STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 3-17-17 The following deficiencies relate to the investigation of complaint #63183 & #65826. (See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C).	F 000		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review, the facility failed to ensure residents were engaged in activities as planned for one of seven residents reviewed. (Resident #4) The facility census was 52 residents. Findings include: 1. The minimum data set (MDS) assessment dated 11/24/16, documented Resident #4 had diagnoses that included hip fracture and Alzheimer's disease and required extensive assistance with bed mobility, transfers, locomotion, dressing, eating and toilet use.	F 248		

VKK 3/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara Lund — TITLE: Administrator — (X6) DATE: 3-17-17

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 248	Continued From page 1 The care plan dated 3/23/16, directed staff to offer re-directive materials such as folding sorting, matching, coloring, rolling yarn and make materials available to him/her. Observation on 2/15/17 at 4:05 p.m., revealed Staff L, certified nurse aide, CNA wheeled the resident from the resident's room to the dining room and sat him/her at the dining room table. The resident continued to sit in the wheelchair at the same dining room table with no food/drink or activity. At 4:40 p.m., drinks were passed to resident's in the dining room. Resident #4 did not have a drink set in front of him/her. At 5:00 p.m., the resident continued to sit at the dining table. No drinks at the resident's place setting. At 5:35 p.m., the resident was observed at the same dining room table. The evening meal and drinks sat at the table and staff positioning themselves to assist at the assisted table. Review of the Policy and Procedure titled Resident Rights (not dated) directed resident right for respect. Resident's have the right to be treated with dignity and respect.	F 248		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 309		

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F 309	Continued From page 2 well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to identify, and provide timely treatment and failed to care for open wounds properly when performing perineal care in order to prevent infection (Resident #1, #7). The sample consisted of 4 residents and the facility identified a census of 52 residents. Findings include: 1. Resident #7 had a MDS (Minimum Data Set) assessment with a reference date of 1/22/17. The MDS identified the resident had diagnoses that included diabetes mellitus, renal deficiency, arthritis, dementia and peripheral venous insufficiency. The MDS identified the resident had a BIMs (Brief Interview of Mental Status) score of 15. A score of 15 indicated no problems with long or short term memory. According to the MDS, the resident required extensive assistance of 2 or	F 309		

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F 309	Continued From page 3 more staff members for bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS identified the resident as frequently incontinent of bowel and bladder. Review of the Care Plan dated 11/7/17, identified the resident had sores present on the left heel and left shin on 11/2/16. The Care Plan directed staff to apply dressing to the excoriated areas and change as needed. Review of the New Skin Area (identified an incident report) dated 1/28/17 indicated the nurse was called to the resident's room to look at the right foot/ankle area. Staff stated there are multiple blisters, open areas and weeping. The open areas to the right inner ankle measured 4.5 by 2 cm (centimeters) and the top of the right foot measured 3 by 3.5 cm. Blisters between the 1st and 2nd toe measured 1 by 0.5 cm, between the 2nd and 3rd toe, 1.5 by 1.3 cm and 4th toe 1.5 by 1.5 cm. On 1/29/17 staff added the resident had new areas of skin breakdown, a long history of skin problems, worsening circulation in legs, areas likely related to circulation. The resident had increased edema and sees the wound care nurse regularly. The physician and wound care nurse recommendations to be followed included heel boots on at all times, air mattress on bed and pressure relieving cushion in wheel chair. Review of the Medical Doctor/Nursing Communications dated 1/28/17 revealed the resident had 2 open areas; 4.5 cm by 2 cm to the right inner ankle and 3 by 2.5 cm to the top of the right foot. The resident also had 3 blisters to the right foot: 1 by 0.5 cm between the 1st and 2nd toe, 1.5 by 1.3 cm between the 2nd and 3rd toes and 1.5 by 1.5 cm between the 3rd and 4th toe.	F 309		

