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Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	C 11/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

(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 For the unannounced complaint survey conducted on November 10-12, 2014, the sample included six sampled residents for complete review. The concerns regarding facility staff failing to provide diabetic and pressure ulcer cares were substantiated.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	1. Residents #2 have had no adverse effects from this practice. 2. All residents with bruising have the potential to be affected by this practice. 3. A binder was made of the policies and procedures dealing with incidents, notifying the appropriate persons, and filling out an incident report. Staff was required to read the binder, sign when completed, take a test, and was tracked in the Learning Center. RN/LPN/CNA 4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 2, then as deemed necessary the QA committee. The Audit will randomly check residents who have visible bruising to make sure an incident was filled change made 01/05/15 @3:55 pm DON per phone call by 24 hours	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Rauda — TITLE: Administrator — (X6) DATE: 12-22-14

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 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to immediately report an injury of unknown origin to the administrator of the facility and to the State survey and certification agency and failed to investigate the origin of the injury for 1 of 1 sampled resident (Resident #2) observed with facial bruising. This failure placed all residents at risk of potential abuse. Findings include: Review of the facility policy titled "Resident . . . Incident Report" occurred on 11/12/14. This policy, revised June 2014, stated, ". . . All incidents . . . occurring within the center or affecting a resident . . . will be documented, investigated, and evaluated to determine contributing factors and to prevent recurrence whenever possible. . . ." - Review of Resident #2's medical record occurred on all days of survey. The significant change Minimum Data Set (MDS), dated 09/10/14, identified moderate cognitive impairment and the need for extensive assistance for transfers and locomotion.	F 225	make sure an incident was filled out and followed up by treatment nurse.	Start Date 12/22/14 1-6-15

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F 225	Continued From page 2 The progress note, dated 07/03/14 at 1:18 a.m., identified, "CNA [certified nursing assistant] reported bruising to left chin. No new incidents reported . . . resident . . . requested to 'let me do my thing and rest now'. call light within reach and bed alarm in place." Staff failed to describe the bruise (i.e.: color, size, etc.) in their documentation. On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed the facility failed to report/investigate Resident #2's injury of unknown origin (facial bruising). She stated, "Contract staff did not fill out [an] incident report." Failure to immediately report Resident #2's injury of unknown origin (facial bruising) to the Administrator of the facility and to the State survey and certification agency limited the facility's ability to ensure her safety and placed all residents at risk of potential abuse.	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: FAILURE TO FOLLOW PHYSICIAN'S ORDERS 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 5 sampled residents (Resident #3 and #4) with diagnoses of pressure ulcers and/or diabetes. Failure to ensure staff follow physician orders has	F 281	**Physician orders** See also F314 and F309 1. Resident # 3 has a dressing per primary physician order and the staff is following. Resident #4's wound is healed and wears slippers during the day and protective boots at night. Refer to F309- Insulin Administration for glucose readings.	

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F 281	Continued From page 3 the potential to cause residents to experience adverse consequences, such as delayed healing of a pressure ulcer (Resident #3 and #4) and/or hyperglycemia (high blood glucose) (Resident #3). Findings include: Taylor, Lillis, and LeMone, Fundamentals of Nursing, The Art & Science of Nursing Care, 4th ed., Lippincott, Philadelphia-New York-Baltimore, 2001, pg 109, stated, "Nurses are legally responsible for carrying out the orders of the physician in charge of a patient unless an order would lead a reasonable person to anticipate injury if it were carried out." Review of the facility policy titled "Pressure Ulcer Practice Guidelines" occurred on 11/12/14. This policy, revised June 2014, stated ". . . Residents at risk for pressure ulcer development and those with pressure ulcers/wounds should be monitored daily for changes in their skin condition. . . . Abnormal findings/changes should be reported to the resident's primary care provider . . ." Review of the facility policy titled "Blood Glucose Monitoring" occurred on 11/12/14. This policy, dated November 2013, stated ". . . The physician's orders should include blood glucose high and low parameters and when to notify the resident's physician. . . . Notify physician if necessary per parameters. . . ." - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 09/15/14, identified moderately impaired cognition, at risk for pressure ulcers, and current diabetic foot	F 281	2. All residents at high risk for skin breakdown as evidenced by a Braden score of 17 or higher have the potential to be effected by this practice. 3. Refer to F314 and F309-Insulin Administration 4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 2, then as deemed necessary the QA committee. Refer to F309 audit for the blood sugar. The Audit will be randomly checking residents with current skin treatments and or dressings to ensure the current treatment matches the physician's orders.	start date 12/22/14 1-6-15

