STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165271	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD SPECIALTY CARE	4201 FIELDCREST DRIVE SIOUX CITY, IA 51104

(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 Correction date 3/21/17 The following deficiencies result from the facility's annual health survey and investigation of 1/30 to 2/2/17. Investigation of facility-reported incident # 65514-I resulted in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to prevent the development of avoidable pressure ulcers and failed to provide care to promote healing of the	F 314		

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

POC accepted 2/27/17 SV minnows

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F 314	Continued From page 1 pressure ulcers (Resident #1, #3, #9). The sample consisted of 5 residents and the facility identified a census of 67 residents. Findings included: 1. According to the MDS (Minimum Data Set) assessment, with a reference date of 11/3/16, Resident #9 scored 6 on the BIMS (brief interview for mental status) test. A score of 6 identified the resident with a severe cognitive impairment. Resident #9 required extensive assistance with ADL's (activities of daily living) including bed mobility, transfers, personal hygiene, and toilet use. Resident #1's diagnoses included diabetes and dementia. The MDS documented Resident #9 was not at risk for developing pressure ulcers and did not have arterial or venous ulcers. The resident had a pressure reducing device for the bed. A Pressure Ulcer Healing Record dated 8/17/16 documented Resident #9 had a Stage II pressure ulcer of the right heel measuring 0.8 by 1 cm. The nurse identified the wound healed on 9/26/16. The MDS identified a Stage II pressure ulcer as a partial loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister. According to the MDS assessment, with a reference date of 1/26/17, Resident #9 Resident #9 required extensive assistance with ADL's including bed mobility, transfers, personal hygiene, and toilet use. The MDS documented Resident #9 was not at risk for developing	F 314		

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F 314	Continued From page 2 pressure ulcers and did not have venous or arterial ulcers. The MDS documented Resident #9 had an unstageable pressure ulcer due to presence of slough and/or eschar, measuring 2.7 by 3.5 cm. Resident #9 had no pressure ulcers on the prior assessment. The MDS identified slough as necrotic tissue in the process of separating from the viable portions of the body and is usually light colored, soft, moist and stringy (at times). The MDS described Eschar as a thick leathery, frequently black or brown in color comprised of necrotic dead or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound. A facsimile dated 10/21/16, indicated the staff notified the physician that Resident #9 had orders for heel lift boots to bilateral feet when in bed, off when out of bed. The fax questioned if they could have orders to apply heel boots to bilateral feet in bed, and may be worn during the day if tolerated. The physician responded and approved. The physician signed the order. The Treatment Record for December 2016 showed Resident #9 wore the heel boots to each foot in bed. The record lacked any documentation of Resident #9 wearing the heel boots during the day as tolerated. The record documented the staff assisted Resident #9 to the recliner after meals, 3 times a day. The Treatment Record for January 2017 showed Resident #9 wore the heel boots in bed until 1/9/17 and then had a new order. The record lacked any documentation of Resident #9 wearing the heel boots during the day as	F 314		

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F 314	Continued From page 3 tolerated. The record documented Resident #9 assisted to the recliner after meals 3 times a day. The Treatment Record showed Resident #9 had the heel boots to the bilateral lower extremities at all times, may remove for hygiene and transfers only, starting 1/9/17. The Care Plan, with an initial goal target date of 8/26/16, identified the resident needed assistance with bed mobility. The interventions included a pressure reducing mattress to the bed and wheelchair cushion, 5/12/15 air mattress to bed, 4/15/16 heel boots to bilateral lower extremities while in bed, 9/5/16 recliner after meals, 1/9/17 heel boots at all times, remove for hygiene and transfers. A fax dated 1/9/17 notified the physician Resident #9 had an area to the inner left heel, white hard area with fluid surrounding measuring 3 by 3.5 cm, and asked for a treatment order. A Pressure Ulcer Healing Record dated 1/9/17 documented Resident #9 had an unstageable pressure ulcer of the inner left heel measuring 3 by 3.5 cm. The record defined an unstageable ulcer as a known ulcer but not stageable due to coverage of the wound by slough and/or eschar (dead/necrotic tissue). The area measured 2.8 by 4.5 cm on 1/30/17 and described as a black, dark purple wound bed. During an observation on 1/31/17 at 1:35 p.m. Resident #9 sat in the recliner. Staff E Licensed Practical Nurse (LPN) performed the treatment to Resident #9's left heel. With the heel boot off, Resident #9's heel rested on the footrest of the recliner. The ulcer appeared purple, circular, with raised crusted edges.	F 314		