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F 309	Continued From page 4 Open areas cleansed and Optifoam applied. The resident denied pain to areas and the skin to the right lower extremity as red and taunt. Open areas are weeping. New orders included to have the resident seen by the wound nurse see or have an appointment in the physician's office. Review of the Medical Doctor/Nursing Communications dated 1/30/17 indicated the dressing change completed to the right leg and the resident noted to have 3 to 4 plus pitting edema to the right leg. The leg noted to have slough tissue peeling off of the leg and the leg weeping clear fluid. The right leg had ABD (large absorbent dressing) applied and wrapped with Kling wrap. The new order included to increase Zaroxolyn (diuretic) 2.5 mg from Monday, Wednesday, Friday to daily for 7 days and BMP (blood test-basic metabolic panel) in 7 days. Review of the Consultation/Clinic Referral sheets revealed the following: On 11/10/16: Leg wound 1.3 cm by 2.5 cm by 0 cm. The orders included change the left leg wound on Mondays and as needed : Clean with saline and gauze. Cover with Xeroform and ABD. Change left heel wound on Mondays and as needed: Clean with saline and gauze. Apply skin prep to periwound and cover with Aquacel AG and Optifoam. On 11/23/16: Change dressing on left heel as needed on Thursdays if unable to be seen by PT on Thursdays. Apply lotion liberally to the bottom of the feet 2 times a day. On 12/1/16: Discontinue left shin wound care (wound healed). Continue current orders on left	F 309		

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F 309	Continued From page 5 heel. On 12/15/16: Left heel discontinue dressing orders (area healed) May resume shoe wear during the day. Continue heel protector at night. Right knee cover with Xeroform and ABD dressing. Change every 3 days and as needed. Left ear cover with Xeroform cut to size and paper tape. Change every 3 days and as needed. Remove glasses as much as possible. On 12/29/16: All large wounds healed. Small scratches remain. Cover knee with Xeroform and hold on with stockinet. No elastic. Review of the Skin Grid for All Other Skin Impairments revealed the following areas identified with treatment: Right skin/knee dated 11/18/16 revealed an area 3 cm by 6.5 cm pink granulation tissue with slight bloody drainage. On 1/26/17 the area 22 cm by 17 cm red scratches scabbed area. Review of the Skin Grid for All Other Skin Impairments revealed the following areas that had resolved: Bottom/Coccyx dated 10/14/16 revealed area 10 cm by 13 cm with maceration/red. On 10/20/16 the area identified healed and intact. On 11/24/16 0.5 cm by 0.5 cm red area. On 12/1/16 2 cm by 0.25 cm scab to left side and pink on right side intact. On 12/8/16 through 1/5/17 the area identified intact. Abdomen-3 cm by 2 cm red/brown scabbed abrasion. On 1/12/17 the area resolved.	F 309		

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F 309	Continued From page 6 Left heel- 11/3/16, 2.5 by 3.2 cm serosanguineous with red wound bed. On 12/15/16 the area healed per wound care nurse. Left shin dated 11/31/16, 5 cm by 3 cm serosanguineous red wound bed. On 12/1/16, the area resolved/healed per the wound care nurse. Right inner knee/thigh measured 18 by 5 cm abrasion scabbed with red wound bed color. On 12/22/16 the area resolved. Review of the Weekly Skin Sweep form dated 1/26/17, revealed no new skin impairment identified. Review of the MAR (medication administration record) dated 1/1/17 through 1/31/17 revealed the following: a. Left ear pressure area cover with Xeroform cut to size and paper tape. Change every 3 days and as needed. b. Right knee cover with Xerofoam and abdominal pad change every 3 days and as needed to right knee every 3 days and as needed. c. Critic ointment to bilateral buttocks 2 times a day for skin irritation. Review of the TAR (treatment administration record) dated 1/1/17 through 1/31/17 revealed the following treatments: a. Cleanse wound front of right shin with saline, cleanse, apply nonstick dressing daily until healed every day for skin. b. Ensure alternating air mattress functioning every shift. c. Clearsite to affected areas as needed for skin.	F 309		