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F 281	Continued From page 4 ulcer. The progress notes identified the following: * 08/18/14, "The resident's daughter visited this evening and observed the resident's toe and alerted this writer, the left great toe is reddened as well as the next toe, and there is redness below the toe. There is scant drainage from the open area on the toe, but it is foul-smelling. . . . She requested that the transparent dressing be removed and a saline wet-to-dry dressing be applied and this was done as per her wishes. . . ." The nurse failed to notify the physician of Resident #3's daughter's request for a different type of dressing and failed to obtain orders prior to making changes to her treatment plan. * 11/03/14, ". . . The resident's daughter brought in some dark-colored stuff that she applied to the resident's L [left] great toe, she stated that she had spoken with [Physician] and he thought it was okay to try it. Dressing changed on coccyx, area looks less reddened. . . ." The nurse failed to identify the substance Resident #3's daughter applied to her wound, and failed to ensure her physician had approved the use of the substance. The current physician's order, dated 10/13/14, identified, "Blood glucose parameters - Over 400 or below 50 notify MD [Medical Doctor]." Review of the blood glucose summaries, dated May 29-November 12, 2014, identified a blood glucose reading of 428 on 11/07/14. On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed the staff failed to notify Resident #3's physician of her high blood glucose reading. - Review of Resident #4's medical record	F 281		

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F 281	Continued From page 5	F 281		

occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 08/16/14, identified severely impaired cognition and at risk for pressure ulcers.

Observation on 11/11/14 at 11:00 a.m. showed two nurses (#2 and #3) treating Resident #4's right toe ulcers. After they finished with her right foot, one of the nurses (#2) stated, "Since [Resident #4] has been having issues with the other foot as well, we'll go ahead and look [at it]." She (#2) assessed wounds on the first toe, the lateral portion of the second toe, and between Resident #4's fourth and fifth toe of her left foot. The nurse (#2) removed her gloves, washed her hands, and applied new gloves, prior to treating the three ulcers. She (#2) told Resident #4 they were going to dress her ulcers with Mepilex and paper tape. She (#2) also stated, "We'll have talk to [the Nurse Practioner] to fix the order." The two nurses (#2 and #3) failed to notify Resident #4's physician and obtain an order prior to treating/dressing the three new ulcers on her left foot.

On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed facility staff should obtain physician's orders prior to providing any treatments.

The facility staff failed to:
* notify the physician of Resident #3's daughter's request for a different type of dressing and failed to obtain orders prior to making changes to her treatment plan.
* identify the substance Resident #3's daughter applied to her wound, and failed to ensure her physician had approved the use of the substance.
* notify Resident #3's physician of her high blood

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F 281	Continued From page 6 glucose reading as per established parameters. * notify Resident #4's physician and obtain an order prior to treating/dressing the three new ulcers on her left foot. NEURO-CHECKS 2. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide care in accordance with professional standards for 3 of 3 sampled residents (Resident #1, #2, and #5) who experienced a fall with head injury. Failure to complete neurological assessments following such a fall has the potential for a head injury to go undetected. Findings include: Review of the facility policy titled "Neurological Evaluation" occurred on 11/12/14. This policy, revised June 2014, stated ". . . After the completion of initial neurological evaluation with vital signs, continue with evaluation every 30 minutes x [times] 4, then every shift x 3 days . . ." - Review of Resident #1's medical record occurred on all days of survey. An incident report, dated 07/30/14 at 7:30 p.m., identified Resident #1 was found on the floor. The resident reported hitting the right side of her head on the floor. Review of Resident #1's Neurological Checks Event Record identified neuro-checks completed on 07/31/14 at 10:30 a.m. and 11:00 p.m., on 08/01/14 at 7:00 a.m., 3:00 p.m., and 11:00 p.m., on 08/02/14 at 2:25 p.m., and on 08/03/14 at 3:47 a.m. Neuro-checks were not intiated until the next day.	F 281	**Neuro-Checks** 1. Residents #1, #2, and #5 have had no residual permanent adverse effects from this practice. 2. All residents that fall and hit their head have the potential to be effected by this practice. 3. **System Change:** A Neuro-Check list to ensure Neuro-checks are completed according to the form instruction and procedure when a resident falls and hits their head. A binder was made of the policies and procedures on including Neuro-Checks and the new Neuro-Check list.. Staff was required to read the binder, sign when completed, take a test, and was tracked in the Learning Center. RN/LPN/CNA 4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 2, then as deemed necessary the QA committee. The Audit will be checking incidents for	

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F 281	Continued From page 7 - Review of Resident #2's medical record occurred on all days of survey. A progress note, dated 09/06/14 at 9:28 a.m., identified Resident #2 was found on the floor with bruising/swelling to her forehead and eyes. Review of Resident #2's Neurological Checks Event Record identified neuro-checks completed on 09/06/14 at 9:28 a.m., 10:00 a.m., 10:30 a.m., 11:30 a.m., and 8:00 p.m., on 09/07/14 at 3:39 a.m., 8:00 a.m., and 8:28 p.m., on 09/08/14 at 10:20 a.m. and 8:37 p.m., on 09/09/14 at 6:56 p.m., and on 09/10/14 at 6:34 a.m. A progress note, dated 10/31/14, identified Resident #2 had fallen and hit her head on the floor, obtaining a 2 centimeter (cm) laceration to her forehead and a 1 cm laceration to her left cheek. Review of Resident #2's Neurological Checks Event Record identified neuro-checks completed on 10/31/14 at 12:46 p.m., 4:00 p.m., and 9:00 p.m., on 11/01/14 at 2:24 a.m., 1:54 p.m., and 8:12 p.m., on 11/02/14 at 5:47 a.m., 12:30 p.m., and 10:01 p.m. - Review of Resident #5's medical record occurred on all days of survey. An incident report, dated 10/05/14 at 12:54 a.m., identified Resident #5 was found on the floor with redness to the left side of her head and bruising to her eye lid. Review of Resident #5's Neurological Checks Event Record identified neuro-checks completed on 10/05/14 at 12:10 a.m., 11:57 a.m., and 8:57 p.m., on 10/06/14 at 2:20 a.m., 12:45 p.m., and 10:14 p.m., and on 10/07/14 at 4:04 a.m.	F 281	4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 2, then as deemed necessary the QA committee. The Audit will be checking incidents for any falls with hitting of their head occurred and if the Neuro-checks are completed per policy.	start date 12/22/14 1-6-15