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F 314	Continued From page 4 During an interview on 2/1/17 at 9:48 a.m. Staff B Certified Nursing Assistant (CNA) stated prior to the left heel ulcer Resident #9 often sat in the recliner after meals with his/her feet elevated. She did not recall anything under his/her legs (to float his/her heels), and thought he/she wore gripper socks. Resident #9 wore the boots in bed. During an interview on 2/1/17 at 9:50 a.m. Staff C CNA stated prior to the left heel ulcer, Resident #9 wore gripper socks. She did not recall using anything under Resident #9's legs (to float his/her heels). Resident #9 wore the heel boots only in bed. During an interview on 2/1/17 at 9:53 a.m. Staff D CNA, stated they had tried a device under Resident #9's legs when in bed at first, but it didn't work, so they used the boots in bed. Staff D stated Resident #9 often sat in the recliner with the footrest elevated, and they did not put anything under his/her legs to float his/her heels that she could remember. Resident #9 currently wore the boots all the time. During an interview on 2/2/17 at 7:30 a.m. the Director of Nursing stated they could find no documentation they tried the boots during the day when out of bed or that Resident #9 could not tolerate them. She could find no documentation they implemented other measures to protect the heels, or to float the heels. 2. Resident #1 had a MDS assessment with a reference date of 1/26/17. The MDS identified Resident #1 demonstrated long and short term memory problems and severely impaired skills for	F 314		

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F 314	Continued From page 5	F 314		

daily decision making. Resident #1 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers, dressing, and toilet use. Resident #1's diagnoses included dementia. Resident #1 was at risk of developing pressure ulcers and had a pressure ulcer.

A Hospice Face to Face Encounter Attestation Form dated 10/26/16 documented Resident #1 had a non-healing stage III coccyx ulcer despite treatment. Resident #1 reliant (dependent on someone) for all ADL's.
A Braden Scale-For Predicting Pressure Sore Risk dated 1/19/17 scored Resident #1 at 14 indicating a moderate risk for developing pressure ulcers.

A Pressure Ulcer Healing Record documented Resident #1 had a pressure ulcer of the coccyx with an onset date of 1/3/16. On 1/30/17 the area measured 4 by 2 cm.

The Care Plan dated 2/25/16, identified Resident #1 required assistance with bed mobility, with a goal. Resident #1 would have no skin breakdown related to pressure with a goal target date of 2/9/17 (resident already had breakdown related to pressure). The interventions included a pressure reducing cushion to the wheelchair and bed, and Prafo boots to bilateral lower extremities at all times. The care plan lacked any kind of repositioning program (the resident required extensive assistance with bed mobility.

During an observation on 1/31/17 at 6:25 a.m. Resident #1 sat in the wheelchair. At 8:45 a.m. Resident #1 sat in the wheelchair in his/her room. Staff stated he/she had just had a whirlpool.

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F 314	Continued From page 6 Resident #1 asked several times if he/she could go to bed. Staff A Certified Nursing Assistant (CNA) and Staff B CNA transferred Resident #1 to bed. Resident #1 laid with his/her legs leaning toward the right, but staff provided no support to keep off his/her back/buttocks/coccyx area. At 10:22 a.m. Staff E, Licensed Practical Nurse (LPN) changed the dressing to Resident #1's coccyx ulcer. The open area had a red base with pink surrounding skin. The ulcer had depth. At 1:30 p.m. Resident #1 laid in bed toward the right. At 4:35 p.m. Resident #1 remained in the same position. During an observation on 2/1/17 at 6:20 a.m. Resident #1 sat in the wheelchair with his/her eyes closed. At 8:20 a.m. Resident #1 remained in the wheelchair. At 8:33 a.m. Resident #1 in bed toward the right. At 10:25 a.m. Resident #1 remained toward the right. At 11:10 a.m. staff went in Resident #1's room. At 11:20 a.m. Resident #1 sat in the wheelchair. During an interview on 2/2/17 at 7:30 a.m. the Director of Nursing stated hospice noted Resident #1's wounds were unavoidable due to terminal condition, but agreed all interventions should be implemented including at least every 2 hour repositioning. The facility policy/procedures titled Prevention of Pressure Ulcers, January 2015 Edition, identified the purpose of the policy was to relieve pressure, restore circulation and promote skin protection in the affected area. The guidelines included utilizing pressure reduction devices on bed and chair as necessary, repositioning resident routinely and positioning with pads and pillows to protect bony prominence's and maintain proper	F 314		

