PRINTED: 07/14/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

(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 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on record review and interview,the facility failed to accurately document the choices for end of life measures for 1 of 11 (R4) sampled residents. The findings included: Based on review of the Advanced Directive in Resident (R) 4's medical record, the resident had clearly outlined her wishes not to be resuscitated in the event her heart should stop beating or she should stop breathing. The resident choice was "Do Not Resuscitate."	F 155	F155 Corrective Action- Physician's order clarified for R4, dated 6/29. 8/5/16 Identification of Others- DNS/designee to conduct audit of all resident's POLST to identify any inconsistencies between POLST and POS. Systemic Changes- Education to SSD, Medical Records and nursing that a physician's order (TO) must be completed any time there is a change to the POLST. Each new admission's POS from Omnicare will be reviewed upon receipt for accurate reflection of Resident/POA wishes. Discrepancies will be clarified on TO and faxed to Omnicare. SDC/designee. Monitoring- DNS/designee to conduct random audit every month for three months for accuracy of POS vs POLST to be reported at QAPI for determination of need/frequency of on-going monitoring.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Revised 8/4/16 TITLE RN/DNS (X6) DATE 8/4/16

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 155	Continued From page 1 Review of the current "Physician's Orders" dated 06/01/16, revealed R4 was a "Full Code" which indicated staff should provide all possible measures to resuscitate the resident. The original order date for the code status was dated 5/26/11. On 6/28/16 at 12:05 p.m., during interview with the Director of Nursing Service (DNS), she confirmed R4's physician orders should be clarified. The DNS further stated she and her staff would refer to the Advanced Directive on a resident's record, not the physician's order.	F 155		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156		

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F 156	Continued From page 2 the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156		

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F 156	Continued From page 3 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post written information about Medicare and Medicaid benefits for any residents or responsible parties to use. The findings included: Observations throughout the facility on 6/28/16 beginning at 2:15 p.m. revealed the information regarding the names, addresses and phone numbers of the Medicaid and Medicare offices and information on how to apply for Medicaid/Medicare Benefits could not be located. During an interview with the Administrator on 6/28/16 at 2:25 p.m., the Administrator reported he was not aware of such a posting. He further reported residents and families were directed to the business office if they had Medicaid or	F 156		

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F 156 F 280 SS=D	Continued From page 4 Medicare questions. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to review and revise the plan of care timely to reduce the likelihood of 2 of 11 sampled residents (R7 and R11) sustaining additional falls resulting in injuries. The findings included: 1. Resident (R) 7 was admitted to the facility 3/17/16 and was 87 years old. His/her current	F 156 F 280	F280 Corrective Action- Comprehensive care plans reviewed and updated on R7 and R11 including identified fall interventions. 8/5/16 Identification of Others- DNS/designee to audit residents identified as high fall risk (fall evaluation score of 13 or >) will have their care plans reviewed to ensure appropriate interventions are in place and/or identify need for additional interventions. Systematic Changes- IDT review will be done after each fall, current interventions will be reviewed and care plans revised to reflect any new, additional or ineffective interventions. Nursing staff will be educated on the fall evaluations and the addition of new interventions to be added to the resident Care Plan. SDC/designee. Monitoring- DNS/designee to conduct random audit of fall care plans from documented fall incidents will be examined for effectiveness every month for three months to be reported to QAPI committee. QAPI will determine need for ongoing monitoring.	

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F 280	Continued From page 5 diagnoses included dementia and hypertension. Review of R7's admission screening and assessment tool ("Minimum Data Set") dated 4/14/16 revealed that his/her cognitive skills for daily decision making were moderately impaired. R7 required extensive assistance of one staff person with activities of daily living. He/she required the physical assistance of two staff persons to transfer to or from bed, chair, wheelchair and standing position. He/she was unable to walk and required staff to propel him/her in a wheelchair. R7's record indicated that prior to being admitted to the facility, he/she was admitted to an acute care emergency room on 3/13/16 and assessed to have severe lower extremity weakness bilaterally (" unable to ambulate . . . "). He/she was subsequently admitted to the acute care hospital. Hospital licensed nurses documented numerous attempts of R7 being confused and attempting to get out of bed. After being admitted to the facility, R7 sustained seven falls resulting in injuries and the care plan was not revised to include approaches/interventions to reduce the likelihood of further falls. R7 sustained a fall in the facility on 3/21/16. A "Fall Evaluation" was conducted the same day, resulting in a score of 16 indicating that the resident should be considered as having a high potential for falls. A care plan was initiated on 3/22/16. Re-evaluation of the care plan was scheduled for 6/22/16. The care plan approaches/interventions	F 280		

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F 280	Continued From page 6 were: 1. Remind R7 to use call light for assistance. 2. Monitor for changes in cognition. 3. Cue R7 to use wheelchair for propelling self. 4. Administer meds as per MD order. Review of "Nurse's Notes" dated 5/11/16 at 3:30 a.m. revealed, "Resident had unwitnessed fall at 01:10 [1:10 am]. Resident appears to have fallen from bed. Resident discovered next to bed. PERRLA. . . 0.5 cm [centimeter] skin tear noted to L [left] upper fore-arm." Another "Fall Evaluation" was conducted on 5/11/16 resulting in a score of 16, the same score as the previous "Fall Evaluation." The instructions on the "Fall Evaluation" tool includes: "If the total score is 13 or greater, the resident should be considered as having a HIGH POTENTIAL for falls. A prevention protocol should be initiated and documented on the care plan." No changes were made to the care plan interventions to reduce the likelihood of R7 experiencing further falls. Documentation in the "Nurses Notes" revealed that an IDT (interdisciplinary Team) meeting was held on 5/11/16 at 10:25 a.m. indicating that "PT and OT to assess for positioning equipment for bed safety." Review of "Nurse's Notes" dated 5/16/16 at 6:45 p.m. revealed "resident was taken to DR [dining room] for evening meal. Within 5 minutes resident was found sitting on DR floor in front of W/C [wheelchair]." The care plan was not revised or updated with approaches or interventions to reduce the	F 280		

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F 280	Continued From page 7 likelihood of further falls. On 5/17/16 at 4:45 p.m. documentation in the "Nurse's Notes" revealed, "Resident slid from w/c seat foot pegs on w/c - witnessed fall. Rt [Resident] did not hit her head." After the fall, the care plan was not revised or updated with approaches or interventions to reduce the likelihood of further falls. Documentation in the "Nurse's Note" on 5/19/16 at 7:00 p.m. revealed, "Resident had an unwitnessed fall in the therapy gym with injuries. Bruise to corner of left eye also around the side of left eye. Bandaids and wound care to right hand and left finger." On the same day, R7's physician orders included the following: 1. Cleanse right hand laceration with wound cleanser, dry, apply TAO [Tagaderm Absorbent Dressing], cover with telfa [non-absorbent wound dressing]. 2. Notify doctor of any signs or symptoms of infection. 3. Change dressing every day until healed. 4. Cleanse left index finger with wound cleanser, dry, cover with Band-Aid. 5. Change and cleanse dressing daily and monitor daily for signs and symptoms of infection until healed. 6. Cleanse left eyebrow with wound cleanser, dry, cover with Band-Aid. 7. Cleanse and change Band-Aid daily. 8. Monitor abrasion to left breast every day. 9. Monitor for late bruising for 3 days.	F 280		

