STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. BUILDING _____ B. WING _____	C 07/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE PAZ HEALTH CARE CENTER	2121 WEST 19TH STREET SIOUX CITY, IA 51103

(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 7/27/17 The following deficiencies were identified during the facility's complaint survey 6/2/17 to 7/12/17. Complaints #68302-C , #68306-C, #68343-C, #68338-C, #68662-C, #68682-C & #69024-C were substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (I) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		

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

[signature] | NHA | 8/15/17

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.

POC accepted 8/18/17 KK

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, family interview and policy review the facility failed to notify family members of a fall and subsequent transfer to the emergency room the following day for diagnostic testing for possible injury for 1 of 22 residents reviewed (Resident #22). The facility identified a census of 56 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 3/1/17, Resident #22 had diagnoses that included hypertension,	F 157		

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F 157	Continued From page 2 hyperlipidemia and arthritis. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact memory and cognition. The assessment documented Resident #22 required the assistance of 2 with transfers and the assistance of 1 with toilet use. The MDS identified the resident required the use of a wheelchair. Review of the Admission Record dated 6/30/17 revealed the facility identified Resident #22's family members as Emergency contact #1 and Emergency contact #2. The facility identified Emergency contact #2 as the resident's responsible party. Review of the Health Status Note dated 6/20/17 at 4:11 PM revealed the resident reported he/she leaned forward and stretched his/her ankles while outside and reported 8 on a scale of 0-10 for pain. Staff administered pain medication per request and ice to his/her ankles and took vital signs, all within normal limits. Staff planned to continue to monitor the resident. The Health Status Note dated 6/21/17 at 12:02 AM documented the resident screamed out in pain to the right foot/ankle area and requested to go to the emergency room. The resident guarded the area, the resident's ankle had swollen and s/he yelled out at touch. Staff administered pain medication at 10:45 PM with no relief obtained and placed a call to the Nurse Practitioner (NP). At 1:24 AM the NP returned the call, gave verbal orders to give an extra dose of pain medication now to control the pain and have seen first thing in the morning to get seen and possible X-rays. On 6/21/17 at 3:57 PM, the Health Status Note recorded the resident returned from the	F 157		

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F 157	Continued From page 3 emergency room to check ankles and foot and no fracture noted. The facility failed to notify the family of the incident and emergency room visit. During an interview with the resident's family (Emergency contact #2) on 6/29/17 at 12:45 PM she stated she did not get a call from the facility. No one called either emergency contact. The resident called her and told her what had happened. Neither family member received notice about Resident #22 going to the ER either. The resident called Emergency contact #1 and told them s/he had been at the ER and contact #1 then notified him/her. The resident's family member further stated she told the facility about it and had been upset about the situation. During an interview with the Administrator on 7/10/17 at 12:15 PM she stated she expected staff to notify the family and physician of a resident change in condition. Review of the Policy and Procedure titled Clinical Change in Condition Management dated 6/2015 directed staff to verify that family/responsible party has been notified.	F 157		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that	F 242		

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F 242	Continued From page 4 are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on clinical record review, drug reference review and staff interview, the facility failed to allow residents to exercise individual preferences regarding sleeping hours and the administration of medications for 1 of 22 total residents reviewed (Resident #3). The facility identified a census of 56. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/20/17 documented Resident #3 had diagnoses that included thyroid disorder, gastroesophageal reflux (GERD) and Non-Alzheimer's dementia. The same MDS documented a Brief Interview of Mental Status score of 3 which indicated severe cognitive impairment. The resident required the assistance of two staff with bed mobility and the assistance of one staff with eating. The resident's care plan, updated 5/3/17, failed to identify a resident preference to receive routine medications between the hours of 10:00 PM-6:00 AM. The resident's Medication Administration Record for June, 2017 documented the facility scheduled staff to administer levothyroxine (a thyroid-regulating hormone) 225 micrograms (mcg) daily at 5:00 AM.	F 242		