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F 314	Continued From page 7 alignment, using elbow and/or heel foot protectors if needed. The care plan would identify the problem, establish goals, and develop approaches. The facility policy and procedures titled General Wound and Skin Care Guidelines, January 2015 edition, documented the following general wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity. Turn/reposition every 2 hours while in bed and at least hourly when in a chair. 3. Resident #3 had a MDS with a reference date of 11/19/15. The MDS documented the resident had no impairment of cognitive function and required extensive assistance of staff for bed mobility and transfers. The resident's Braden Scale Pressure Sore Risk assessment documented the resident at mild risk for the development of pressure sores from 2/15/16 through 1/6/17. During an observation on 2/1/17, Staff E, Licensed Practical Nurse (LPN) provided a treatment to an open area on the resident's coccyx/sacrum. Observation identified the resident's mattress as a standard mattress and not pressure reducing. Staff F, LPN stated and confirmed the mattress to be a regular mattress and not pressure reducing. During an interview on 2/1/17 at 11:15 a.m. the Director of Nursing (DON) stated the area was not due to pressure, but due to the resident picking at the area. A 1/19/16 Wound Clinic Progress Note documented the resident had an open wound in the gluteal crease that measured 0.8 by 0.4 by	F 314		

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F 314	Continued From page 8 0.2 cm. which underwent excisional debridement of surrounding necrotic tissue and scar to a size of 1.4 by 0.7 by 0.2 cm. The Progress Note diagnosed the wound as a Stage III decubitus ulcer of the coccyx. The MDS defines a Stage III Decubitus (Pressure) Ulcer as full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling. On 1/28/16 Wound Clinic notes documented the coccyx wound 1.0 by 0.8 by 0.4 cm. The facility staff documented the area healed on 2/8/16. On 2/18/16 Wound Clinic notes documented the coccyx ulcer 1.0 by 1.3 by 0.2 cm. and described the area as Stage III decubitus ulcer with the fat layer exposed. Facility records lacked any further assessment of the coccyx ulcer until 5/30/16. Wound Clinic notes documented the following: On 3/15/16 the Stage III decubitus coccyx ulcer with fat layer exposed measured 1 by 0.3 by 0.1 cm. On 3/29/16 the Stage III decubitus coccyx ulcer with fat layer exposed measured 1 by 0.4 by 0.4 cm. On 4/12/16 the Stage III decubitus coccyx ulcer with fat layer exposed measured 0.4 by 0.3 by 0.2 cm. On 4/26/16 the Stage III decubitus ulcer with fat layer exposed measured 0.1 by 0.1 by 0.1 cm. On 5/10/16 the Stage III decubitus ulcer with fat layer exposed measured 0.6 by 0.3 by 0.1 cm. slightly larger. They also identified an open wound to the right upper posterior back 1.4 by 1.5 by 0.4	F 314		

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F 314	Continued From page 9 cm. which may have been a remnant from an abscess. On 4/11/16 at 3:20 p.m. staff documented in the Nurse's Notes the resident had a red area to the right back/shoulder which measured 1.2 by 1.2 cm. Wound Clinic Notes subsequently documented on 5/26/16 the Stage III decubitus of the sacrum/coccyx measured 1.2 by 0.3 by 0.2 cm. initially and 3.5 by 1.5 by 1.0 cm. after excision and debridement. The ulcer was then primarily closed. They documented the back lesion 0.8 by 0.8 by 0.2 cm. and described it now as a decubitus ulcer with breakdown of skin. Facility staff continued to document condition of the right back/shoulder lesion on a Non-Pressure Skin Condition Report. The record lacked any documentation indicating staff recognized either area as a pressure sore (decubitus ulcer) or implemented any interventions appropriate to treatment of pressure ulcers. On 5/30/16 facility staff documented on a Non-Pressure Skin Condition Report a surgical wound on the Gluteal Crease. They documented the area tender with assessment. Staff measured the area 4 by 1 cm. On 6/6/16 facility staff documented the area measured 4 by 2 cm. and noted the sutures spreading. On 6/9/16 Wound Clinic Notes documented the coccyx ulcer measured 4 by 2 by 1 cm. after the removal of the sutures. Wound Clinic staff documented another small ulcer on the left	F 314		