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F 280	Continued From page 8 Another "Fall Evaluation" was conducted on 5/19/16 with the same results as the previous "Fall Evaluations." The score was 16 indicating that fall prevention interventions were necessary. No changes were made to the care plan interventions to reduce the likelihood of further falls. A late entry in the "Nurse's Notes" on 5/24/16 at 6:00 p.m. revealed R7 "Does not understand LTC [Long Term Care] placement or safety issues." Documentation in the "Nurse's Notes" on 5/25/16 at 4:00 p.m. revealed, "One-on-one supervision required to prevent falls - Is unaware of safety concerns - Staff anticipated needs - Therapy note a decline in participation, weakness." On 6/7/16 at 1:00 p.m. documentation in the "Nurse's Notes," revealed, He/she "has decreased safety awareness related to cognitive decline. Staff are unable to redirect easily." Documentation in the "Nurses' Notes" on 6/9/16 at 2:00 p.m. revealed, " Rt [Resident] this am at 0730 [7:30] dozed off in WC [wheelchair] witnessed but unable to get to resident in time. Fell on L [left] side in front of nurse's station, hit head. . . Sustained .75 cm laceration to L index finger." The plan of care remained the same and was not revised or updated with approaches or interventions to reduce the likelihood of further falls. On 6/16/16 at 6:25 p.m., a licensed nurse documented in the "Nurse's Notes," Rt fell from WC to floor when she was trying to p/u [pick up]	F 280		

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F 280	Continued From page 9 wallet. No bruises, did not hit head. Witnessed fall by CNA." R7's physician ordered the following on 6/16/16: 1. Cleanse top of left foot abrasion area every day with wound cleanser and TAO with Band-Aid every day for 7 days. On 6/22/16 at 11:00 a.m., R7's the care plan meeting that was scheduled when the care plan was initiated was held. The "Nurses Notes" indicate that R7's son attended. Documentation in the "Nurses Notes" revealed, "Discussed risk for falls r/t [related to] impulsivity and interventions in place to reduce risk for injury." During interview with the DNS (Director of Nursing Services) on 6/28/16 at 1:10 p.m., she stated, "R7 has advanced Alzheimer's. He/she was head of housekeeping which contributes to her impulsiveness. Resident cannot remember that he/she cannot walk." The DNS acknowledged waiting for R7's scheduled care plan date to revise care plan while R7 continued to sustain falls with injuries. She also stated that an anti-rollback device that automatically locks the wheelchair when R7 attempts to get out of the chair was ordered. Observation of R7 on 6/29/16 revealed that a device to prevent him/her from rising was attached to his/her wheel chair. The facility failed to provide care and services, to reduce R7's risk for falls. R7 was cognitively impaired, unable to walk, and dependent upon staff to ensure her safety. Per facility documentation R7 was impulsive, did not	F 280		

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F 280	Continued From page 10	F 280		

understand LTC placement or safety issues and required one-on-one supervision to prevent falls. The facility failed to revise the care plan or facility approaches to include strategies to reduce the likelihood of R7 sustaining additional falls.

2. Resident (R) 11 was admitted to the facility on 8/8/14 and was 86 years old. His/her current diagnoses included dementia, muscle weakness, and hypertension.

Review of R11's quarterly screening and assessment tool ("Minimum Data Set") dated 5/26/16 revealed that he/she was cognitively impaired and had difficulty focusing attention (easily distracted, out of touch). His/her thinking was disorganized or incoherent (rambling or irrelevant conversation). R11 required extensive assistance of one staff person with bed mobility; transferring to and from bed, chair, wheelchair and standing position; dressing and personal hygiene. He/she required assistance of one staff person for walking. He/she propelled himself in a wheelchair when staff was not available to assist with walking.

R11 sustained ten falls resulting in injuries and the care plan was not revised to include interventions to reduce the likelihood of further falls.

A care plan was initiated on 9/27/14. Re-evaluation of the care plan was scheduled for 9/1/15. The care plan interventions were:

1. Anticipate and meet R11's needs. He has a pattern of daily activities & events that he performs.

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F 280	Continued From page 11 2. Assess risk for falls - complete the assessment that will identify R11's risk for falls, wandering, bed safety, full nursing assessment, bladder, pain per policy & procedures. 3. Be sure the call light is within reach and encourage R11 to use it for assistance as needed. 4. R11 needs activities that minimize the potential for falls while providing diversion and distraction. 5. R11 has wander guard. 6. R11 is in the "Falling Stars" program. 7. R11 needs a safe environment with: free from spills and/or clutter, the bed in low position at night, personal items within reach. 8. R11's room is close to the nurse's station to utilize full staff assistance as needed and monitor for safety. 9. Educate/remind R11 to request assistance prior to transfer or short distance. Review of R11's "Nurse's Notes" revealed the following falls: 12/31/15 at 7:45 p.m., "Pt. [patient] found on floor. Pt stated he was trying to walk to bathroom sink by self and tripped on O2 tubing. No injuries noted." 01/04/16 at 9:30 a.m., "Res [resident] roommate rang call light CNA staff heard bang et [and]	F 280		

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F 280	Continued From page 12 called for assist to room. Res is found on floor in doorway of BR [bathroom]. Riser from toilet is on its side et wipes are also noted on the floor as well as his brief et BM [bowel movement] on the floor. Res denies hitting his head." 01/05/16 at 10:30 a.m. Interdisciplinary team met. No changes were made to the care plan interventions to reduce the likelihood of further falls. 01/07/16 at 11:25 a.m. "Resident found on floor by staff member. Lying on R [right] side. Denies hitting head. Said he was trying to get to W/C [wheelchair] when he fell. Small bruise noted on upper R [right] arm." 01/10/16 at 4:30 p.m. "Resident found sitting in floor of room. Says he did not fall. O2 off. Alert to place & person." 01/11/16 at 10:15 a.m. Interdisciplinary team met to review "fall occurring 1/7/16." No changes were made to the care plan interventions to reduce the likelihood of R11 sustaining further falls. 01/12/16 at 10:05 a.m. Interdisciplinary team met to review "fall occurring 1/10/16." No changes were made to the care plan interventions to reduce the likelihood of R11 sustaining further falls. 01/12/16 at 2:30 p.m. "Resident turned BR [bathroom] light on in room. Found on floor (sitting with back against wall & legs drawn up). Oxygen off. . . Placed back in W/C [wheelchair] and brought to nurses station."	F 280		

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F 280	Continued From page 13	F 280		

01/13/16 at 4:20 p.m. "Resident found on floor. [Resident] was reaching for toothbrush. Found on buttocks. No bruises, cuts or lacerations noted. [Resident] denies hitting head."

01/14/16 Interdisciplinary team met to review falls of "1/12 and 1/13/16." No changes were made to the care plan interventions to reduce the likelihood of R11 sustaining further falls.

02/20/16 at 1:55 a.m. "Heard the fall at 1835 [6:35 p.m.]. Found resident lying on his back. Stated he was reaching for his coat that was on his bed, fell out of W/C. Stated he hit his head - no injuries noted to head. Noted red mark to upper left side of back."

02/22/16 Interdisciplinary team met to review fall of 2/20/16. Documentation indicates that the 'care plan' was updated. Review of the care plan revealed that the date 2/12/16 was entered on the care plan under goal. The Goal and Interventions were not changed or updated.

03/19/16 at 4:45, "Resident found on floor by CNA. Found next to bed facing bed. Legs out stretched up on R elbow."