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F 242	Continued From page 5 According to Medscape.com, levothryoxine should be taken with a full glass of water preferably 30-60 minutes before breakfast on an empty stomach. The posted dining room meal times documented breakfast: served 7:30-9:00 AM. During interview on 6/22/17 at 10:00 AM Staff H, Registered Nurse (RN) stated she works either 10 PM-6 AM or 10 PM- 10 AM. She stated that she has to start medication pass around 4:30 -5:00 AM in order to get them all passed. She stated residents have to receive levothyroxine as it is ordered to be given 1 hour before breakfast and if medication pass started any later they would be non-complaint with that directive. She stated she has been told there is a regulation that states you are not to wake up residents to pass medications or do treatments but she was not sure what could be done. If residents complain about being awakened they will adjust the time scheduled but she did not not believe anyone has complained for awhile. She also acknowledged there are some residents who are unable to complain due to cognitive or physical impairment.	F 242		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 246		

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F 246	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on clinical record review, transportation schedule review and staff and physician interview the facility failed to ensure resident rights maintained to accommodate the needs of the residents for 2 of 22 residents reviewed (Residents #8 & #16). The facility identified a census of 56 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 6/13/17, Resident #16 had diagnoses that included peripheral vascular disease, diabetes mellitus, arthritis, left side sciatica and unspecified and low back pain. According to the MDS the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognition. The MDS identified the resident required limited assistance with bed mobility, transfers, dressing and toilet use. According to the MDS the resident not assessed to have pressure ulcers The MDS identified the resident required use of pressure reducing device for chair and bed and application of dressings to their feet with/without topical medications. The care plan, updated 6/12/17, directed staff to provide pressure reduction surface in bed and wheelchair. The care plan did not identify skin impairment or wound care. During an interview with the resident's physician on 6/20/17 at 11:00 AM he stated the resident had a recent hospitalization for ulcers but had been discharged. The resident had an appointment at his office on 6/12/17 and did not	F 246		

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F 246	Continued From page 7 come to the appointment. According to the facility they told them they forgot to write down the time. During an interview with Staff Q, CNA (certified nursing assistant) on 6/28/17 at 8:30 AM she stated the facility missed the resident's appointment on 6/12/17. The appointment had been on the transfer paper from the hospital and it was not passed onto her so did not get on the schedule. On 6/20/17 the transportation van broke down and she called the physician's office. She later called the physician's office and notified them she had Resident # 16 mixed up with another resident. The resident had already discharged from the facility. Review of the Resident Appointment schedule dated 6/12/17 revealed the resident not listed for either appointment or transportation. 2. According to the MDS assessment dated 4/21/17, Resident #8 had diagnoses that included heart failure, hypertension, pneumonia, septicemia, diabetes mellitus and chronic lung disease. The MDS identified the resident had a BIMS score of 11 which indicated moderate cognitive and memory impairment. According to the MDS the resident required the assistance of 2 with bed mobility and transfers. The MDS identified the resident had range of motion impairment on both sides of the lower extremities. According to the MDS the resident had no risk of developing pressure ulcers and had no pressure ulcers since the last assessment. The care plan dated 4/11/17 directed staff to monitor/document the location, size and treatment of a skin injury and report abnormalities, failure to heal, signs/symptoms of	F 246		

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F 246	Continued From page 8 infection and maceration. The care plan also directed staff to use a pressure reduction cushion to the wheelchair and an air mattress to the bed. Staff should assist the resident with repositioning frequently throughout each shift and as needed and provide treatments per physician orders. Review of the Maintenance Log dated 6/7/17 revealed the resident's head of the bed switch was not working. On 6/14/17, staff documented the bed as repaired. Observation on 6/14/17 at 3:45 PM revealed the Resident #8 in the wheelchair in his/her room. The resident's bed rail jammed and the head of the bed control did not work. At 5:30 PM staff switched the resident's bed with another bed with a working head of bed and side rail. During an interview with the DON (Director of Nursing) on 6/14/17 at 4:50 PM she stated when equipment is broken staff fill out a form at the nursing station for maintenance. During an interview with the Maintenance Supervisor on 6/23/17 at 7:50 AM he stated he received a request on 6/7/17. He further stated he looked at the bed on 6/11/17. The bedrails worked but the head of the bed did not. He directed staff to flip the beds but it did not get done.	F 246		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes	F 273		