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F 309	Continued From page 7 d. Duoderm/lexical to affected areas as needed for skin. e. Hydrofilm/opsite to affected areas as needed for skin. f. Steri-strips to affected areas as needed for skin. The TAR failed to document areas identified with treatment of dressing to the buttocks or left heel. Review of the Progress Notes dated 1/31/17 at 9:43 AM revealed the resident noted to have large red, warm, swollen area to the right inner upper thigh. The area tender to touch and slightly shiny. The nurse notified the physician. On 1/31/17 at 11:44 AM, a telephone call from the physician's clinic nurse, directed the nurse to have the resident evaluated in the emergency room since it may be a clot. At 12:30 PM, the resident was transported to the hospital emergency room. Review of the Emergency Room Visit Notes dated 1/31/17 at 1:00 PM revealed the resident presented for increasing bilateral lower extremity edema with new areas of redness and firmness in the right thigh. The resident had a history of diabetes mellitus and non ambulatory. The resident reported pain in his/her feet and can't really state when it started. The resident had previously followed with wound care but hasn't been seen in several weeks. The resident had numerous small open areas on the buttocks. He/she had a large area of erythema and induration of the right thigh medial and posterior. He/she had more stasis dermatitis of lower legs/feet with weeping and sloughing of the skin. The tip of the left toe black. The Emergency Department documentation	F 309		

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F 309	Continued From page 8 dated 1/31/17 at 3:30 PM revealed the resident placed on the bed pan checking wounds to the bottom and legs. Wounds moist and bleeding on the bottom. Multiple wounds all over the bottom. Wounds to the lower legs as well. Multiple wounds and sores to the legs. The lower legs warm and wet to touch. Resident painful to touch in the buttocks area. Resident had numerous open areas on the bilateral buttocks bleeding at times. Roughly around 10 areas. Review of the Hospital Progress Note dated 2/1/17 revealed the following ulcers: a. Ulcer of heel: Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin. b. Ulcer of toe: Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin. c. Ulcer of toe: Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin. d. Pressure ulcer, buttock: Unspecified pressure ulcer stage. Review of the hospital wound measurements dated 2/1/17 revealed the following: a. Right lateral knee 0.3 by 0.3 cm b. Right knee midline 0.3 by 0.2 cm - 5 spots c. Right knee medial 0.3 by 0.4 cm - 4 spots d. Right knee patellar notch 0.7 by 0.2 cm e. Right knee proximal tibia 5.5 by 1.5 by 0.1 cm f. Right knee lateral distal 1.4 by 0.9 cm and 0.3 by 0.3 cm g. Right lateral foot 7.8 by 7 cm h. Right proximal 2nd toe 1.8 by 2.2 cm I. Right medial great toe 1.8 by 1.4 k. Plantar foot 11 by 8.4 cm l. Plantar metheads digits 2-4 2.4 by 4.8 cm m. Between 1-2 toe 3 by 2 cm n. Right calf 11.1 by 12 cm o. Left lateral mid thigh 0.8 by 0.6, 3.5, by 0.2 and	F 309		

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F 309	Continued From page 9 0.4 by 0.4 cm. p. Left lateral knee 1.1 by 1.1 cm q. Left mid knee 0.5 by 0.4 cm, 0.5 by 0.5 cm, 0.4 by 1.2 cm. r. Left knee medial/distal 1.4 by 1.7 cm s. Medial knee 0.3 by 0.2 - 9 spots t. Distal lateral 1.7 by 1.9 cm u. Proximal tibia midline 1.9 by 2.9 cm v. Left dorsal foot 11.7 by 5.9 cm w. Left dorsal 2nd toe 2.5 by 2 cm x. Left great toe distal 4.2 by 3.8 cm y. Left plantar 2nd toe 0.5 by 1.6 cm z. Left lateral mid leg 4.4 by 0.4 cm and 0.6 by 0.4 cm aa. Left heel medial 1.3 by 2 cm blister bb. Left heel lateral 1.8 by 3.2 cm black cc. Ride side proximal medial 3.5 by 3 cm dd. Right side midline 3.5 by 0.5 cm ee. Left medial 2.5 by 3.5, 0.7 by 0.5 cm and 0.3 by 0.3 cm ff. Proximal right thigh 4 by 4.5 cm gg. Proximal left thigh 7.5 by 5 cm hh. Proximal left thigh-below 0.5 by 1.5 cm ii. Medial proximal right thigh 1 by 1.4 cm During an interview with Staff D, CNA on 2/17/17 at 11:15 AM she stated she cleaned the resident during morning cares. She stated she saw both of the resident's ankles and heels areas wrapped. She placed the protective boots on the resident. Staff D stated she saw a dressing on the resident's bottom. She identified the area on the coccyx area. During an interview with Staff E, CNA on 2/17/17 at 2:05 PM, she stated had worked with the resident the same day he/she went to the hospital. Staff E stated she saw both feet wrapped and knew they had not been wrapped 1	F 309		