R11's physician ordered the following the same day:

1. Cleanse laceration on nose with dermaklenz, dry, apply TAO and cover with band-Aid every day and as needed until healed.
2. Notify doctor of any signs or symptoms of infection.
3. Monitor for late bruising for 7 days.
4. Monitor bruise on upper right arm.

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F 280	Continued From page 14 5. Notify doctor of any adverse effects. 03/21/16 at 10:00 a.m. Interdisciplinary team met to review "fall occurring 3/19/16." No changes were made to the care plan interventions to reduce the likelihood of R11 sustaining further falls. 04/12/16 at 7:20 p.m. "Noise heard in resident room upon staff entrance into room Resident is sitting on floor with back against bed. Un-witnessed fall noted at 1815 [6:15 p.m.]. Resident MAEX4 [moves all extremities - arms and legs]. No noted redness or bruises." R11's physician ordered the following the same day: 1. Cleanse skin tear to right elbow with derma-cleanse, apply steri-strips, apply antibiotic ointment, and cover with telfa - island dressing. 04/13/16 at 10:00 a.m. Interdisciplinary team met to review "fall occurring 4/12/16. Resident fell while transferring from W/C to bed sustaining S/T [skin tear] to R forearm area." No changes were made to the care plan interventions to reduce the likelihood of R11 sustaining further falls. 04/17/16 at 12:00 p.m. "Resident was found in room, laying on left side on the floor in front of his bed, on the gray mat. When asked what happened, resident states he was, 'trying to get back to bed.' Resident had been sitting in W/C." 04/18/16 Interdisciplinary team met to review "fall occurring 4/17/16." No changes were made to the care plan interventions to reduce the likelihood of	F 280		

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F 280	Continued From page 15 R11 sustaining further falls. On 4/20/16, R11's physician ordered, "May have mat to floor, low bed at night for resident safety." 04/22/16 at 1:30 p.m., "Was found on floor sitting mostly on R side." A "Fall Evaluation" was conducted 4/23/16 resulting in a score of 26. The instructions on the "Fall Evaluation" tool includes; "If the total score is 13 or greater, the resident should be considered as having a HIGH POTENTIAL for falls. A prevention protocol should be initiated and documented on the care plan." 04/25/16 Interdisciplinary team met to review "fall occurring 4/22/16. . . Will continue with all current interventions." The care plan interventions remained the same. On 5/17/16, R11's physician ordered, "Resident to be evaluated and treated by PT services as indicated." 06/04/16 at 4:45 p.m., " . . . heard bang noise in resident's room and went in found him on floor where his closets are. Said he tried not to hit head but he did." 06/06/16 Interdisciplinary team met to review "fall on 6/4/16. . . Anti-roll back has been ordered it will be placed. Continue all current interventions." During interview with the DNS (Director of Nursing Services) on 6/28/16 at 1:10 p.m., the DNS indicated R11 had decreased safety awareness related to cognitive decline. He refuses to call for assistance. He is depressed	F 280		

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F 280	Continued From page 16 because his wife died. On 6/29/16, an entry on R11's care plan indicated "roll back W/C." Observation of R11 during the survey revealed that he/she was able to propel himself in the wheelchair. The facility failed to provide care and services, to reduce R11's risk for falls. R11 was cognitively impaired with decreased safety awareness. He was dependent upon staff to assist him/her with ambulating and to ensure his safety. During R11's repeated falls, the facility failed to address the effectiveness of the care plan's interventions and the need to adjust the interventions to make them more effective and include prevention strategies to reduce the risks of falls. There was no evidence provided to show justification for continuing the existing plan despite R11's repeated falls.	F 280		
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:	F 314	F314 Corrective action- DNS/designee reviewed documentation pertaining to R1 wounds to identify that appropriate interventions were in place. 8/5/16 Identification of others- DNS/designee to audit residents identified as "at risk" for pressure ulcers as indicated by MDS/formal assessment will be evaluated for need of pressure ulcer interventions. Systemic Changes- SDC/ designee to provide education to care staff will be increased to twice annually as well as being completed with all new hires. Monitoring- Skin evaluation forms will be reviewed on new admissions, weekly skin checks are audited three times a week to verify completion and identify any new or "at risk" skin areas. DNS/designee. Three time a week random audits to be conducted to ensure re-positioning as appropriate for residents at risk for pressure ulcers. Results of audits will be taken to QAPI for determination of need/frequency of on-going monitoring.	

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F 314	Continued From page 17 Based on observation, interview, and record review, the facility failed to provide 1 of 11 sampled residents (R1) with necessary care and services to prevent the deterioration of pressure ulcers through adequate and timely skin assessments, monitoring and evaluation of interventions for effectiveness, revision of the care plan, and documenting the existence of new pressure sores. The findings included: On 6/28/16 at 10:30 a.m. and 6/29/16 at 6:25 p.m., policies and procedures regarding pressure sores were requested; however, a policy was not provided during or after the survey. Licensed nurses assessed the skin only weekly as R1's skin integrity and tissue tolerance continued to deteriorate, without documented evidence of re-evaluating interventions for effectiveness. The resident developed an additional pressure sore on the coccyx that was only documented on a weekly skin assessment; therefore, the factors that influenced its development, the potential for development of additional ulcers or for the deterioration of the pressure ulcer were not assessed and addressed. The resident was not adequately repositioned. Specifically: According to the "Face Sheet," Resident (R) 1 was admitted to the facility 1/27/05. R1 was 82 years old and his current diagnoses included dementia, coronary artery disease, and peripheral vascular disease. Review of R1's quarterly "Minimum Data Set (MDS)" dated 2/13/16 revealed that he did not	F 314		

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F 314	Continued From page 18 have pressure ulcers. A significant change MDS dated 5/18/16 revealed he was cognitively impaired with short and long term memory problems. R1 could recall staff names and faces, location of his/her room and that he was in a nursing home. R1 was totally dependent upon the physical assistance of one staff member for all activities of daily living. He required the physical assistance of two staff members to transfer to and from bed, chair, wheelchair. R1 did not walk and used a wheelchair propelled by staff for movement throughout the facility. The MDS also indicated R1 had one unstageable pressure ulcer due to coverage of wound bed by slough/eschar, and one unstageable pressure ulcer with suspected deep tissue injury in evolution. The pressure ulcers were not identified as venous or arterial ulcers. Interview with the MDS coordinator on 6/28/16 at 2:40 p.m. revealed the previous annual MDS was not available because the "previous owners took all residents records with them because they were proprietary." R1 developed pressure sores and contractures as follows: A. Review of R1's plan of care revealed a "Focus - Potential for skin breakdown r/t (related to) decreased mobility. Date initiated: 11/23/12." The Focus was to be reviewed on 11/13/15. The "Target" date was 2/13/16. The "Interventions" were: 1. Encourage R1 to drink fluids at meal times and PRN (as needed).	F 314		