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F 281	Continued From page 8 On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed the staff failed to perform neuro-checks for Resident #1, #2, and #5 per facility policy.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on information provided by the complainant, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #3) diagnosed with diabetes. Failure to ensure Resident #3 ate in a timely manner following insulin administration, and failure to establish high and low blood glucose parameters placed Resident #3 at risk of serious adverse events. Findings include: Information provided to the State agency indicated facility staff failed to assess Resident #3's blood glucose in a timely manner.	F 309	Insulin Administration 1. Resident #3 diabetic parameters have been updated as of 10/9/14 and are being followed. 2. All diabetic residents have the positional to be effected by this practice. 3. **System change:** Per our medical director we will have new parameters done with Insulin (specific amount per resident deemed by the primary physician) being given with blood sugars above 400 and recheck after 2 hours then if still above 400 to notify physician and to notify when blood sugar is below a set number (unless otherwise specified by the Physician orders). Parameters were set in PCC to alert staff to a high or low.	

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F 309	Continued From page 9 Review of the facility policy titled "Blood Glucose Monitoring" occurred on 11/12/14. This policy, dated November 2013, stated ". . . The physician's orders should include blood glucose high and low parameters and when to notify the resident's physician. . . ." Review of Resident #3's medical record occurred on all days of survey. The resident was admitted to the facility in May 2014 with a diagnosis of diabetes. The quarterly Minimum Data Set (MDS), dated 09/15/14, identified moderately impaired cognition, independence-to-limited assistance required for Activities of Daily Living (ADLs). The current physician's order, dated 06/05/14, identified, "8 Units Novolog Mix 70/30 100 units/milliliters (ml)" every a.m. and "Accu check BID [twice daily]." The medication administration record identified accu checks were to be completed at 5:00 a.m. and 4:30 p.m. and insulin to be administered before breakfast. The pharmacy review progress note, dated 06/20/14, identified, "Add blood glucose parameters to Accuchek to specify when to contact doctor regarding highs and lows. . ." Review of the blood sugar summaries, dated May 29-October 13, 2014, identified blood glucose readings ranging from 66 to 496 milligrams per deciliter(mg/dL). The facility failed to establish individualized parameters, and notify the physician when Resident #3 experienced high and low blood glucose levels, placing her at risk of complications.	F 309	A binder was made of the procedure on Blood Glucose monitoring and side note with our parameters per physician and to inform physician when blood glucose is outside of these parameters. Staff was required to read the binder, sign when completed, take a test, and was tracked in the Learning Center. RN/LPN/CNA Nursing staff educated reminded per binder that residents mush eat or drink within 5-15 minutes after receiving the insulin injection to avoid hypoglycemic reaction. 4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 2, then as deemed necessary the QA committee. The Audit will monitor PCC for High and low blood sugars and if the insulin was given or doctor called and if the recheck of the blood sugar was done per physician order.	start date 12/22/14 1/6/15

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The current physician's order, dated 10/13/14, identified, "Blood glucose parameters - Over 400 or below 50 notify MD." The facility failed to obtain an order for individualized blood glucose parameters for Resident #3 until 6 months after she was admitted to the facility.

A handwritten note by an unidentified nurse, dated 10/17/14, stated, "On Oct. [October] 14 a.m., I gave a.m. insulin to [Resident #3]. I did not realize it was her bath day. I ordered a room tray for her. After giving a.m. meds [medications] in dining room [Resident #3] appeared to be very unfocused. Daughter was giving juice. . . ." The note failed to identify the time the nurse administered the insulin and failed to identify when Resident #3 ate breakfast.

"Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Philadelphia, pages 735-738, identified, ". . . Give NovoLog Mix 70/30 up to 15 minutes before start of meal. . . ."

The blood sugar summary, dated 10/14/14, identified accu checks were completed at 5:29 a.m. and 5:13 p.m.

The progress note, dated 10/14/14, identified, ". . . Insulin dependent diabetic, accuchecks and insulin as ordered. . . ." The record failed to reflect Resident #3 was showing signs/symptoms of hypoglycemia and failed to show the nurse rechecked Resident #3's blood glucose level after identifying she was symptomatic.