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F 309	Continued From page 10	F 309		

week prior to that day. She put soft blue boots on both feet. She further stated she saw red all the way up the resident's leg. She showed the nurse the red areas and the resident said he/she had been feeling hot.

During an interview with Staff G, CNA on 2/21/17 at 1:30 PM, she stated approximately 4 days prior to the resident's hospitalization, a nurse had come to the room and put a bandage on an open area on the resident's bottom. The area identified close to the crease and the open area identified an approximate size of a nickel.

During an interview with Staff H, CNA on 2/21/17 at 2:30 PM she stated she remembered seeing an area the approximate size of a nickel on the resident's bottom but unable to remember who. The nurse told her there had really been nothing they could do about it. At a later date she talked to the MDS coordinator about it and she told her she did something about the open area.

During an interview with Staff D, CNA on 2/23/17 at 1:20 PM, she stated she cleaned the resident during morning cares. She stated she saw both of the resident's ankles and heels wrapped. She placed the protective boots on the resident. She also stated she saw a dressing on the resident's bottom. She identified the area on the coccyx area.

During an interview with Staff J, LPN (Licensed Practical Nurse) on 2/21/17 at 4:30 PM she stated she did the resident's skin check on 1/26/17. When she did skin checks she looks at previous identified areas and ask the CNAs. The resident always scratched areas on his/her legs. The resident sometimes had a dressing on if the

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F 309	Continued From page 11 skin had been pink so not to break open. She did not think at that time the resident had a dressing in place. If the resident did, it would be documented on the TAR (treatment administration record). During an interview with Staff C, RN on 2/23/17 at 1:00 PM, she stated the resident had a history of open areas on his/her bottom. The areas reopen and heal. She stated she put another dressing on the resident's bottom that had been an excoriated area but could not identify the size of the excoriated area. She did not remember if she documented it or not but did state the dressing had been optifoam that had a foam to absorb drainage. She further stated she normally would document. She did not remember when she placed the dressing and thought possibly done on the weekend or could have been before. She identified the area on the left ischeal tuberosity (lower buttock) area. Staff C stated she did not know about an area on the resident's heel. During an interview with the Emergency Room Nurses on 2/21/17 at 10:30 AM, they stated the resident had both feet wrapped. The Physician removed the 4 by 4 dressing wrapped in kling from the resident's left foot. The left heel had a wound and the left great toe observed to be blackened. They also stated the physician had removed the dressing from the resident's bottom. The dressings had been like Mepilex dressing with Band-Aid area and cushion in the middle. They further stated the wound nurse measured the resident's wounds after he/she was admitted. On 2/21/17 at 3:10 PM the resident's physician was interviewed and stated had documentation from the facility that identified wounds on the right	F 309		

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F 309	Continued From page 12 ankle and foot only. He stated the resident had a history of venous stasis type ulcers in the past and had documentation of a history of wounds in 2016. The resident had cellulitis and no open area needed to cause septicemia. He also stated the resident had severe edema and diabetes mellitus and sat with his/her legs down no matter how the facility tried to elevate. He stated the cause of death had been acute hypoxia. On 3/2/17 at 12:55 PM the hospital emergency room physician was interviewed and stated the resident came to the emergency room and had Kerlix wrapped and around both his/her feet and ankles. The resident also presented with a dressing on the right side of the gluteal fold in the rectal area. The resident had heel boots on both feet. She also stated the resident had been incontinent and saturated in urine. The resident had a Stage I to stage II pressure area on the sacrum and had more than 10 open areas on the buttocks that appeared macerated from laying in urine [not pressure but from incontinency]. The physician stated the wounds on the heel had more of an appearance of pressure ulcers. The physician stated there would not be a chance of developing the wounds from the facility to the hospital. The resident also had acute renal failure and could not urinate enough in that amount of time to be saturated with urine. The physician stated she had spoke to the attending physician and the attending had not been aware of all of the resident's wounds. Review of the policy and procedures titled Skin Care and Wound Management dated 6/2015, directed staff to do the following: a. Identification of resident/patients at risk for developing pressure ulcers.	F 309		