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F 314	Continued From page 19 2. Pressure relieving mattress and w/c (wheelchair) cushion. 3. Report areas of breakdown and treat as ordered. 4. Skin checks weekly with showers and prn. Review of R1's "Weekly Skin Evaluation" dated 3/2/16 revealed he developed a round shaped area on the right heel that was black/brown and measured 2.5 centimeters (cm) in length, 2.5 cm in width and 1 cm in depth. On 4/8/16 the "Weekly Skin Evaluation" revealed the area had progressed to 95% eschar, 3 cm in length, 2.5 cm in width and .3 in depth. The condition of the heel was not entered on the care plan until a month later on 4/9/16 and indicated "Actual skin impairment heel. Rt (Resident) has air flow mattress." Review of "Nurse's Notes" revealed an Interdisciplinary Team (IDT) Meeting was held on 4/11/16 regarding a blister on left elbow due to R1 leaning to the left side and referral to therapy for positioning. Documentation that R1's right heel was addressed during the meeting was lacking. On 4/22/16 a pressure ulcer care plan was developed for the "R med heel" (right medial heel). The plan was to be reviewed on 5/22/16. All areas of the pre-printed approaches were checked except "turn and reposition every two (2) hours." On 4/25/16 the "Weekly Skin Evaluation" revealed a description of the right medial heel wound bed was lacking. The length of the wound was 2 cm, width was 1.5 cm and depth .2 cm.	F 314		

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F 314	Continued From page 20 There was no further "Weekly Skin Evaluation" documentation regarding R1's heel after 4/25/16. Documentation the care plan was reviewed or updated was lacking. Evidence of monitoring/ assessing the area was lacking. This included lack of CNA (Certified Nurse Aide) documentation. On 5/31/16 R1's physician ordered "d/c (discontinue) heal dressing to R (right) medial heel. Cleanse area (right medial heel) pat dry, apply skin prep to peri wound every day - relieve pressure with positioning." R1's right heel was observed on 6/29/16. Measurement by licensed nurse (LN) 3 who was responsible for providing care and services to R1 revealed an area of 100% eschar 3 cm in length and 2 cm in width. B. Review of R1's "Weekly Skin Evaluation" dated 5/28/16 revealed that he developed a pink/beefy red opened area 2 cm round with minimal drainage" on the "L (left) inner buttock." The skin condition was not entered on the care plan. This was the only documentation regarding the area. Evidence of notification of R1's physician, monitoring or treatment was lacking. Observation of R1's inner buttock on 6/29/16 revealed a closed round reddened area on the coccyx area 0.7 cm in length. LN3 stated, "It was open last week." C. Review of R1's "Weekly Skin Evaluation" dated 4/4/16 revealed that he developed a suspected deep tissue injury (SDTI) on the right buttock that was black/brown and 95% eschar. It	F 314		

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F 314	Continued From page 21 measured 3.5 cm in length, 2.5 cm in width and .4 cm in depth. It had a minimal amount of sero-sanguineous drainage with a slight odor. The SDTI was not entered on the care plan until 18 days later on 4/22/16 and indicated "SDTI R (right) buttock; actual impairment R (right) buttock and L (left) elbow. The "Approach plan" was not to be re-evaluated until 5/22/16. The care plan included: 1. Alternating pressure mattress 2. Positioning pillows 3. Heel and elbow protectors 4. Monitor meal intake as indicated. 5. Referral/Monitoring by Nutrition/Hydration/Skin Committee. 6. Diagnostic testing as indicated by physician. 7. Therapist evaluation and treatment per physician order. On 4/25/16 the "Weekly Skin Evaluation" revealed that the area had progressed to 4 cm in length, 3 cm in width and 0.3 in depth. There was a minimal amount of sero-sanguineous drainage with a slight odor. There was no further "Weekly Skin Evaluation" documentation regarding R1's right buttock after 4/25/16. The care plan indicated that it was revised on 5/6/16, however, there were no new interventions entered on the care plan. Documentation of monitoring the area was lacking. On 6/27/16 R1's physician ordered "apply a thin layer of Santyl (cream that selectively removes necrotic tissue without harming healthy granulation tissue) to necrotic tissue at wound	F 314		

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F 314	Continued From page 22 bed, cover with gauze and 4 x 4s and an ABD (abdominal) pad secure with tape. Change every day and as necessary for saturation. Start once Santyl arrives - update patient care plan on 7/3/16 with progress." Observation of R1's right buttock on 6/29/16 revealed an opened area showing muscle and tissue. Measurement by LN3 who was responsible for providing care and services to R1 revealed the area had progressed to 7 cm in length, 11 cm in width and 3.4 cm in depth. LN2 stated, "Necrotic tissue was there last week. It was right in the center. It is gone." D. On 3/23/16 R1's personal physician documented in his/her "nursing home annual physical" that his/her extremities had "full range of motion, no deformities." Documentation in the record revealed a "PT Evaluation & Plan of Treatment" dated 5/25/16 for onset of services for lower extremities. The 3 "Short-Term Goals" were established to "facilitate Nurses' access to suprapubic catheter for hygiene and care." Observation on 6/29/16 at 8:50 a.m. revealed R1 had bilateral contractures of the lower extremities. CNA1 and CNA2 lifted R1 to transfer him from the wheelchair to the bed. Interview with the CNAs at that time revealed the contractures of both legs began approximately 1 month ago. When CNA2 who was responsible for providing care and services to R1 was queried about positioning, CNA2 stated, "I just prop him up and he always turns on his left side. There is no special way." When queried about the frequency of positioning CNA 1 stated "He always lay on his	F 314		

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F 314	Continued From page 23 left. There is no positioning schedule." Observation of R1 throughout the survey revealed he was not repositioned to relieve pressure. Example: R1 was observed at half hour intervals on 6/28/16. At 8:15 a.m. he was taken to the dining room table. At 8:50 a.m. he was returned to his bed, lying on his left side watching television. At 12:15 p.m. he was taken to the dining room for lunch. He was returned to bed at 1:00 p.m. where he remained lying on his left side until dinner at 5:45 p.m. During interview with the Director of Nursing Services (DNS) on 6/29/16 at 6:25 p.m., she stated, "He had a shear elongated and thin. The pressure sores happened over a weekend within 48 to 72 hours. She stated that R1's decline was medically anticipated. This was documented in R1's "nursing home annual physical" dated 3/23/16. However, R1's physician also documented his "Plan to continue present care and therapies." When queried regarding how resident care and services was communicated to staff she stated that they had "care cards." She produced a "Care Directive Form" that was completed on 12/14/15, over 6 months old, which included interventions no longer relevant to the specific resident.	F 314		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;	F 328	F328 Corrective action- O2 tanks on identified residents were replaced. 8/5/16 Identification of Others- DNS/designee reviewed all resident receiving O2 therapy for current treatment orders.	

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F 328	Continued From page 24 Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure residents received proper treatment and care for the administration of oxygen therapy for 4 of 13 sample and supplemental residents (R3, R8, R12 and R13). The staff failed to monitor that oxygen tanks were checked and filled prior to taking them to the dining room. The findings included: 1. R3 was initially admitted to the facility on 10/23/12. His current diagnoses included muscle weakness, chronic pain, hepatitis C, general edema, cellulitis of lower legs with methicillin resistant staphylococcus aureus (MRSA), obesity, and dyspnea (difficulty breathing). He was admitted to the hospital on 2/16/16 with hypoxia (low oxygenation levels) and pneumonia. His care plan indicated R3 had shortness of breath (SOB) related to obesity. There were no specific directions for use of oxygen or the need to check his oxygen saturation levels. His most recent physician's order for oxygen was dated 6/8/16 and read, "Apply oxygen @ 2L/NC (2 liters per minute via nasal cannula) for O2 sats (oxygen saturation levels) below 90% and/or signs of cyanosis (a bluish discoloration of the skin resulting from poor circulation or inadequate	F 328	Systemic Changes- SDC/designee will provide education on O2 therapy and timeliness of O2 tank replacement. Monitoring- Random daily audit of residents receiving O2 therapy for one month with results reported to QAPI for determination of ongoing need/frequency of audits. DNS/designee.	