On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed Resident #3's medical record lacked high and low blood glucose parameters (prior to 10/13/14) and failed to identify when staff

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F 309	Continued From page 11 were to notify the physician of abnormal blood glucose readings. She also confirmed the unidentified nurse failed to ensure Resident #3 ate in a timely manner following insulin administration. The facility failed to: * establish individualized parameters, and notify the physician when Resident #3 experienced high and low blood glucose levels, placing her at risk of complications. * obtain an order for individualized blood glucose parameters for Resident #3 until 6 months after she was admitted to the facility. * ensure Resident #3 ate in a timely manner following insulin administration. * document Resident #3's signs/symptoms of hypoglycemia on 10/14/14. * rechecked Resident #3's blood glucose level after identifying she was symptomatic. DIABETIC ULCERS 2. Based on information provided by the complainant, observation, record review, and staff interviews, the facility failed to provide the necessary treatment and services to prevent the occurrence and promote the healing of diabetic ulcers for 1 of 1 sampled resident (Resident #3) identified with diabetic ulcers. Failure to provide timely and appropriate assessment/continued monitoring resulted in the delayed treatment of Resident #3's diabetic ulcer. Findings include: Information provided by the complainant indicated facility staff failed to assess Resident #3's skin and were unaware of the development of a	F 309	**Diabetic Ulcers** **Refer to F314** 1. Resident #3 left toe had been removed on 12/17/14 per primary physician's order. Care Plan updated to include this fact in the problem statement. 2. All residents with diabetes have the potential to be affected by this practice. 3. Refer to F314 - included diabetic ulcers.	

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F 309	Continued From page 12 diabetic ulcer to her left toe. - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 09/15/14, identified moderately impaired cognition, limited assistance required for toileting and transfers, current diabetic foot ulcer, surgical wound, nutritional interventions, surgical wound care, and dressings. The current care plan further identified: * Diabetes/Diabetic Ulcers: ". . . Check all of body for breaks in skin and treat promptly as ordered by health care provider. . . . Monitor progress in wound healing on an ongoing basis. Notify health care provider as indicated. . . . Monitor/report to health care provider PRN [as needed] changes in wound color, temp [temperature] sensation, pain, or presence of drainage and color. . . . Ensure appropriate protective devices as NWB [no weight bearing] to left foot. Elevate left foot on pillow when in bed. . . ." The progress notes identified the following: * 08/12/14, "Resident's daughter reported that resident has an area on her left great toe, the area was observed and is 1.0 x [times] 1.3 cm [centimeters] yellowish-reddish area with callus surrounding it. Her daughter called [Clinic] and made an appointment for 1:00 p.m. tomorrow." Facility staff failed to identify Resident #3's left toe ulcer until after the resident's family member brought it to their attention. * 08/13/14, "Call from [Clinic] that resident will be admitted to [Hospital] for diabetic foot ulcer and possible debridement." * 08/16/14, "Resident returned from [Hospital] . . . The resident . . . was started on Cipro [antibiotic]	F 309	4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 2, then as deemed necessary the QA committee. The Audit will be checking PCC to ensure completion of the wound assessment UDA's being done at least every 7 days and review of CNA's documentation of the skin daily with routine cares and bathing.	start date 12/22/14 1-6-15

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oral as ordered for infected lesion on left great toe. There was scant drainage on the dressing removed, it was yellowish. . . ."
* 08/18/14, "The resident's daughter visited this evening and observed the resident's toe and alerted this writer, the left great toe is reddened as well as the next toe, and there is redness below the toe. There is scant drainage from the open area on the toe, but it is foul-smelling. The daughter states she will make an appointment for tomorrow for the resident to be seen at the clinic. . . . The area is indeed much more reddened from yesterday, when it was very minimal. . . ."
* 08/19/14, ". . . Lt [Left] Great toe and 2nd toe are Red and warm to touch . . . [Physician's Assistant (PA)] d/c'd [discontinued] Cipro and ordered Cephalexin [another antibiotic] 500 mg [milligrams] po [orally] TId [three times daily] until culture returns. . . . Cleansed and tegaderm clear drsg [dressing] applied as ordered.with kerlix around toe. Wound bed yellow area around wound white and macerated. Took heavy quilt off of foot. L [Left] ft [foot] elevated on pillow. . . ."
* 08/21/14, "Resident was seen by [Physician's Assistant] on rounds for left great toe. New orders: send to clinic . . . Lt great toe had been debrided 1.5 x 1.5. Dressing is duodurm or safetac applied daily or as often as needed depending on drainage. No weightbearing Elevate in bed Continue keflex as ordered. Return to clinic . . ."
* 09/02/14, ". . . Receiving treament [sic] to left great toe per MD order. On oral a/b [antibiotic] for infected toe. No other skin issues at this time, but skin is monitored closely. . . ."
* 10/13/14, ". . . Receving [sic] daily dressing changes to diabetic ulcer to toe on left foot. Area is scabbed over at this time. . . . No other skin issues. . . ."