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	165248	A. BUILDING _____ B. WING _____	C 03/03/2017

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F 309	Continued From page 13 b. Implementation of prevention strategies to minimize the potential for developing pressure ulcers and skin integrity issues. c. Weekly monitoring of resident/patient skin status. d. Daily monitoring of existing wounds. e. Application of treatment protocols based on clinical "best-practice" standards for promotion of wound healing. f. Interdisciplinary review of identified skin impairments. g. Monitoring for consistent implementation of interventions and effectiveness of interventions. Review and modification of treatment plans, as applicable. Analysis of facility pressure ulcer data for quality improvement opportunities. 2. Resident #1 had a MDS assessment with a reference date of 1/19/17. The MDS identified the resident had diagnoses including heart failure, diabetes mellitus, Parkinson's disease (neurological disease), fracture and chronic obstructive pulmonary disease (lung disease). The MDS identified the resident had a BIMs (brief interview for mental status) score of 8. A score represented the resident had moderate impairment of cognitive skills impairment. According to the MDS, the resident required extensive assistance of 2 staff members with bed mobility, transfers, personal hygiene and toilet use. The MDS identified the resident had 1 Stage III pressure ulcer present upon admission. The pressure ulcer measured 2.5 centimeters (length) by 3.2 centimeters(width). The MDS indicated the resident had a pressure relieve device on the bed and chair. The MDS identified no turning or repositioning program.	F 309		

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F 309	Continued From page 14 The care plan dated 10/6/16 directed staff to monitor the resident for skin breakdown 2 times a day with cares and twice weekly with baths. The care plan directed staff to provide pericare [cleansing of the perineal area] 2 times daily and as needed after any episode of incontinence and to provide an air mattress on the bed. Review of the Braden Scale dated 1/5/17 revealed the resident had a total score of 17. A score of 17 identified the resident at low risk for the development of developing pressure ulcers. Review of the Physician Nursing Home Note dated 1/18/17, identified the resident had a pressure ulcer on the left calcaneus [heel], approximately 3 cm (centimeter) in diameter and had a thick eschar and thus unstageable [cannot see the wound bed due to eschar covering] i.e.: eschar is a collection of dead tissue cells. . Review of the Skin Grid for All "Other" Skin Impairments dated 11/4/16 identified a pressure ulcer on the left heel. The form indicated on 2/10/17 the left heel area measured 2.5 cm by 2.5 cm area with serous drainage and granulation slough tissue. The wound had no odor present. The Care Plan identified the skin breakdown to the left heel, could be from friction/shear and on 9/22/16, initiated the resident to wear heel protectors to the right foot/ ankle at night The intervention initated on 1/26/17 directed staff to perform a dressing change to the left heel per the wound nurse/physician orders and do a skin prep to the right heel per the physician's orders. The Care Plan did not address floatation of heels to prevent the development of pressure ulcers.	F 309		