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F 328	Continued From page 25 oxygenation of the blood)." R3 was observed to have his oxygen in place while in his room, as well as while out of his room. 2. R8 was admitted to the facility on 6/24/16 with diagnoses including essential hypertension, heart disease, chronic obstructive pulmonary disease (COPD) with acute exacerbation (extreme worsening), spinal stenosis, and chronic pain. According to his admission orders, dated 6/24/16, R8 was to have oxygen administered at 4 LPM (liters per minute) continuously. R8 was observed to have his oxygen in place while in his room, as well as while out of his room. On 6/27/16 at approximately 12:35 p.m., R3 and R8 were observed to be in the dining room for the lunch meal, with E-Tanks attached to their wheelchairs. They both had nasal cannulas in place and oxygen tubing was connected to their tanks. The tanks were observed to be on, however, the gauge showed they were in the red zone and that the tanks were empty. Neither resident was observed to be in distress, or to have altered breathing. The Director of Rehabilitation Therapy was nearby assisting another resident. She was notified of the lack of oxygen being administered for those two residents and immediately got up, checked the tanks (verified they were empty) and first filled R3's tank and then R8's tank. She stated the staff should have checked their tanks before bringing them to the dining room. On 6/28/16 at approximately 12:45 p.m., a subsequent check of all residents in the dining room with oxygen in place were observed. R3, R12, and R13 were observed in the dining room for the lunch meal, with E-Tanks attached to their	F 328		

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F 328	Continued From page 26 wheelchairs. All 3 residents had nasal cannulas in place and oxygen tubing was connected to their tanks. The tanks were observed to be on, but the gauge showed they were in the red zone and that the tanks were empty. None of the residents were observed to be in distress, or to have altered breathing. 3. R12 was admitted to the facility on 2/16/16 with diagnoses that included chronic heart failure, atrial fibrillation, chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute respiratory failure with hypoxia, hypertension, and chronic pain. According to his admission orders, dated 2/16/16, he was to have oxygen therapy, "O2 @ 2LPM/NC continuously." The same directions were listed on his care plan. R12 was observed to have his oxygen in place while in his room, as well as while out of his room. 4. R13 was admitted to the facility on 8/9/13 with diagnoses including diabetes mellitus type 2, hypertension, generalized weakness, and Alzheimer's disease. His most recent physician's order for oxygen was dated 6/8/16 and read, "Apply oxygen @ 2L/NC for O2 sats below 90% and/or signs of cyanosis (a bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood)." The same directions were listed on his care plan. R13 was observed to have his oxygen in place while in his room, as well as while out of his room. During the second observation of lunch on 6/28/16, the Nursing Home Administrator was in	F 328		

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F 328	Continued From page 27	F 328		

the dining room and the closest staff member when the empty tanks were observed again. He was notified and immediately had staff members come and address the situation. He stated he was not aware the same thing occurred the day before, even though a member of management was involved in the resolution.

The surveyor went to the nurse (LPN 1) on the front hall and asked if she could check pulse oximeter levels for the 3 residents whose tanks were empty. She stated she did not have a pulse oximeter on her cart and thought that perhaps someone had taken it home accidentally. When asked how she would check someone's pulse ox, she stated she did not know where to get another one but that perhaps the other nurse (on the back hall) would have one. LPN 2 was asked to check the pulse ox for the remaining two residents (R12 and R13) as R3 had been taken back to his room. By the time the second nurse checked the oxygen saturation levels, approximately five minutes had passed since they had been properly connected to full oxygen tanks, and their levels were within normal levels.

The Director of Nursing Services (DNS) was briefly interviewed at approximately 1:00 p.m. She had a pulse oximeter in her hand and stated she was taking it to LPN 1, on the front hall as she did not have one. The DNS stated she had no idea where the pulse oximeter for that cart was. The DNS also stated she was not aware of the same type of occurrence the day before, where residents were observed to be in the dining room with empty oxygen tanks. When asked for the facility policy on oxygen use, she stated, "We have none." At no time during the survey, did the DNS or any other staff member provide any

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F 328	Continued From page 28 policies regarding oxygen therapy administration, monitoring or documentation.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 13 sample and supplemental sample residents (R5) had a drug regimen free from unnecessary drugs. Specifically, a medication ordered for muscle	F 329	F329 Corrective Action- Resident R5 interviewed by DNS/ED in regard to level of pain and current medication regimen including medications prescribed as documented on pain assessment and pain monitoring flowsheet to establish justification for anti-spasmodic medications. Resident reported positive for muscle spasms and/or pain related to muscle spasms. 8/5/16 Identification of Others- Pharmacy review of medication regime is conducted every month. Random and weekly evaluation of pain flow sheets for patients who are flagging for pain according to MDS/pain monitor flow sheets are monitored with efficacy of treatment to be audited/reviewed to ensure no unnecessary medications. DNS/designee. Systemic Changes- Education provided to nursing staff on pain assessment, type of pain and evaluated for appropriate treatment with medications identified as unnecessary or unused to be discontinued with order by physician per SDC. Monitoring- Random and weekly evaluation of pain flow sheets for patients who are flagging for pain according to MDS monitored with efficacy of treatment to be audited/reviewed to ensure no unnecessary medications. Results will be taken to QAPI for determination of on-going monitoring. DNS/designee.	

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spasms was administered for complaints of pain, not muscle type in nature, without adequate indications for its use, and without consideration of potential drug interactions, and side effects of the muscle relaxant.

The findings included:

Resident (R) 5 was admitted to the facility initially on 8/10/04. Her current diagnoses included a non-ruptured cerebral aneurysm, chronic pulmonary heart disease, bipolar disorder, depression, congestive heart failure (CHF), chronic airway obstruction, esophagitis, and chronic pain.

According to her most recent "Minimum Data Set (MDS)," a quarterly review dated 5/22/16 indicated she had a "Brief Interview for Mental Status (BIMS)" score of 15/15, meaning no cognitive or behavioral impairment, she was capable of being interviewed, and she was able to answer appropriately. R5 was noted to have frequent pain, moderate in nature. She was completely wheelchair dependent, but only required staff supervision for her activities of daily living (ADLs), which included transfers, locomotion off unit, and toilet use. She required the physical assistance of one with bathing/showering.