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F 314	Continued From page 10 buttock measuring 0.3 by 0.3 by 0.1 cm. The sutures were removed and new sutures placed to re-approximate the edges. On 6/13/16 facility staff documented the area on the gluteal crease 4 by 2 cm. and noted 5 sutures. On 6/16/16 Wound Clinic Notes stated the resident still had a lot of pain at the site of the coccyx ulcer. The sutures tended to pull through the skin causing a lot of pain with movement. They removed the stitches. The note lacked any measurements of the coccyx ulcer or any mention of the left buttock ulcer. On 6/27/16 facility staff documented the wound on the gluteal crease measured 3 by 4 by 0.1 cm. On 6/28/16 Wound Clinic Staff documented the Stage III decubitus ulcer measured 3.7 by 1.4 by 0.8 cm. with the fat layer exposed. They did no debridement at that visit. On 7/4/16 facility staff documented the area measured 4.2 by 3.2 by 0.4 cm. On 7/5/16 Wound Clinic staff documented the resident had less pain with the sutures removed but was still bothered especially when they removed the dry dressings. They measured the Stage III decubitus ulcer of the coccyx 4 by 3 by 0.3 cm. They did not debride the ulcer. On 7/11/16 facility staff documented the area measured 4 by 3 by 0.2 cm. On 9/5/16 facility staff measured the area 3.5 by 1.1 by .1 cm. From 7/12/16 to 9/6/16 Wound Clinic staff	F 314		

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F 314	Continued From page 11 documented the Stage III ulcer progressively decreased in size from 4 cm. by 3 cm. by 0.3 cm. to 3 by 1 by 0.6 cm. On 9/6/16 they also documented an open area on the right buttock 0.8 by 0.8 cm. On 9/12/16 facility staff documented the area on the gluteal crease as 3.5 by 1 by 0.1 cm. On 9/13/16, Wound Clinic staff documented the coccyx ulcer 3 by 0.5 by 0.5 cm. They noted an ulcer on the left buttocks, possibly related to tape trauma which measured 0.6 by 0.8 by 0.1 cm. The note made no mention of the open area on the right buttocks. They debrided both areas. On 9/20/16 Wound Clinic staff documented the left buttocks ulcer measured 0.8 by 0.8 by 0.1 cm. The sacral ulcer measured 3 by 1 by 0.1 cm. and noted it had developed an area of dead tissue. They measured it post debridement 3.7 by 1.7 by 0.1 cm. On 9/27/16 Wound Clinic staff documented the ulcer 4 by 2 by 0.4 cm. and noted it continued to enlarge in size. Again they debrided the ulcer which then measured 4 by 2.5 by 0.5 cm. From 10/11/16 to 1/31/17 Wound Clinic Notes documented weekly debridement of the coccyx/sacral ulcer. The size of the ulcer varied slightly from week to week. On 1/31/17 they measured the ulcer 3.2 by 2 by 0.3 cm. During an interview on 2/1/17 the DON stated they had not treated the coccyx wound as a pressure ulcer. She confirmed the resident did not have a pressure relieving device on the bed. She stated the facility had not obtained any of the Wound Clinic Progress notes until that day. They	F 314		

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F 314	Continued From page 12 had not considered the open area a pressure ulcer. The resident's Care Plan stated he/she needed assistance with repositioning related to left hemiplegia and identified a goal the resident would have no skin breakdown related to pressure. The Care Plan indicated the resident should have a pressure reducing mattress on the bed, but staff identified the mattress as standard. The Care Plan made no mention of the open area on the resident's coccyx.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD SPECIALTY CARE	4201 FIELDCREST DRIVE SIOUX CITY, IA 51104