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F 309	Continued From page 14 * 10/21/14, ". . . Dressing changed to Lt great toe. Noted changes to site. Site proceeds proximally another 1 cm. Area is yellow with some drainage. . . . new orders . . . Bactrim [antibiotic] . . ." * 10/23/14, "Culture form toe ulcer returned from lab. oxicillin (methicillin) resistant staphylococcus aureus (MRSA). Sent to [Nurse Practioner (NP)] for confirmation of MRSA. . . ." The wound data collection form stated, ". . . Measurements - Required at least once every 7 days. . . ." Resident #3's left toe ulcer/wound data collection forms were completed as follows: 09/11/14, 09/12/14, 09/13/14, 09/24/14 (11 days), 10/18/14 (24 days), 10/30/14 (12 days). * 10/30/14, ". . . unstageable, dark area on posterior aspect/base of the left great toe" which measured "2 cm in length and 1.5 cm in width, with drainage . . ." The facility failed to provide this surveyor any wound data collection forms for the month of November. Facility staff failed to measure Resident #3's left toe ulcer with every dressing change or every seven days per policy. Observation on 11/11/14 at 11:15 a.m. showed two nurses (#2 and #3) providing Resident #3's ulcer treatments following her bath (with the CNA #6). One of the nurses (#2) described the wound on Resident #4's left foot as a "2.3 cm x 1.3 cm black [area] with a red/purple [area] around [it]," as the other nurse (#3) wrote the measurements on her inner arm. The first nurse (#2) removed her gloves, washed her hands, and regloved. The nurses (#2 and #3) treated Resident #3's left toe ulcer, removed their gloves, washed their hands, and applied new gloves. Following this observation, the second nurse (#3) approached	F 309		

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F 309	Continued From page 15 this surveyor and asked "What was 2.3 cm x 1.3 cm?" The second nurse (#3) failed to accurately document the measurements of Resident #3's left toe ulcer. On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed staff are to measure wounds on a weekly basis. The facility staff failed to: * identify Resident #3's left toe ulcer prior to the resident's family member bringing it to their attention and the ulcer requiring debridement. * measure Resident #3's left toe ulcer with every dressing change or every seven days per policy. * accurately document the measurements of Resident #3's left toe ulcer.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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: Based on information provided by the complainant, observation, record review, review of facility policy, and staff interviews, the facility failed to provide the necessary treatment and services to prevent the occurrence and promote	F 314	1. Residents #4 pressure areas are healed as of 12/13/14. She continues to wear slippers during the day and boots at night. Resident #1 coccyx is healed as of 11/17/14. Her area to her vertebrae is improving as the measurements are smaller in size. A protective dressing is applied to the area per physicians order. Resident #3 coccyx is improving by decrease of size and only a scant amount of drainage. Dressing is applied per physicians order. Care Plans reviewed and updated as needed.	

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F 314	Continued From page 16 the healing of pressure ulcers for 3 of 3 sampled residents (Resident #1, #3, and #4) identified with pressure ulcers. Failure to provide timely and appropriate interventions and ensure staff consistently implemented existing interventions resulted in the development of new pressure ulcers for Resident #3 and #4. Findings include: Information provided to the State agency indicated facility staff failed to assess Resident #3's skin and were unaware of the development of pressure ulcers to her buttocks. Review of the facility policy titled "Pressure Ulcers" occurred on 11/12/14. This policy, dated September 2012, stated ". . . Based on the resident's comprehensive assessment, the center will use prevention and assessment interventions to ensure that a resident entering the center without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable. . . ." Review of the facility policy titled "Pressure Ulcer Practice Guidelines" occurred on 11/12/14. This policy, revised June 2014, stated ". . . Residents at risk for pressure ulcer development and those with pressure ulcers/wounds should be monitored daily for changes in their skin condition. This may occur during the course of the resident's daily care and/or bathing where the CNA [certified nursing assistant] should perform a head-to-toe check of the resident's skin, paying particular attention to: . . . The surfaces of the skin that come in contact with the bed and chair . . . Bony prominences . . . The surfaces of the skin that	F 314	2. All residents with current pressure areas and those residents at high risk for impaired skin integrity as indicated by a Braden Scale of 17 or higher have the potential to be effected by this practice. 3. An educational binder was made including Orabutrelbad on the procedure "Pressure Ulcer" with a focus on how to assess, record, monitor wound healing daily for open pressure ulcers with a weekly RN analysis and prn with the CNA staff to monitor skin during routine cares and bathing and to report immediately any improvement or declines to the nurse and to treat wounds according to physician orders notifying for orders prior to changes. Staff was required to RN/LPN/CNA read the binder, sign when completed, take a test, and the education will be tracked in the Learning Center. CNA meeting was held on 12/11/14 and it was stressed to make sure we are looking for any changes in the skin every time the residents are being dressed or undressed. If any change is noted notify the charge nurses ASAP.	