Record review, conducted on 6/28/16 revealed the resident had the following physician orders related to pain relief and edema:

–Norco 10 mg/325 mg 1 tablet by mouth every 8 hours for pain. Norco was used in the treatment of back pain; pain, rheumatoid arthritis and belongs to the drug class narcotic analgesic

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F 329	Continued From page 30 combinations. The drug was scheduled for 8 a.m., 4:00 p.m., and midnight every day on a routine basis. --Acetaminophen 500 mg caplet, one caplet 4 times a day, prn (as needed) for pain/fever. Acetaminophen was a non-narcotic analgesic. --tizanidine HCL (aka Zanaflex) 4 mg tablet, every 8 hours prn, specifically ordered for diagnosis of muscle spasms. --Aldactone (aka spironolactone) 25 mg tablet, ordered twice daily for edema. According to www.medscape.com, potential drug interactions with other scheduled medications for R5 included: --Aldactone (given for edema) - Tizanidine increases the effects of Aldactone - risk of hypotension, which would include a higher fall risk. According to www.medscape.com, potential side effects with tizanidine included: --Sedation may occur and may potentiate effect of sedative drugs, such as her regularly scheduled dose of Norco (a combo drug consisting of 10 mg of hydrocodone and 325 mg of acetaminophen), which she received three times a day. --Hallucinations may occur --Dry mouth --Dizziness. Even though R5 had a prn order to receive Acetaminophen for pain, she was most often	F 329		

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F 329	Continued From page 31 given the tizanidine prn ordered for muscle spasms, which had more risks and potential side effects associated with its use. R5 had specific orders to monitor her pain level every shift (6 a.m. - 6 p.m., and 6 p.m. - 6 a.m.) and to rate the pain on a scale of 0-10, 10 being the worst. The nursing staff was to also identify the location/type of pain, as follows: 1 - Back pain 2 - Bone pain 3 - Chest pain during normal activities 4 - Headache 5 - Hip pain 6 - Incisional pain 7 - Joint pain (other than hip) 8 - Soft tissue/muscle pain 9 - Stomach pain 10 - Other (document location). Review of the "Medication Administration Record (MAR)" for June 2016 revealed the resident complained of joint pain on June 1 - June 10 and was administered tizanidine 4 mg, although it was ordered for muscle spasms. R5 had complaints of muscle pain June 12 - June 28 and also received tizanidine as ordered. R5 had complaints of bone pain and muscle pain on 6/3, 6/4, 6/6, 6/8, 6/9, 6/11 and 6/12/16 and was given Acetaminophen and tizanidine, at different times. R5 was interviewed on 6/29/16 at 2:30 p.m. When asked to describe her type and location of pain, she stated her pain was most often in her ankles, her joints or back. When asked	F 329		

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F 329	Continued From page 32 specifically, if the pain seemed muscular in nature, she stated, "Oh no it's in my bones and joints." The facility was advised of the use of the tizanidine for complaints of bone/joint pain, and that the resident stated her complaints of pain were most often in her bones and joints on 6/29/16 at approximately 5:30 p.m. On 6/30/16, the Regional Nurse Consultant (RNC), stated they interviewed R5 after the surveyor, and that she told her the pain was mostly muscular. The RNC stated the discrepancy was part of R5's behaviors. However, while R5 was taking Seroquel (for bipolar disorder) and Zoloft (for depression), the behaviors the facility was monitoring for were: crying and tearfulness, resulting in psychosocial harm; verbal aggression or verbal behaviors toward staff or others; refusal of necessary cares, resulting in needs not being met; increased anxiety that result in arguing, demanding behaviors, calling out, mood changes, self-isolation or refusal of necessary cares that may result in psychosocial harm; and reduced socialization, resulting in potential for self-isolation and/or psychosocial harm. Record review showed the facility indicated no documentation of any of those behaviors during the month of June 2016. In fact, those behaviors were all documented as "0" for the entire month, through 6/28/16.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and Policy review, it was determined that the facility failed to maintain a medication error rate of five percent or less. The error rate for medication administration pass was 29.6 percent. The findings included: 1. During medication administration observation on 6/28/16 at 8:15 a.m., one resident was sitting in a wheelchair near the medication administration cart waiting for Licensed Practical Nurse (LPN) 1 to administer her medications. LPN1 crushed a 10 mEq (milliequivalent) potassium tablet and administered the crushed potassium to the resident. Review of the bubble pack at this time revealed a pharmacist sticker on the potassium bubble pack that read, "DO NOT CRUSH and GIVE WITH PLENTY OF WATER." Continued observation revealed after crushing the potassium, LPN1 mixed the potassium in a medication cup containing a small amount of applesauce and spoon fed the potassium to the resident. The resident then turned and wheeled herself toward her room. During an interview with the Regional Nurse Consultant (RNC) on 6/29/16 at 8:45 a.m., she confirmed the medication should not have been crushed and should have been given with plenty of water per the manufacturer's guidelines. 2. On 6/28/16 at 8:27 a.m., LPN1 was observed during medication pass. LPN1 administered meloxicam 15 milligrams to a resident for pain.	F 332	F332 Corrective Action- Immediate In-service completed for nursing staff on following manufacturers recommendations/warnings when administering medications and treatments. SDC. 8/5/16 Identification of Others- Potential for any residents receiving medications with specific manufacturer's instructions to be effected. Systemic Changes- Medications identified as "take with food", "take with plenty of water", "do not crush", etc. will be added to the Medication Administration Records (MARS). DNS/designee. Monitoring- Random audit of medication pass three times a week to ensure manufacturer's recommendations are followed. Results of audits will be reported to QAPI for determination of frequency/need for on-going monitoring. DNS/designee.	

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F 332	Continued From page 34 Review of the bubble pack at this time revealed a pharmacy sticker on the medication pack that read "TAKE WITH FOOD and PLENTY OF WATER." Observation revealed the nurse administered the meloxicam without any food and failed to offer/encourage the resident to drink more than 2 sips of water. The resident had eaten breakfast more than 30 minutes prior to the administration of the medication. During an interview on 6/28/16 at 8:33 a.m. with LPN1, she reported she did not notice the sticker and going forward would keep crackers of some sort on her cart to administer medications with food. LPN1 also stated she will begin to encourage residents to drink more than a sip of water with their medications unless otherwise indicated by the doctor. 3. On 6/28/16 at 8:39 a.m., LPN1 was observed administering the drug phenytoin to a resident on the front hall. LPN1 placed the medication phenytoin in a medication cup. Upon review of the bubble pack at this time a sticker was noted on the bubble pack which read, "TAKE WITH PLENTY OF WATER." Additionally, the LPN removed 1 capsule from a bottle labeled "Dairy Aid." LPN1 placed one of the capsules in the cup with the phenytoin. Closer review of the bottle labeled "Dietary Aid" revealed manufacturer's instructions to "CHEW WITH FIRST BITE OF DIARY FOOD BEFORE MEALS." After administration of the 2 medications, LPN1 reported the resident had already eaten and therefore she did not administer the "Diary Aid" before meals. LPN1 also reported she did not encourage the resident to drink plenty of water with the phenytoin. The resident was observed taking 4 small sips of water to swallow her pills;	F 332		

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F 332	Continued From page 35 LPN1 thanked the resident, turned and walked away. According to " Health Information Guidelines " located on the Diary Aid website, failure to drink a minimum of 4-8 ounces of water when taking the drug phenytoin may cause severe constipation. During an interview with LPN1 on 6/28/16 at 9:00 a.m., she said she was not aware "Diary Aid" was not to be given on an empty stomach. 4. Medication Pass on the front hall with LPN1 revealed on 6/28/16 at 9:03 a.m. Synthroid was administered to Resident (R) 6, after the resident finished eating her breakfast. The resident was handed the medication cup and as she accepted the cup, R6 stated to LPN1, "You know, I should have had this Synthroid a long time ago, way before my breakfast. Should be around 6 a.m." LPN1 in return stated, "Yes ma'am you are correct, I am running behind and I work slower than most nurses." In accordance with the 2015 Drug Safety Information Manual, "Take SYNTHROID as a single dose, preferably on an empty stomach, one-half to one hour before breakfast. Your body's ability to absorb SYNTHROID is improved when you take it on an empty stomach." 5. R6 was administered the drug meloxicam 7.5 mg by mouth for pain. LPN1 administered the drug on 6/28/16 at 9:08 a.m. Review of the bubble pack at this time revealed a pharmacy sticker on the medication pack that read "TAKE WITH FOOD and PLENTY OF WATER." Observation of LPN1 revealed the nurse administered the meloxicam without any food and failed to offer/encourage the resident to drink more than half cup of water filled to 6 ounces. During an interview on 6/28/16 at 9:15 a.m. with	F 332		