(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 323	Continued From page 13 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interviews with staff and a resident, the facility failed to follow manufacturer's recommendations for the use of a security/safety belt with residents bathing in a whirlpool tub for 1 of 13 current residents reviewed (Resident #12). The facility reported a census of 67 residents. Findings included: Resident #12's 9/8/16 Minimum Data Set documented the resident had no impairment of cognitive or memory function. The assessment documented his/her diagnoses included dementia, anemia, anxiety disorder and osteoporosis. The assessment documented Resident #12 required the assistance of 2 with transfers and personal hygiene and required physical assistance for bathing. Nurse's Notes dated 10/21/16 at 7:05 p.m. documented staff had been removing the resident from the whirlpool tub when a roller on the tub chair malfunctioned causing the resident to be ejected from the chair to the floor of the tub. During interview on 2/1/17 at 9:25 a.m. Resident #12 stated when s/he fell from the whirlpool chair s/he thought one side of the chair fell down. The resident stated he/she did not get hurt, but at the time of the fall staff had not applied a safety belt. On 2/1/17 at 9:18 a.m. Staff D, Certified Nursing Assistant (CNA) demonstrated how the whirlpool tub and chair worked. At the foot of the tub a door	F 323		

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F 323	Continued From page 14 opened and the chair could be brought forward to the opening to position a resident in the chair. The chair then could be rolled on a track back in the tub and the door closed to fill the tub with water. She showed a safety belt but stated not all the residents used it. During interview on 2/1/17 at 9:44 a.m. the Nurse Consultant stated the facility had no policy related to use of the safety belt in the whirlpool chair. During interview on 2/1/17 at 10:28 a.m. the Director of Nursing (DON) stated the Maintenance Supervisor trained nursing staff on use of the whirlpool. She stated they only used a safety belt for residents who couldn't support themselves in the chair. During interview on 2/1/17 at 10:44 a.m. Staff I, Registered Nurse provided a copy of the MasterCare Integrity Bath, System Operation Procedures - Important Safety Instructions: Read and follow all instructions in this manual. She stated nursing staff had not seen the instructions previously because the Maintenance Supervisor kept the manual with the product warranty and maintenance procedures manual. The manual directed that a resident using the transfer system who is not secured with the security belts provided with the system as outlined in this manual is at risk of falling from the chair. The Operations Instructions: Secure the Resident instructed that after resident is transferred into the chair, secure them into the chair with the security belts and pads provided. The Upper Body Belts are attached by pushing the hole at one end of the belt over the Belt Knob and pulling the belt across the individual and attaching it to the opposite Belt Knob through the appropriate	F 323		

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F 323	Continued From page 15 hole so the belt is snug. Do this for both the lap and chest belts. As a variation you can criss cross the belts across the chest. During interview on 2/1/17 at 10:46 a.m. the Director of Nursing confirmed the product information directed staff to use the safety belt for all residents.	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic	F 328		

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F 328	Continued From page 16 abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and physician interview, the facility failed to assure a resident received oxygen per the physician orders consistent with professional standards of care for 1 of 2 residents who required oxygen therapy (Resident #15). The facility reported a census of 67 residents. Findings include: According to the MDS (Minimum Data Set)	F 328		

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F 328	Continued From page 17 assessment dated 11/10/16, Resident #15 scored 14 on the brief interview for mental status (BIMS) indicating no cognitive impairment and that s/he required the assistance of 2 with bed mobility, transfers and toilet use and the assistance of 1 with personal hygiene. The resident's Care Plan dated 6/7/16 identified Resident #15 had shortness of breath at times and wore oxygen (O2). The interventions included to administer O2 per doctor's order, obtain an O2 sat (O2 saturation) per doctor order and as necessary, monitor for signs and symptoms and/or complaints of shortness of breath or respiratory distress. A History and Physical final report dated 1/7/17 documented Resident #15's diagnoses included urinary tract infection, metabolic encephalopathy, chronic kidney disease, paroxysmal atrial fibrillation, pulmonary hypertension, diabetes, and chronic diastolic heart failure appeared compensated. A Dismissal/Interagency Instruction Sheet dated 1/11/17 documented Resident #15 discharged from the hospital to the facility. The comments included administration of O2 to keep saturations (sats) 89% or greater. A Physician's Order for Oxygen dated 1/11/17 directed that Resident #15 should receive O2 at 2 - 4 liters per minute continuously. The Nurse's Notes dated 1/11/17 at 2:00 p.m. documented Resident #15 re-admitted to the facility. Resident #15 had oxygen at 2 liters per nasal cannula with oxygen saturation (O2 sat) at 90%. At 10:07 p.m. Resident #15 wore O2	F 328		