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F 314	Continued From page 17 come in contact with each other . . . Abnormal findings/changes should be reported to the resident's primary care provider . . . It is recommended that the Wound Data Collection . . . reflects the nurse's observation and management of wounds from a shift-to-shift perspective and with each dressing change. At a minimum, weekly documentation is recommended to provide a review of the pressure ulcer/wound. Weekly documentation should include the date observed and . . . Measurements . . . Presence, type, color, odor, appearance and approximate amount of any exudate, Presence, nature and frequency of pain, Wound bed characteristics . . . Description of wound edges and surrounding skin . . . Once a resident experiences a pressure ulcer, an assessment should take place immediately that determines the severity of injury and treatment interventions necessary. . . ." - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 09/15/14, identified moderately impaired cognition, limited assistance required for toileting and transfers, at risk for pressure ulcers, nutritional interventions, and dressings. The current care plan further identified: * Pressure Ulcers: ". . . Assess/record/monitor wound healing weekly and prn. Report improvements and declines to the health care provider. treatment per MD [medical doctor] orders. . . . Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. . . ."	F 314	**System change**: all residents with wound cares will have a Wound Data Collection tool UDA scheduled to trigger daily. A nurse will complete the weekly assessment to ensure the wound is healing. At risk residents with a Braden Scale of 17 or greater will have a new intervention added to the at risk care plan informing staff to inspect skin daily during routine cared and report to charge Nurse. 4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 2, then as deemed necessary the QA committee. The Audit will be checking PCC to ensure completion of the Wound Data Collection tool UDA's being done daily for residents with pressure ulcers and an evaluation 7 days. CNA's charting will be reviewed to ensure staff is completing the intervention for skin inspection.	start date 12/22/14 1-6-15

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The progress notes identified the following:
* 10/20/14, "Resident's daughter here this evening and expressed concern for L great toe ulcer and for black and blue area at coccyx . . ."
Facility staff failed to identify Resident #3's coccyx ulcer until after the resident's family member brought it to their attention.
* 10/21/14, ". . . Notified by staff of skin area to coccyx. Area is 6 cm long by 4 cm wide, dark purple color. Area has 3 slits of 0.8 cm. One below the other. Resident complains of some discomfort to area. . . ."
* 10/23/14, ". . . Culture from coccyx wound. Oxicillin resistant staphylococcus aureus. Sent to [Nurse Practioner (NP)] for confirmation of MRSA."

The wound data collection form stated, ". . . Measurements - Required at least once every 7 days. . . ."
Resident #3's coccyx ulcer/wound data collection forms were completed as follows: 10/21/14 and 10/30/14 (9 days).
* 10/30/14, ". . . Stage 3, open irregular-shaped area on coccyx" which measured "3.75 cm in length, 2 cm in width, and 0.2 cm in depth, with tan drainage, and an odor . . ."
The facility failed to provide this surveyor any wound data collection forms for the month of November. Facility staff failed to measure Resident #3's coccyx ulcers with every dressing change or every seven days per policy.

Observation on 11/11/14 at 11:15 a.m. showed two nurses (#2 and #3) providing Resident #3's ulcer treatments following her bath (with the CNA #6). Both nurses (#2 and #3) cued Resident #3 to stand. The first nurse (#2) then described the wound on Resident #4's coccyx as a "2.5 cm x 3

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cm draining [area] with a white center/core and yellow tissue around [it]," as the second nurse (#3) wrote the measurements on her inner arm. The second nurse (#3) applied a dressing before both nurses (#2 and #3) removed their gloves and exited the bathing room. Following the observation, the second nurse (#3) approached this surveyor and asked "What was 2.3 cm x 1.3 cm? Did you write down the buttocks?" The second nurse failed to accurately document the measurements of Resident #3's coccyx ulcers.

- Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 08/16/14, identified severely impaired cognition, extensive-to-total assistance required for toileting and transfers, at risk for pressure ulcers, bed/chair pressure reducing devices, repositioning program, nutritional interventions, and dressings.

The current care plan for pressure ulcers further identified, ". . . Treatment to right heel, right great and 1st toe per MD [medical doctor] orders. . . . Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. . . ."

The progress notes identified the following:
* 09/21/14, "When CNA was dressing resident, noted blood to right foot. Resident pulled away in pain when toes were moved. Nurse cleansed and assessed the wound. Stage 2 pressure ulcer to inner Right great toe. Stage 2 pressure ulcer to medial 1st toe. Orders from [Provider] for meplix dressing and have wound assessed at housecalls." Facility staff failed to identify Resident #4's right toe ulcer until it had reached a

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F 314	Continued From page 20 Stage 2 (a shallow open ulcer with a red pink wound bed). * 09/24/14, "Wound assessment completed on right great toe and right 2nd toe. . . ." Nursing staff failed to assess (i.e.: measure) the status of Resident #4's toe ulcers for three days after being alerted by direct care staff of their presence. Resident #4's right toe ulcers/wound data collection forms were completed as follows: 09/24/14, 10/01/14, 10/02/14, 10/16/14 (15 days). * 10/02/14, ". . . pressure ulcer between toes" which measured "0.75 cm in length and 0.4 cm in width, with drainage, and an odor. . . ." * 10/16/14, ". . . open area on the lateral portion of right great toe" which measured "1 cm in length and 1 cm in width, with drainage, and an increased odor. . . open area on medial portion of the second toe" which measured "0.5 cm in length and 0.5 cm in width. . . ." The facility failed to provide this surveyor any wound data collection forms for the month of November. Facility staff failed to measure Resident #4's right toe ulcers every dressing change or every seven days per policy. The progress notes identified the following: * 10/16/14, "[Provider] ordered C & S [Culture and Susceptibility] of right great toe wound on 10-17-14, since there has been no improvement and there is drainage and odor." * 10/19/14, "Culture to Toe. Staphylococcus aureus. Susceptibility to follow." * 10/20/14, "Received orders from [Provider] for Bactrim [antibiotic] . . ." * 10/21/14-10/30/14, "Resident on oral antibiotic for MRSA infection of right toes without adverse reaction. . . ." * 10/31/14, "Resident received last dose of ATB	F 314		