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F 309	Continued From page 15 Review of the Weekly Skin Sweep dated 2/10/17 revealed no new skin impairment identified. The TAR (Treatment/Medication Administration Record dated 1/20/17, indicated the resident is to wear pressure reducing boot to the right and left heels when in bed every day and evening shift. Observation on 2/15/17 at 5:10 PM revealed Staff K, CNA (certified nursing assistant) Staff L, CNA and Staff M, CNA provided incontinent care for the resident. The resident had been incontinent of a moderate amount of loose stool. Staff removed the incontinent brief and turned the resident on his/her left side. Observation identified 4 superficial open areas noted. One open area on the coccyx and 3 areas on the buttocks (buttocks not pressure). Staff M provided incontinent care and wiped the perineal-rectal area with a cleansing wipe and moved it directly over the open areas. Staff M did not use a clean wipe on the open areas. Staff applied a clean incontinent brief and transferred the resident to the wheelchair. Staff M did not identify the open areas to the nursing staff. On 2/16/17 at 9:25 AM, a nurse was asked to visualize the resident's open areas. Staff B, RN (Registered Nurse) and the DON (Director of Nursing) were present. The resident transferred from the wheel chair to bed. The resident turned to the left side and 4 open areas were observed and identified. The DON measured the areas as follows: a. Top of crease (coccyx) 1 cm by 1 cm with 0.5 cm by 0.3 cm area of granulation b. Right buttock lateral to coccyx: 1 cm by 1 cm c. Right buttock distal to coccyx: 1 cm by 0.5 cm d. Right buttock lower area: 0.5 cm by 0.5 cm	F 309		

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F 309	Continued From page 16 During an interview with the DON on 2/16/17 at 9:25 AM, she stated staff will let the physician know and will ask if he wants a barrier cream or a dressing applied. Note: At the time of the complaint investigation, the complaint was coded at a "J", immediate and serious jeopardy. By 2/23/17, the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "G" level. The Director of Nursing examined all residents to determine if other residents had open skin issues not identified. The Director of Nursing provided training to certified nursing assistants about proper perineal care. All nurses were provided education on physical assessment of wounds and charting, prevention strategies, reporting to physician and obtaining orders for treatment according to treatment protocols and or physician orders, implementation of new interventions, daily monitoring of existing wounds, review and modification of treatment plans, updating and following care plans. As of the 3/3/17 exit date, the facility needed to: Continue to monitor nursing staff to assure compliance with the education provided to the nursing personnel regarding skin problems and perineal care. Continue to monitor staff to ensure the policy/procedure titled Skin Care and Wound Management Is followed by staff.	F 309		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 17 DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and facility policy review, the facility failed to ensure staff provided complete incontinent care for two of four residents observed. (Resident #1 & #2) The facility census was 52 residents. Findings include: 1. The minimum data set (MDS) dated 1/19/17, documented Resident #1 had diagnoses that included heart failure, diabetes mellitus and Parkinson's disease and required extensive assistance with bed mobility, transfers and toilet use and had a urinary catheter and was frequently incontinent of bowel. The care plan dated 10/6/16, directed staff to provide pericare 2 times daily and as needed. The resident was frequently incontinent of bowel and bladder. The resident alerts staff to needs during the day and staff check every round at night. Observation on 2/15/17 at 5:10 p.m., revealed Staff K, certified nurse aide, CNA Staff L, CNA and Staff M, CNA provided incontinent care for the resident. Staff turned the resident from his/her back to the left side and checked for incontinence. The resident was incontinent of a moderate amount loose stool. Staff removed the incontinent brief and Staff M cleansed the peri	F 312		

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F 312	Continued From page 18 rectal area using a crumpled cleansing wipe and made repeated wiping motions 3 times prior to changing to a clean wipe. Staff M used the crumpled wipe and made 5 repeated wiping motions on the peri rectal area and wiped directly over 4 superficial open areas. 2. The Nursing Admission Data Collection dated 2/14/17, documented Resident #2 had diagnoses that included acute respiratory failure with hypoxia and chronic obstructive pulmonary disease and required extensive assistance with bed mobility, transfers, dressing and toilet use. The Data Collection form identified the resident had no bladder or bowel control. The initial care pan dated 2/14/17, directed staff to check for incontinence per protocol and provide briefs, depends or panty-liners when out of bed. Observation on 2/15/17 at 5:20 p.m., revealed Staff K, CNA, Staff L, CNA and Staff M, CNA provided incontinent care for the resident. Observation revealed the resident was was incontinent of urine. Staff M cleansed the residents groin area, Staff rolled the resident to the left as Staff M cleansed the residents inner buttocks and used the same wipe to cleanse the buttock. Staff failed to cleanse the entire buttocks or use clean areas of the wipe to complete cares. Policy: Review of the Policy and Procedure titled Perineal Care dated 4/13 directed staff to do the following: a. Separate the genitalia with one hand and wash with the other, using gentle downward strokes	F 312		