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F 328	Continued From page 18 continuously. The Nurse's Notes dated 1/12/17 documented at 3:00 p.m. a nurse went to Resident #15's room and noted Resident #15 unresponsive, pale, and cyanotic, opening eyes to sternal rub only. Resident #15's portable O2 tank was empty and his/her O2 sat measured 64%. The nurse switched Resident #15 to the O2 concentrator and applied an O2 mask at 4 liters per nasal cannula, bringing the O2 sat up to 91%. The Physical Therapy Treatment Encounter Notes dated 1/12/17 documented Physical Therapy (PT) and Occupational Therapy (OT) staff went to Resident #15's room around 9:30 a.m. Resident #15 had supplemental 02 while laying in bed. PT and OT staff assisted the resident in sitting up and getting dressed. Resident #15 sat on the edge of the bed and PT placed a gaitbelt around the resident. Both OT and PT assisted the resident to do a sit-to-stand transfer and pivot transfer from the bed to the wheelchair with both utilized the gait belt to assist with the transfer with 1 hand of each therapist around the belt. OT staff placed a new full O2 tank in the resident's wheelchair and Resident #15 received 2 liters. Resident #15 responded to questions appropriately and reported no pain or discomfort. Resident #15 was taken to the therapy room for about 45 minutes for treatment with continued O2. Upon return to the room, Resident #15's O2 sat measured 92% at 2 liters. Resident #15 stated s/he wanted to stay up because of the need to go to the bathroom soon and it would be easier to stay in the wheelchair. PT staff placed the bedside table next to Resident #15's wheelchair with his/her call light and left the room about 10:15 a.m.	F 328		

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F 328	Continued From page 19 Interviews regarding 1/12/17 revealed: a. During an interview on 1/30/17 at 9:45 a.m. the Director Of Nursing (DON) stated Resident #15 did have an 02 concentrator in his/her room, but had the 02 going at 2 liters per the tank. She said based on the chart at 2 liters the oxygen canister would last 5 1/2 hours. She said they previously used the 02 concentrators in the rooms and 02 tanks when out of the room. At 3:00 p.m. the DON stated they had no policy regarding 02 used prior to the incident. She and the MDS coordinator stated they would have put Resident #15 back on the 02 concentrator, but could not say it was required. b. During an interview on 1/30/17 at 3:20 PM the OT stated she got a fresh new tank of 02 and took the tubing off the empty portable tank to put on the new tank. She said normally they were to put the resident back on the 02 concentrator. She did not go to the room after therapy with the resident. The PT told her the resident wanted to stay in the wheelchair because he/she would need the bathroom soon. She did not know how long the 02 tank would last. c. During an interview on 1/30/17 at 3:38 p.m. the PT stated around 9:30 a.m. they changed Resident #15's brief and got him/her dressed. They transferred him/her to a sitting position and did a stand and pivot transfer. Resident #15 used the 02 concentrator. They had an empty tank in the room, so they got a new tank and Resident #15 used 2 liters to keep 02 sats at greater than 90%. During therapy, Resident #15 had a drop in 02 sat and they bumped the 02 up to 3 liters for 5 to 10 minutes and then back to 2 liters. Resident	F 328		