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F 273	Continued From page 9 specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to complete an admission Minimum Data Set (MDS) assessment for 1 of 2 residents admitted to the facility since 5/1/17 (Resident #4). The facility identified a census of 56. Findings include: 1. The e-chart Diagnosis sheet documented that Resident #4 had diagnoses that included unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, hypertension, type II diabetes mellitus and muscle weakness. The resident's care plan dated 6/13/17 documented the resident had a head injury with left side weakness, as dependent upon staff for completion of activities of daily living, withe impaired speech, unable to eat or drink anything by mouth (NPO) and with a feeding tube for all nutrition and hydration needs. The care plan documented Resident #4 entered the facility on 5/19/17.	F 273		

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F 273	Continued From page 10 Review of the resident's electronic clinical record revealed an admission MDS assessment in progress with an assessment reference date of 5/25/17 with the following assessment sections not completed: Section B which assesses the resident's speech, hearing and vision; Section G0300 which assesses the resident's balance; Section G0400 which assesses the resident's functional range of motion; Section G0600 which assesses the resident's mobility devices; Section G0900 which assess the residents functional rehabilitation potential; Section H which assesses the resident's bladder and bowel function; Section I which lists all the resident's diagnoses; Section J which assesses the resident's pain level, other health conditions, prognosis and fall history prior to and/ or after admission; Section L which assesses the resident oral/dental status; Section M which assesses the resident risk for pressure ulcers and documentation of any pressure ulcer or skin condition; Section N which assess the resident's medications; Section O which assesses the resident's special treatments, procedures and programs; Section P which assesses restraints, if any, used by the resident; Section Q which documents who participated in the the assessment and goal setting for the resident; Section V which is the care area assessment summary for development of the comprehensive resident care plan.	F 273		

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F 273	Continued From page 11 During interview on 6/14/17 at 4:25 PM, Staff A, Registered Nurse (RN), stated she is the MDS Coordinator for the facility at this time but has been assisting the nurses on duty as much as possible as they are short of nurses. She stated the Administrator is aware that MDS assessments are not being completed. During interview on 6/15/17 at 10:40 AM the Administrator stated she chose to have Staff A assist the nurses on the floor rather than having her complete MDS assessments. Corporate staff will be assisting with completion of the MDS's at this time. On 6/22/17 at 9:08 AM the Administrator stated the facility has temporarily hired an RN, who currently works in another facility as an Assistant Director of Nursing, to complete MDS assessments.	F 273		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to complete a	F 274		

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F 274	Continued From page 12 comprehensive Minimum Data Set (MDS) assessment within 14 days after determination of a significant change in resident status for 1 of 22 sampled residents (Resident #1). The facility identified a census of 56. Findings include: 1. The MDS assessment dated 2/7/17 documented Resident #1 had diagnoses that included Non-Alzheimer's dementia, malnutrition, anxiety, depression and schizophrenia. The same MDS documented Brief Interview of Mental Status score of 0 which indicated severe cognitive and memory impairment. Resident #1 exhibited no behavioral symptoms during the 7-day assessment period and s/he required assistance for completion of activities of daily living except eating. The care plan problem initiated 6/13/16 and revised on 3/14/17 identified the resident had a mood problem and behaviors of yelling out and cursing at staff and other residents. Review of the resident's Progress Notes dated 4/3 - 5/5/17 documented a significant increase in resident's verbal behaviors and some random physical behaviors. The resident entered a geriatric psychiatric unit on 5/5/17 and returned to the facility on 5/17/17. Review of the resident's electronic medical record revealed a significant change MDS in progress with and assessment reference date (ARD) of 5/24/17 showed the following sections as not completed: Section A which is resident identification information;	F 274		