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F 312	Continued From page 19 from the front to the back of the perineum. b. Use a clean wash cloth/wipe and rinse thoroughly from front to back. Some perineal washes/wipes do not require a rinse. c. Pat the area dry with a bath towel. d. Apply ordered creams or ointments. Remove gloves, wash hands, and apply clean gloves if original gloves were heavily soiled. e. Cleanse, rinse and dry the rectal area, starting at the posterior wiping from front to back. Remove gloves, wash hands and apply clean gloves if original gloves were heavily soiled. f. Apply skin barrier to prevent breakdown as needed.	F 312		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 353		

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F 353	Continued From page 20 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, the facility failed to answer resident call lights in a timely manner for two of seven residents reviewed. (Resident #13 & #14) The facility census was 52 residents. Findings include: 1. The minimum data set (MDS) assessment dated 1/19/17, documented Resident #13 had diagnoses that included Parkinson's disease and malignant neoplasm of the prostate and had a BIMS (brief interview for mental status) score of	F 353		

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F 353	Continued From page 21 13, indicating intact cognition. The MDS documented the resident required limited assistance with bad mobility and toilet use and extensive assistance with transfers and personal hygiene. During interview on 2/16/17 at 3:00 p.m., the resident stated it did take more than 15 minutes for the call light to be answered and stated he/she did have accidents at times when waiting greater than 15 minutes for staff assistance. 2. The MDS assessment dated 1/30/17, documented Resident #14 had diagnoses that included a fracture of the lower leg and difficulty in walking and had a BIMS score of 10, indicating moderate cognitive impairment. The MDS assessment documented the resident required extensive assistance with bed mobility, transfers dressing, toilet use and personal hygiene. During interview on 2/15/17 at 3:25 p.m., the resident stated staff in the evening take longer than 15 minutes to answer the call light. The resident stated it did cause him/her to have wet pants. During interview on 2/16/17 at 9:10 a.m., the director of nursing stated the facility implemented a performance informant plan on 1/19/17 for call lights after complaints were received from residents and families. She stated the call lights identified on neon sign that the CNAs watch for. The call light alarms the nurse pager after 10 minutes if not answered. The nurse then communicates to the CNA by walky talky. She further stated all of the alarms identified are call lights and not safety alarm notifications. The	F 353		

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F 353	Continued From page 22 target date for resolution to the call light response time 7/18/17.	F 353		
F 497 SS=B	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on employee file review and staff interview, the facility failed to provide 12 hours of inservice's annually for 10 certified nurse aides, CNA employed greater than one year. (Staff E, Q, R, S, T, U, V, W, X & Y) The facility census was 52 residents. Findings include: 1. The employee file for Staff E, certified nurse aide, CNA had a hire date of 6/23/16 and completed 2 of 12 in-service hours. 2. The employee file for Staff Q, CNA had a hire date of 5/29/13 and completed 0 of 12 in-service hours. 3. The employee file for Staff R, CNA had a hire date of 4/2/10 and completed 0 of 12 in-service hours. 4. The employee file for Staff S, CNA had a hire date of 7/16/15 and completed 0 of 12 in-service	F 497		

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F 497	Continued From page 23 hours. 5. The employee file for Staff T, CNA had a hire date of 8/3/15 and completed 0 of 12 in-service hours. 6. The employee file for Staff U, CNA had a hire date of 7/19/13 and completed 3 of 12 in-service hours. 7. The employee file for Staff V, CNA had a hire date of 7/29/14 and completed 0 of 12 in-service hours. 8. The employee file for Staff W, CNA had a hire date of 7/15/15 and completed 2 of 12 in-service hours. 9. The employee file for Staff X, CNA had a hire date of 7/29/15 and completed 2 of 12 in-service hours. 10. The employee file for Staff Y, CNA had a hire date of 6/28/16 and completed 2 of 12 in-service hours. During interview on 2/28/17 at 12:30 p.m., the administrator stated the facility used Silver chair to provide in-services for staff.	F 497		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.

F248 It is the practice of the facility to ensure residents are engaged in activities as planned.