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F 332	Continued From page 36 LPN1, she reported she did not notice the sticker and going forward would keep crackers of some sort on her cart to administer medications with food. LPN1 also stated she would begin to encourage residents to drink more than a sip of water with their medications unless otherwise indicated by the doctor. The resident did not eat breakfast for more than 30 minutes after receiving the medication. 6. On 6/29/16 during an interview with the Regional Nurse Consultant (RNC) in the conference room at 9:30 a.m., she reported education had been conducted the night before regarding proper administration of medications. Review of the policy did not outline use of the pharmacy stickers or manufacturer's guidelines.	F 332		
F 441 SS=F	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. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F441 Corrective action- Immediate in-service was conducted with all staff on contact precautions versus isolation and the use of personal protective equipment to enforce infection control procedures. Infection control line-listing will be updated and reviewed to include R3 & R9. R3 and R9 wounds were re-cultured. SDC/designee. 8/5/16 Identification of others- Audit of existing infections/cultures will be completed to determine the necessity and level of contact precautions and/or isolation. Random audit three times a week for appropriate infection control technique during resident cares. DNS/designee. Systemic Changes- Education to Infection Control nurse, Director of Nursing Services and Infection Sub-Committee on proper tracking/trending of infections and the necessary precautions for each. DNS/designee. Monitoring- Results of audit of existing infections and infection tracking/trending to be reviewed by Infection Sub-Committee for accuracy, trends and any additional education needs to be presented to QAPI each month. SDC/designee.	

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F 441	Continued From page 37 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 observations, interviews, and record review, the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for all residents, but specifically for 2 of 13 sampled and supplemental sample residents, (R3 and R9) in the facility. The failures included: I. Inadequate tracking/trending of identified infections; II. Improper use of Infection Control procedures, which included an inability to properly define the types of precautions that needed to be in use, as well as a lack of ensuring competency on the part	F 441	any additional education needs to be presented to QAPI each month. SDC/designee.	

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of their staff (both in practice and the ability to define what types of PPE - personal protective equipment - was needed); and

III. A lack of oversight of the Infection Control Program by the Director of Nursing Services (DNS).

The findings included:

1. Record review:

a. Resident (R) 3's medical record was reviewed and it revealed that R3 was initially admitted to the facility on 10/23/12. His current diagnoses included muscle weakness, chronic pain, hepatitis C, general edema, cellulitis of lower legs with methicillin resistant staphylococcus aureus (MRSA), obesity, and dyspnea (difficulty breathing). He was admitted to the hospital on 2/16/16 with hypoxia (low oxygenation levels) and pneumonia. He also had a suprapubic indwelling catheter in place.

b. According to the "Face Sheet," Resident (R) 9 was admitted to the facility on 9/3/14 with diagnoses of pain, diabetes, dermatitis, depressive disorder and venous insufficiency. Review of the infection control data provided by the facility, revealed R9 was on isolation for cellulitis on her skin. The infection control data did not list where on the skin or any additional data.

2. Observations:

a. During the initial tour of the facility, two resident rooms (R3 and R9) were noted to have large (approximately 3 feet wide and 4 feet long) white, metal boxes hanging on the outside of their room

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F 441	Continued From page 39 doors. They had spaces for gloves, gowns, face masks and hair covers. Each door also had the following four signs posted, and they read, in pertinent parts: 1) First Sign: "STOP - CONTACT PRECAUTIONS ... Visitors must report to the Nursing Station before entering. -Perform hand hygiene before entering and before leaving room. -Wear gloves when entering room or cubicle, and when touching patient's intact skin, surfaces, or articles in close proximity. -Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces. -Use patient-dedicated or single-use disposable shared equipment (BP (blood pressure) cuff, thermometers) between patients ..." There was also a warning in Spanish at the bottom of the page. 2) Second Sign: "ATTENTION - PROTECTIVE PRECAUTIONS: -Perform hand hygiene before entering and before leaving room -No persons with infections may enter -No dried or live plants or flowers -No non-peelable fresh fruits or vegetables ..." There were three boxes that could be, but were not checked: " ... Wear Mask, Wear Gloves, Wear Gown." There was also a warning in Spanish at the bottom of the page. 3) Third Sign: "Sequence for putting on Personal Protective	F 441		

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F 441	Continued From page 40 Equipment (PPE)" which had step by step instructions for donning gown, mask or respirator, goggles or face shield and gloves ... At the bottom of the sign it read ... "Use safe work practices to protect yourself and limit the spread of contamination. -Keep hands away from face -Limit surfaces touched -Change gloves when torn or heavily contaminated -Perform hand hygiene." 4) Fourth Sign: "How to safely remove Personal Protective Equipment (PPE) ..." and it gave step by step instructions for doffing (removing) gown/gloves, goggles or face shield, mask or respirator. It also read, " ... Wash hands or use an alcohol based hand sanitizer immediately after removing all PPE ... Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE." b. On 6/29/16 at 12:15 p.m., Resident (R) 5 was observed with a severe red irritation on his scrotum and perineal area and had a Supra Pubic catheter. Nurse Aide (NA) 2 and the resident agreed to allow observation of cleansing of the scrotum, perineal area and Supra Pubic catheter. The following was observed. NA2 informed the resident what care would be provided. R3 nodded in agreement and understanding. NA2 pulled back the resident's covers, placed gloves on both her hands and removed one sanitary wipe out of a container. Utilizing the same wipe, the NA triple wiped the perineal area,	F 441		

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although brown stool was evident on the wipe. The resident asked NA2 if she would put cream on his scrotal area, the NA said she would. With the same soiled gloves on, the NA opened the resident's bedside table drawer and removed a tube of barrier cream. The NA applied the cream to the resident's scrotum using her soiled gloves and replaced the tube of barrier cream back in the drawer with the soiled gloves on.

NA2 then used her right hand with the soiled glove on and placed her hand in the basket containing the wipes and removed one more wipe. The NA then proceeded to clean the supra pubic catheter. She wiped the abdominal fold on the left and the abdominal fold on the right and the insertion site of the catheter. The NA did not wipe the actual catheter tubing.

The NA then removed the soiled gloves, tossed them in the garbage can located in the resident's room where they remained as we left the room. The resident was on MRSA isolation precautions. Immediately following the resident care the NA2 reported "That's how I perform the care".

c. Resident #9 was admitted to the facility on 9/3/14 with a diagnoses of pain, diabetes, dermatitis, depressive disorder, and venous insufficiency.
During the initial tour of the facility on 6/27/16 at 8:30 a.m., with the Activity Assistant (AA), she provided information related to the two residents in one of the rooms. The Activity assistant knocked on the door and was given permission to enter. After entrance to the room, a Nurse Aide (NA) was observed as she provided care for Resident (R) 9.