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F 274	Continued From page 13 Section B which assess the resident's speech, hearing and vision; Section G which assesses the resident's physical functional status ; Section H which assesses the resident's bladder and bowel function; Section I which lists all the resident's diagnoses; Section J which assesses the resident's pain level, other health conditions, prognosis, and fall history prior to and/ or after admission; Section L which assesses the resident oral/dental status; Section M which assesses the resident risk for pressure ulcers and documentation of any pressure ulcer or skin condition; Section N which assess the resident's medications; Section O which assesses the resident's special treatments, procedures and programs; Section P which assesses restraints, if any, used by the resident. During interview on 6/14/17 at 4:25 PM, Staff A, Registered Nurse (RN), stated she is the MDS Coordinator for the facility at this time but has been assisting the nurses on duty as much as possible as they are short of nurses. She stated the Administrator is aware that MDS assessments are not being completed. During interview on 6/15/17 at 10:40 AM the Administrator stated she chose to have Staff A assist the nurses on the floor rather than having her complete MDS assessments. Corporate staff will be assisting with completion of the MDS's at this time. On 6/22/17 at 9:08 AM the Administrator stated the facility has temporarily hired an RN, who currently works in another facility as an Assistant Director of Nursing, to	F 274		

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F 274	Continued From page 14 complete MDS assessments.	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to complete quarterly review assessments at least once every 3 months for 2 of 22 residents reviewed (Residents #13 and #14). The facility identified a census of 56 residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment dated 2/23/17, Resident #13 had diagnoses that included peripheral vascular disease, hypertension, hyperlipidemia and depression. The MDS identified the resident had a BIMs (brief interview for mental status) score of 13 which indicated intact memory and cognition. According to the MDS the resident required the assistance of one with bed mobility, dressing and personal hygiene and the assistance of two with transfers and toilet use. The MDS identified the resident had no risk for developing pressure ulcers, but s/he had one pressure ulcer present on the prior assessment and two venous and arterial ulcers present. Review of the electronic record revealed the quarterly MDS assessment dated 5/22/17 as in	F 276		

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F 276	Continued From page 15 progress. 2. According to the MDS assessment dated 3/6/17 Resident #14 had diagnoses that included peripheral vascular disease, anxiety disorder, depression, psychotic disorder, Guillain-Barré syndrome (a neurological disorder), borderline personality disorder and pseudobulbar affect (a nervous system disorder). The MDS identified the resident had a BIMs score of 15 which indicated intact memory and cognition. The assessment documented Resident #14 required the assistance of one with bed mobility, transfers, dressing and toilet use. Review of the electronic record revealed the quarterly MDS dated 6/5/17 as in progress. During interview on 6/14/17 at 4:25 PM, Staff A, Registered Nurse (RN), stated she is the MDS Coordinator for the facility at this time but has been assisting the nurses on duty as much as possible as they are short of nurses. She stated the Administrator is aware that MDS assessments are not being completed. During interview on 6/15/17 at 10:40 AM the Administrator stated she chose to have Staff A assist the nurses on the floor rather than having her complete MDS assessments. Corporate staff will be assisting with completion of the MDS's at this time. On 6/22/17 at 9:08 AM the Administrator stated the facility has temporarily hired an RN, who currently works in another facility as an Assistant Director of Nursing, to complete MDS assessments.	F 276		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 16 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		

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F 279	Continued From page 17 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and policy review the facility failed to update the residents care plan with interventions to direct resident care for 4 of 22 residents reviewed (Residents #14, #16, #17,& #18) The facility identified a current census of 56 residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 6/13/17, Resident #16 had diagnoses that included peripheral vascular disease, diabetes mellitus, arthritis, left side sciatica and unspecified and low back pain. According to the MDS the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognition. The MDS	F 279		

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F 279	Continued From page 18 identified the resident required limited assistance with bed mobility, transfers, dressing and toilet use. According to the MDS the resident not assessed to have pressure ulcers The MDS identified the resident required use of pressure reducing device for chair and bed and application of dressings to their feet with/without topical medications. The resident's care plan, updated 6/12/17, directed staff to provide a pressure reduction surface in bed and wheelchair. Review of the Hospital Podiatry Consult (physician orders) dated 6/2/17 revealed the resident had the following wounds: a. An ulceration to the medial hindfoot completely granular base with no acute signs of infection such as drainage, purulence, cellulitis, ascending lymphangitis, probing, tracking or undermining. Prior to and after debridement, the ulceration measured 1.1 by 1.0 by 0.1 cm (centimeters). The area identified etiology as pressure. b. An ulceration to the plantar aspect of the 1st metatarsal head had extensive hyperkeratotic tissue prior to debridement. There was no acute signs of infection noted. Following debridement the ulceration measured 1.2 by 0.8 by 0.1 cm. The area identified etiology pressure. The full thickness ulceration located to the plantar aspect of the right 1st metatarsal head and medial hindfoot bandaged with Betadine, 4 by 4, kerlix and ace bandage. He/she to be in a post operative shoe at all times with ambulation. The dressings are to be changed daily in a similar manner and follow up with the physician in the office one week after discharge The care plan failed to identify wound care needs	F 279		

