 ML of water every 6 hours provides 1620 calories, 69 grams (grms) of protein, 1640 ML of free water, 2500 total fluids. Clean PEG (Percutaneous Endoscopic Gastrostomy) tube site with NS, pat dry, and cover with 4x4 daily. On 5/30/19 at 10:35 AM, an interview with the Director of Nursing, (DON) revealed, wiping in a back and forth motion is cross contamination and she (referring to LPN #1) should have wiped in a circular motion. A review of the facility's Face Sheet revealed, the facility admitted Resident #37 on 10/27/12 with a diagnosis of Hemiplegia following unspecified Cerebrovascular Disease affecting left	F 693	tubes (PEG) by the Staff Development Nurse on 5/30/2019. Staff nurses will be re-educated every six months by the Staff Development Nurse on the policy and procedure for cleaning Percutaneous Endoscopic Gastrostomy tube (PEG). Newly hired nurses will be educated on the policy and procedure for cleaning Percutaneous Endoscopic Gastrostomy tube (PEG) upon hire and every six months by the Staff Development Nurse. 4. The Staff Development Nurse will observe nurses providing Percutaneous Endoscopic Gastrostomy site care weekly times four weeks beginning 5/30/2019 then monthly to ensure that nurses are following the policy and procedure for cleaning. Staff nurses will be re-educated every six months by the Staff Development Nurse on the policy and procedure for cleaning Percutaneous Endoscopic Gastrostomy tube (PEG). Newly hired nurses will be educated upon hire and every six months by the Staff Development Nurse on the policy and procedure for cleaning Percutaneous Endoscopic Gastrostomy tubes (PEG). Findings of the Staff Development Nurse will be submitted to the Quality Assurance Performance Improvement Committee monthly by the Staff Development Nurse for further review and recommendations to ensure substantial compliance is maintained. Changes to the plan will be made as deemed necessary by the Quality Assurance Performance Improvement Committee.	

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F 693	Continued From page 17 non-dominant side. Review of the most recent Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/6/19, revealed Resident #37 was coded for tube feeding in the section K. Swallowing/Nutritional Status. Resident #9's BIMS score was 9, which indicated moderate cognitive impairment. Review of the Significant Change MDS, with an ARD of 08/26/18, revealed Resident #37 was coded to include tube feeding. Review of the Face Sheet revealed Resident #37 was admitted by the facility, on 10/27/12, and readmitted on 03/06/15, with the included diagnoses: Hemiplegia following unspecified Cerebrovascular Disease affecting left nonodominant side, Malignant Neoplasm of unspecified site of unspecified female breast, Gastrostomy Status, Major Depression, and Vascular Dementia without behavior disturbance.	F 693		

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	255164	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 06/26/2019

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

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/28/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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