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F 441	Continued From page 42 The NA had a clear plastic bag in her hand which contained items to be discarded after completion of the care. The NA walked out the room with the items and the AA began the introductions. R9 was asked about her isolation precautions per the signage on the door. The resident reported she was not on isolation precautions and neither was her roommate. R9 further reported she had been in isolation for MRSA in her urine but, it had since cleared up. The AA agreed with the resident and stated she was not on isolation although there was an isolation precaution sign on the door with instructions for staff to follow. The AA further stated isolation information was posted for nursing and she was not privileged to that information. 3. Staff Interviews: a. A brief interview with the Director of Nursing Services (DNS) took place on 6/27/16, in the presence of two surveyors, at approximately 3:30 p.m. When asked if they had any residents on isolation she stated, "No. If a resident is on isolation that means they are restricted to their room." When asked what the source of infection was for R3 and R9, the DNS initially stated they both had MRSA in their urine. She later amended that statement. b. Review of the policy and procedure presented by the DNS labeled, "EmpRres HealthCare, ICM\Regulations -9.01 Infection Control Regulations_ 5005 Published May 2015 Pages 1-17", revealed the policy and procedure provided no guidance to ensure the facility established an Infection Control Program under which it decides what procedures, such as isolation, should be	F 441		

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F 441	Continued From page 43 applied to an individual resident. During an interview with the DNS on 6/28/16 at 8:45 a.m., she reported the data in the facility's infection control manual provided little information regarding isolation therefore, the facility defers to the "Lippincott Book" for infection control information." Review of the infection control log yielded no additional clarification as to how the facility managed and prevented the spread of infection or how they identify residents who required isolation precautions. No physician's order could be found related to isolation precautions. c. During an interview with the DNS on 6/28/16 at 2:40 p.m., she reported the resident (9)was on isolation precautions for MRSA in her urine and she would provide additional data. Random observations revealed the isolation precaution sign with protective equipment remained on the resident's door throughout the survey and staff entered and left the room without any PPE. 4. Infection Control Program Record Review: a. On 6/29/16 at approximately 4:30 p.m., the DNS provided a "Mandatory Education Schedule for All Staff" that showed the required mandatory inservice training. For April, "Infection Control - Isolation TB, HB, PPE" was listed. The facility had a change of ownership in October 2015, and the DNS stated the former company that owned the facility, took all proprietary information (anything with their name on it) and would release what they had to, but that it could take 48 hours or longer. That was confirmed by the Nursing Home Administrator (NHA) as well as the Regional Nurse Consultant (RNC) - who were also in	F 441		

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F 441	Continued From page 44 attendance for that meeting. The facility was unable to provide documentation of Infection Control education - though it was scheduled for April 2016. It was in this meeting, the DNS maintained that she did not state that R3 and R9 had MRSA in their urine, but in wounds. b. During the same meeting noted above, they provided a blank form entitled "Infection Control Committee Meeting Minutes Form" but could not provide one that had been filled out, nor any other evidence they were having regular Infection Control Committee Meetings. They also provided the following blank forms: -"Monthly Infection Report By Site" -"Monthly Infection Report By Pathogen" -"Healthcare-Associated Infections Worksheet - Sites and Pathogens" -"Line Listings of Infections By Resident" (they did provide this form, by same name, in a different format, for 5/1/16 - 5/7/16, and 6/1/16 - 6/9/16) -"Resident Infection Treatmnet (sic) Tracking Report" c. Even though they reported the former owner took all proprietary information, they provided reports showing the "Total Number of Healthcare Associated Infections (HAI)" and hospital/community acquired infections for June 2015 through September 2015. They redacted all resident information except for the two residents (R3 and R9) who were specifically reviewed. 1) June 2015 --R3 was listed as having cellulitis of unknown organism for June 2015. He was also listed for	F 441		

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F 441	Continued From page 45 having hepatitis C. Negative for isolation. --R9 was listed as having cellulitis of unknown organism for June 2015. Negative for isolation. 2) July 2015 --R3 was listed as having an undocumented site of infection, but noted to be taking Levaquin. NOTE: He did have chronic Urinary Tract Infections (UTIs). Negative for isolation. --R9 was listed as having an abdominal/skin infection with MRSA. Negative for isolation. 3) August 2015 --R3 was not listed. --R9 was listed as having an abdominal/skin infection with MRSA. Negative for isolation. 4) September 2015 --R3 was listed as having cellulitis in skin and was treated with Cleocin - organism not identified. He was also listed for having Hepatitis C. Negative for isolation. --R9 was listed as having a surgical infection and abdominal/skin infection with MRSA. Negative for isolation. d. Resident Specific Documentation --The facility provided Line Listing of Infections by resident for 5/1/16 through 5/7/16 - but neither R3 nor R9 were documented as having had any infection.	F 441		

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--The facility provided Line Listing of infections by resident for 6/1/16 through 6/9/16 - but R9 was not documented as having had any infection. R3 was listed as having a UTI and cellulitis with "multiple" listed as the pathogen.

--The DNS was asked to provide culture results for both R3 and R9.

--The DNS provided a wound culture report for R9, dated 8/1/15, which read the resident had Klebsiella pneumonaie, enterococcus faecalis and MRSA present in an undisclosed wound.

--The DNS also provided a culture result for R3 dated 1/10/16, which read he had Rare Methicillin Resistant Staphylococcus Aureus - and Rare Klebsiella pneumoniae in an undisclosed wound.

e. The Staff Development Coordinator (SDC) oversaw the tracking, trending and documentation of infections. The DNS was responsible for oversight of the program, per the DNS and the RNC during a meeting on 6/29/16 with the DNS, RNC and NHA

f. The SDC used a color coded tracking form to map monthly current infections, as evidenced by the color coded maps she provided. January through April 2016 mapping forms and monthly "Line Listings" (listings by month, by resident, showing who had any infections and what type) were reviewed. The color coding was not consistent month to month. R3 and R9 were not appropriately documented month to month, and were omitted at times. Specifically, they showed the following:

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F 441	Continued From page 47 1) January 2016 --R3 was not originally listed. His cellulitis was supposed to be coded pink under skin but was not. There was a color coding system used, however it was not exactly the same each month. The colors would change, so you had to rely on the coding each month. When the copies were provided, the floor map had been changed and the copy was corrected. Investigation showed that the Health Information Manager (HIM) Director noted the error and corrected before giving to surveyor. That was confirmed by the RNC, who said it was done as a matter of catching an error. The Line Listing for January 2016, listed R3 as MRSA in his skin as of 1/13/16. --R9 was coded green as "other" and was not on the Line Listing for January 2016. 2) February 2016 --R3 was listed and coded green (for that month green represented respiratory infections). --R9 was coded green as "other" and listed as cellulitis. 3) March 2016 --R3 was not listed or coded for any type infection, nor was he on the "Line Listing." --R9 was coded pink as "skin" and listed as having had cellulitis - undisclosed location. 4) April 2016 --R3 was coded as green for "other" but on the Line Listing, it showed he had a recurrent UTI.	F 441		

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F 441	Continued From page 48 --R9 was not color coded on the floor map, but was listed on the "Line Listing" as having a skin infection - read "recurrent skin erruptions (sic) - with no pathogen." 5) Even though it was the end of June 2016, the tracking and trending for May 2016 had not been compiled and was not available for review. g. On 6/30/16 at approximately 10:15 a.m., the RNC and SDC were both interviewed together. When asked about the color coding errors on the mapping pages, the SDC stated, "I missed it. Sorry." The RNC was asked about the lack of consistency and who was responsible for overseeing the Infection Control Program. She stated it was ultimately the responsibility of the DNS to ensure the program was being managed effectively and accurately. She also acknowledged the seriousness of the omissions and miscoding.	F 441		