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F 279	Continued From page 19 for the resident. 2. According to the MDS assessment dated 3/25/17, Resident #17 had diagnoses that included fracture and multiple sclerosis. The MDS identified the resident had a BIMs score of 15. According to the MDS the resident required the assistance of two with bed mobility, dressing and personal hygiene. The assessment did not record the presence of any wounds but the resident required applications of ointments/medications. The resident's care plan, updated 3/15/17, directed staff to monitor resident's skin daily with cares and with showers and update the physician of any changes in resident's skin integrity as needed. The care plan also directed staff to perform weekly skin assessments per facility policy. Review of the Physician Visit document dated 5/4/17 revealed Resident #17 had a non healing surgical wound. Review of the Skin Grid for All Other Skin Impairments dated 4/26/17 revealed a lower right leg surgical wound had the following measurements: a. 4/26/17 - 1.4 cm by 1.0 cm by 0.3 cm with moderate drainage and yellow bed wound; b. 5/3/17 - 2.2 cm by 1.4 cm by 2.2 cm with a scant amount yellow drainage and yellow wound bed; c. 5/10/17 - 2.0 cm by 1.2 cm by 2.2 cm with a scant clear drainage and yellow wound bed; d. 6/1/17 - 2.3 cm by 1.5 cm with scant, clear drainage and a yellow wound bed; e. 6/14/17 - 2.2 cm by 1.1 cm wound.	F 279		

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F 279	Continued From page 20 The resident's care plan failed to identify current skin impairment or wound care. 3. According to the MDS assessment dated 4/13/17, Resident #18 had diagnoses that included anemia, heart failure, hypertension, cerebrovascular accident and depression. The MDS identified the resident had a BIMs score of 15 which indicated intact cognition. The resident displayed independence with bed mobility, transfers, dressing and supervision with toilet use. The MDS documented no behavioral symptoms during the assessment period. The resident's care plan, updated 2/1/17, directed staff to monitor actions for appropriateness and remind the resident behavior inappropriate and remove from situation as needed. The care plan also directed staff to remind the resident that throwing silverware or glasses on the floor not the proper way to handle concerns, to report to dietary staff and they will bring out new silverware or glasses if he/she would like. The care plan failed to identify any resident to resident incidents. Review of the Progress Notes dated 6/21/17 at 9:35 PM revealed staff reported Resident #18 had been cursing at his/her roommate (Resident #14) and threw a bottle of hand sanitizer at him/her. Resident #14 kept going over the the resident telling him/her to pull the curtains shut and he/she got tired of it and yelled at Resident #14 to leave him/her alone. Resident #14 got mad and dumped Resident #18's table onto the floor. Resident #8 stated he/she did not throw anything at Resident #14 and everything on the floor was from his/her table. Staff talked to the resident about not cursing at other residents to just pull call light so staff can deal with things like	F 279		

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F 279	Continued From page 21 that. Staff moved Resident #14 downstairs for the time being. 4. According to the MDS assessment dated 3/6/17 Resident #14 had diagnoses that included peripheral vascular disease, anxiety disorder, depression, psychotic disorder, Guillain-Barré syndrome (a neurological disorder), borderline personality disorder and pseudobulbar affect (a nervous system disorder). The MDS identified the resident had a BIMs score of 15 which indicated intact memory and cognition. The assessment documented Resident #14 required the assistance of one with bed mobility, transfers, dressing and toilet use. The care plan dated 3/31/17 directed staff to be reassuring and listen to concerns and to educate Resident #14 on staying out of other resident rooms. Staff should monitor resident's whereabouts when up and re-direct as needed, monitor his/her decisions and intervene for safety or inappropriateness as needed. Review of the medical record revealed no documentation of the altercation with Resident #18. The facility's Policy and Procedure titled Clinical Change in Condition Management, dated 6/15, directed staff to review care plan goals and intervention, modify as indicated. Update staff of changes.	F 279		
F 281 SS=F	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	F 281		