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F 314	Continued From page 21 [antibiotic] for MRSA in toe wound at 10am today. . . ." Observation on 11/11/14 at 11:00 a.m. showed two nurses (#2 and #3) prepping for Resident #4's ulcer treatment. As the nurses gloved, one (#2) stated, "It's her right big toe and first toe." The second nurse (#3) countered with, "No, it's her left foot." The first nurse (#2) paused and responded, "Well, the orders are for the right foot." The second nurse (#3) countered with, "I get mixed up." The first nurse (#2) then used a scissors to cut the soiled dressing from Resident #4's right toe, which had been secured with band-aids. She (#2) described one of the wounds on Resident #4's right foot as a "pin-sized, 0.4 x 0.1 cm, circular, open area to the knuckle on the first toe," and the other as a "0.2 x 0.2 cm, pink, circular [wound] between the big and second toe, with no drainage and good tissue around it." She removed her gloves, washed her hands, and regloved. The nurses (#2 and #3) treated Resident #1's right toe ulcers, removed their gloves, washed their hands, and applied new gloves. The first nurse (#2) stated, "Since she has been having issues with the other foot as well, we'll go ahead and look [at it]." The second nurse (#3) cut a dressing into four pieces, removed her gloves, and exited the room. The first nurse (#2) described the wound on the "first toe [of Resident #4's left foot] as a "1 cm x 0.2 cm red area with a darker scab on it, no drainage, and pink surrounding tissue," the wound on the lateral portion of second toe as a "0.1 cm x 0.3 cm scabbed over area, [with] no drainage or infection around it," and the wound between her fourth and fifth toes as a "1.2 cm x 0.4 cm pink area, open, with scant pink drainage." She (#2) further stated, "I'm worried about the top of her	F 314		

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small toe. [There is a] small amount of pinkness." The first nurse (#2) removed her gloves, washed her hands, regloved, and treated Resident #4's left toe ulcers. The second nurse (#3) re-entered Resident #4's room and began writing the date on each of the dressings. The first nurse (#2) told Resident #4 they were going to dress her ulcers with Mepilex and paper tape as "the band-aids could cause irritation." She (#2) also stated, "We'll have talk to [the Nurse Practioner] to fix the order." The second nurse (#3) regloved and put Resident #4's socks and blue boots on her feet. Both nurses then removed their gloves, washed their hands, and exited the room. Although the two nurses (#2 and #3) were aware Resident #4 was "having issues with [her left] foot," they failed to assess and evaluate her skin prior to 11/11/14 at 11:00 a.m.; at which time she had three new ulcers and one area of concern on the top of her small toe. The two nurses (#2 and #3) failed to notify Resident #1's physician of the three new pressure ulcers on her left foot and obtain new orders prior to providing treatment/ulcer care.

On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed direct care staff were aware of the ulcers on Resident #4's left foot. She stated, "The bath aide forgot to tell someone about [Resident #4's] toes."

- Review of Resident #1's medical record occurred on all days of survey. The significant change MDS, dated 08/21/14, identified intact cognition, extensive assistance required for toileting and transfers, two current Stage 2 pressure ulcers, bed/chair pressure reducing devices, repositioning program, nutritional interventions, and dressings.

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	355095	A. BUILDING _____ B. WING _____	C 11/12/2014

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F 314	Continued From page 23 Resident #1's vertebrae ulcer/wound data collection forms were completed as follows: 08/30/14, 09/09/14 (10 days), 09/17/14 (8 days), 09/24/14, 10/04/14 (10 days), 10/16/14 (12 days), 10/30/14 (14 days). * 10/30/14, "Stage 2 open area at mid spine" which measured "4 cm in length, 2 cm in width, and 0.1 cm in depth, and had scant tan drainage." The facility failed to provide this surveyor any wound data collection forms for the month of November. Facility staff failed to measure Resident #1's vertebrae ulcer with every dressing change or every seven days per policy. Observation on 11/11/14 at 10:30 a.m. showed two nurses (#2 and #3) removing the soiled dressings from Resident #1's back and buttocks. After they finished treating Resident #1's vertebrae ulcer, they placed new dressings over both areas. The two nurses (#2 and #3) failed to assess and evaluate (i.e.: measure) the status of Resident #1's vertebrae ulcer for progress toward healing. On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed staff are to measure wounds on a weekly basis. The facility failed to: * identify Resident #3's coccyx ulcer prior to the resident's family member bringing it to their attention. * measure Resident #3's coccyx ulcer with every dressing change or every seven days per policy. * accurately document the measurements of Resident #3's coccyx ulcer. * identify Resident #4's right toe ulcer until it had reached a Stage 2 (a shallow open ulcer with a red pink wound bed).	F 314		