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F 328	Continued From page 20 #15 had to go to the bathroom so PT left him/her on the 02 tank. PT thought they would be helping Resident #15 to the toilet and they would change him/her to the concentrator, or s/he would be going out to lunch. PT did not know how long the 02 tank would last. d. During an interview on 1/30/17 at 4:00 p.m. Staff K Licensed Practical Nurse (LPN) stated she changed Resident #15's 02 tubing at 11:30 to 12 p.m. She changed the concentrator and the nebulizer tubing. She put new tubing on the tank the day before. She didn't know how long tanks last or when they started the tank. She said they used tanks if leaving the room and concentrators when in the room. She assumed they had Resident #15 on an 02 tank for a reason. She did not switch Resident #15 to the concentrator. e. During an interview on 1/30/17 at 4:12 Staff G Registered Nurse (RN) stated she went to do an assessment on Resident #15, s/he did not respond and his/her lips were blue. She checked Resident #15's 02 saturation and it measured 64%. The 02 tank was empty and she switched to the concentrator. Staff G stated the normal routine was to use the tank for therapy or when out of the room and the 02 concentrator in the room. She said that a tank ran for 4 to 5 hours. She said tanks would run out, but usually the resident could tell them they needed a new tank. f. On 1/30/17 at 4:19 p.m. Staff H Certified Nursing Assistant (CNA) stated when she did rounds Resident #15 slept in the wheelchair. The off-going CNA said therapy got the resident after lunch and s/he had been sleeping since. The off-going CNA said nothing about the 02. Staff H stated when in their rooms residents were to be	F 328		

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F 328	Continued From page 21 on the concentrator. g. During an interview on 1/30/17 at 4:23 p.m. Staff F Licensed Practical Nurse stated she finished charting and Staff G Registered Nurse(RN) said Resident #15 had an empty 02 tank and was unresponsive. Resident #15 stayed in his/her room for lunch and meals since coming back from the hospital. Staff F stated Resident #15 had a cannula in his/her nose but didn't know if s/he used the tank or the concentrator. Staff F stated residents usually used concentrator in their room, and tank out of the room. She said they should check in 2 to 3 hours if a resident started a full tank of 02. Staff F stated she really did not know what happened. h. During an interview on 1/31/17 at 9:26 a.m. Staff C CNA stated she asked Resident #15 if s/he needed the bathroom at 11:00 a.m. and the resident said no, therapy had taken them. Staff C checked Resident #15's incontinent brief while in the chair. Resident #15 said s/he didn't sleep very well and would stay in for lunch, so she got Resident #15 a lunch tray. At 1:15 p.m. Resident #15 slept. Staff C stated the 02 tank was on the edge of green going into the white. Staff C stated when residents were in their rooms, they were supposed to be on the 02 concentrator. Staff C assumed therapy planned to come back to work with Resident #15. Staff C thought the 02 tank lasted about 3 hours. i. During an interview on 2/1/17 at 8:50 a.m., Resident #15's physician stated she did not think the period without oxygen caused a negative impact for the resident.	F 328		

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 314. This allegation does not constitute guilt but that the facility is in compliance to F 314

F 314

Interventions for residents 1, 3, and 9 have been put into place, ie pressure relieving air mattresses, heal boots, and pressure relieving cushion to wheel Chair and room chairs. Care Plans have been update.

All resident have been accessed for pressure relieving devices to prevent skin breakdown and/or to promote healing to wounds that have been admitted. Care Plans have been updated.

Nursing staff have been trained on the importance of repositioning residents at least every 2 hours to prevent skin breakdown, and to float heals when in bed to prevent pressure ulcers. Training date, 2/7/17.

Residents will be audited to assure pressure relieving devices are in place and repositioning is occurring as needed. Problems will be corrected as they are identified.

DON, Nurse Manager, and QA team will monitor for compliance

Completion Date 2/21/17

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This is my credible allegation of compliance to F 323. This allegation does not constitute guilt but that the facility is in compliance to F 323

F 323

The resident environment does remain as free from accidents as possible.

In regard to resident # 12, safety belts are now being using as recommended by the manufacture when bathing in the mastercraft tub. For those residents refusing the safety straps, the risks of not being belted into the seat of the tub has been explained and they are being care planned accordingly.

Nursing staff have been inserviced on the proper bathing procedure according to the mastercraft tub guidelines. This training was done on 2/7/17.

Charge nurses and nurse manager will monitor for compliance.

Completion Date 2/21/17

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 328. This allegation does not constitute guilt but that the facility is in compliance to F 328

F 328

Respiratory care is being provided to those residents who have physician orders for oxygen. Alarming regulators for our oxygen bottles to alert the staff that the oxygen tank is below 500 psi have been purchased for all of oxygen cylinders.

Staff have been inserviced as to how to operated these regulators and directed to change cylinders when alarm sounds. This training was done on 2/7/17

Staff have been instructed to switch persons back to the concentrator when in their rooms.

Charge nurses will monitor when giving cares ongoing.

Completion Date 2/21/17