1. For resident #4, staff were educated by Director of Nursing (DON) on 2/16/17 to ensure that residents are engaged in activities as planned.
2. DON and Administrator conducted an audit on 3/17/17 to identify residents unable to self-direct their own activities and require staff assistance.
3. Nursing staff were educated by DON/designee on 3/17/17 regarding the need to ensure residents are engaged in activities as planned.
4. Administrator/designee will randomly observe residents at least weekly to ensure they are engaged in activities as planned. Administrator/designee will report findings to monthly Quality Assurance Performance Improvement Committee (QAPI) for three months.

Completion date: 3/17/17

F309 It is the practice of the facility to identify and provide timely treatment and to care for open wounds properly when performing perineal care in order to prevent infection.

1. Resident #7 no longer resides at the facility; no further corrective action could be implemented. For resident #1, staff were educated by DON on 2/16/17 on proper peri-care in order to prevent infection, as well as the need to ensure a licensed nurse is informed immediately of any new skin breakdown. Open areas for Resident #1 were assessed, documented, physician and family notified, and treatment implemented and plan of care updated.
2. DON and licensed nursing staff performed full head to toe assessments on all residents on 2/22/17. Any areas identified were assessed and documented; physician and family notified, treatments implemented, and care plans updated with new interventions.
3. In-service education was provided to C.N.A.'s on 2/22/17 and 2/23/17 by DON/designee regarding proper perineal care and reporting any skin breakdown to licensed nurse immediately. Education was provided to licensed nursing staff on 2/22/17 and 2/23/17 by DON/designee regarding physical assessment of wounds and documentation, prevention strategies, physician notification, and obtaining physicians' orders for treatment, implementation of new interventions, monitoring of existing wounds, review and modification of treatment plans, and updating and following care plans.
4. The clinical team will meet each weekday to review skin documentation. DON/designee will physically assess wounds weekly to verify documentation. DON/designee will conduct random weekly observations of perineal care to ensure infection control practices are maintained. DON/designee will report findings to QAPI committee for three months.

Completion date: 3/15/17

F312 It is the practice of the facility to provide complete incontinence care for incontinent residents.

1. For resident #1, staff were educated by DON about the need to provide proper incontinence care on 2/16/17. For resident #2, staff were educated by DON about the need to provide complete incontinence care using proper techniques on 2/16/17.
2. DON/designee conducted an audit on 3/17/17 to identify residents with incontinence. Interdisciplinary team reviewed care plans to ensure appropriate interventions were in place regarding incontinence care.
3. In-service education was provided to nursing staff by DON/designee on 2/22/17 and 2/23/17 on proper technique for providing incontinence care and the need to provide complete incontinence care with each incontinent episode.
4. DON/designee will observe incontinence care at least weekly to ensure complete incontinence care is provided. DON/designee will report findings to monthly QAPI committee for three months.

Completion date: 3/17/17

F353 It is the practice of the facility to answer resident call lights in a timely manner.

1. Staff were educated on 2/16/17 regarding the care needs and preferences for Residents #13 and #14.
2. An audit of residents requiring staff assistance with toileting was conducted on 3/17/17 to evaluate needs and staffing patterns by hallway.
3. In-service education was provided to all nursing staff to regarding the use of pagers to ensure call lights are answered timely. Staff patterns adjusted related to resident care needs.
4. Administrator/designee will complete random interviews of resident satisfaction regarding call light response time at least weekly. Administrator/designee will report findings to QAPI committee for three months.

Completion date: 3/17/17

F497 It is the practice of the facility to provide 12 hours of in-service's annually for certified nursing assistants.

1. The Administrator educated nurse aides regarding the requirement to complete at least 12 hours of in-service education annually.
2. Administrator conducted an audit of in-service education records on 3/17/17 to identify in-service education hours completed to date of each certified nursing assistant employed by the facility.
3. Nursing aides were educated by administrator/designee on requirement to complete 12 hours of in-service education annually.
4. Administrator/designee will complete monthly reviews of nurse aide in-service education hours to ensure compliance with the requirement. Administrator will report findings of reviews to monthly QAPI committee for three months.

Completion date: 3/17/17