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F 314	Continued From page 24 * assess (i.e.: measure) the status of Resident #4's right toe ulcers for three days, after being alerted by direct care staff of their presence. * measure Resident #4's right toe ulcers with every dressing change or every seven days per policy. * clarify which of Resident #4's feet (right foot) required treatment prior to entering her room. * report abnormal findings/changes to Resident #4's left foot to the supervising nurse * assess and evaluate Resident #4's left foot prior to 11/11/14 at 11:00 a.m.; at which time she had three new ulcers and one area of concern. * notify Resident #4's primary physician of the three new pressure ulcers on her left foot and obtain new orders prior to providing treatment/ulcer care. * measure Resident #1's vertebrae ulcer with every dressing change or every seven days per policy.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	1. For residents #1, #3, and #4 a visual cue has been placed on the back of the door to remind staff to wash hands before leaving room. For resident #3 staff has been educated to never let the catheter bag touch the floor. 2. All residents that receive staff assistance or those with a Foley catheter the potential to be affected by this practice.	

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F 441	Continued From page 25 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 3 of 6 sampled residents (Resident #1, #3, and #4) observed during toileting and/or ulcer cares. Failure to follow infection control practices related to glove usage and hand hygiene has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 11/12/14. This policy, revised June 2014, stated ". . . use an	F 441	3. C.N.A. meeting was held on the November 13, 2014 and education was given on hand hygiene with the focus on when hand washing should occur after assisting resident. An educational binder was compiled of procedure on infection control including wound dressing change, catheter care and how infections are spread. Staff RN/LPN/CNA was required to read the binder, sign when completed, take a test, and was tracked in the Learning Center. We will be adding infection control reminder/posters thought out the building to help remind staff to hand washing and to be aware of the spread of infections. 4. An audit will be developed and completed by the QA coordinator or designee weekly for 4 times, monthly for 2, then quarterly times 3, then as deemed necessary the QA committee. The Audit will do random checks of hand washing of staff exiting resident's rooms. Also will observe Foley Catheters placement during transfers to ensure they are not placed on the floor.	staff date 12/22/14 1-6-15

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alcohol-based hand rub for routinely cleaning your hands: Before having direct contact with residents, After having direct contact with a resident's skin . . . After touching equipment or furniture near the resident, After removing gloves. . . ."

Review of the facility policy titled "Wound Dressing Change" occurred on 11/12/14. This policy, revised November 2013, stated ". . . Remove dressing from inner wrapper; avoid finger contact with the dressing. . . ."

- Review of Resident #1's medical record occurred on all days of survey. The significant change Minimum Data Set (MDS), dated 08/21/14, identified intact cognition and extensive assistance required for toileting.

Observation on 11/10/14 at 5:15 p.m. showed a certified nursing assistant (CNA) (#1) assisted Resident #1 with toileting cares. After the resident voided, the CNA (#1) donned gloves, assisted the resident to stand, and provided perineal cares. At the completion of the perineal cares, the CNA (#1) removed his soiled gloves, assisted Resident #1 to stand-pivot into her wheelchair, and transported her to the dining room. The CNA (#1) failed to perform hand hygiene prior to exiting Resident #1's room.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included methicillin resistant staphylococcus aureus (MRSA). The quarterly Minimum Data Set (MDS), dated 09/15/14, identified moderately impaired cognition, at risk for pressure ulcers, and current diabetic foot ulcer.

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Observation on 11/11/14 at 11:15 a.m. showed two nurses (#2 and #3) provided Resident #3's ulcer treatment following her bath [with the CNA #6]. The nurses (#2 and #3) cued Resident #3 to stand. As she stood, the CNA (#6) pulled her wheelchair back with the resident's catheter bag attached. Both nurses (#2 and #3) grabbed for the wheelchair; to stop the backward movement. The CNA (#6) unhooked the resident's catheter bag from under the wheelchair and threw it on the floor between Resident #3's legs. The CNA failed to ensure Resident #3's catheter bag was stored in a sanitary manner. After the nurses (#2 and #3) assessed and treated Resident #3's toe and coccyx ulcers, they removed their gloves and exited the bathing room. The nurses (#2 and #3) failed to perform hand hygiene after treating Resident #3's toe and coccyx ulcers and prior to exiting the bathing room, and failed to cleanse the catheter bag after it lay on the floor during the dressing change.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included MRSA. The quarterly MDS, dated 08/16/14, identified severely impaired cognition, and extensive assistance required for toileting.

Observation on 11/10/14 at 5:15 p.m. showed two CNAs (#4 and #5) assisted Resident #4 with toileting cares. After the resident voided, one CNA (#5) raised the stand lift as the other CNA (#4) donned gloves, provided perineal cares, and removed her soiled gloves. At the completion of the toileting cares, the two CNAs (#4 and #5) transferred Resident #4 into her wheelchair. One CNA (#4) washed her hands as the other CNA (#5) exited Resident #4's room to answer another

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F 441	Continued From page 28 resident's call light. The CNA (#5) failed to perform hand hygiene prior to exiting Resident #4's room and entering another resident's room. On 11/12/14 at 1:00 p.m., an administrative nurse (#7) confirmed staff are to perform hand hygiene before having direct contact with residents, after having direct contact with a resident's skin and/or equipment/furniture, and after removing their gloves.	F 441		