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F 281	Continued From page 22 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, facility policy review, review of manufacturer's guidelines and resident and staff interviews, the facility failed to administer medications at the designated times or according to physician's orders for 10 of 22 sampled residents (Residents #1, 2, 3, 4, 5, 6. 7, 8, 14 and 15). The facility reported a census of 56 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/19/17 for Resident # 5 recorded diagnoses of hypertension (high blood pressure), diabetes mellitus, cerebrovascular accident (stroke), seizure disorder, depression and chronic lung disease. The MDS recorded the resident had no impairment in short and long-term memory. The assessment documented the resident received insulin injections for 6 of the 7-day assessment period. a. Review of the Physician's Order Summary Report dated 6/2017, revealed the physician prescribed the following: aspirin 325 mg (milligrams) once a day (qd) calcitriol (calcium supplement) 0.25 mcg (micrograms) qd clopidogrel (platelet inhibitor) 75 mg qd lisinopril (for blood pressure) 20 mg qd metformin (for blood sugar control) 500 mg twice a day (BID)	F 281		

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F 281	Continued From page 23 metoprolol succinate extended release (ER) (for blood pressure) 50 mg qd nexium delayed release (DR) (for acid reflux) 40 mg qd potassium (supplement) 10 milli-equivalents (meq) qd novolog (insulin) 20 units subcutaneously (SQ) before meals novolog SQ per sliding scale before meals (if blood sugar 151- 200, give 5 units SQ) The Medication Administration Record (MAR) listed the following medications administered by Staff D, Registered Nurse (RN), on 6/14/17: aspirin 325 mg; calcitriol 0.25 mcg; clopidogrel 75 mg; lisinopril 20 mg; metformin 500 mg; metoprolol succinate ER 50 mg; nexium DR 40 mg; potassium 10 meq. Staff D documented a code of "other/see nurse's notes" on the MAR by the novolog 20 units SQ and novolog sliding scale entries. Staff D documented on the MAR, the resident's AM blood sugar reading measured 183 and no blood sugar recorded for the 11:00 a.m. entry. The medication cards sent from pharmacy had a "morning" label on the top right hand corner of the card. The label indicated these medications administered in the "morning": aspirin 325 mg; calcitriol 0.25 mcg; clopidogrel 75 mg; lisinopril 20 mg; metformin 500 mg;	F 281		

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metoprolol succinate ER 50 mg;
nexium DR 40 mg ;
potassium 10 meq.

The Medication Administration Audit report dated 6/14/17 revealed the scheduled medication times and the times staff administered the following medications:

Medication	Time scheduled	Time Administered
aspirin 325 mg	7:30 a.m.	2:25 p.m.
calcitriol 0.25 mcg	7:30 a.m.	2:25 p.m.
clopidogrel 75 mg	7:30 a.m.	2:25 p.m.
lisinopril 20 mg	7:30 a.m.	2:25 p.m.
metformin 500 mg	7:30 a.m.	2:25 p.m.
potassium 10 meq	7:30 a.m.	2:25 p.m.
metoprolol ER 50 mg	7:00 a.m.	2:25 p.m.
nexium DR 40 mg	9:00 a.m.	2:25 p.m.
novolog 20 units SQ	8:00 a.m.	3:34 p.m.
novolog SQ sliding scale	8:00 a.m.	3:34 p.m.
novolog 20 units SQ	11:00 a.m.	3:36 p.m.
novolog SQ sliding scale	11:00 a.m.	3:35 p.m.
novolog 12 units SQ	11:00 a.m.	2:05 p.m.
tresiba insulin 42 units SQ	7:30 a.m.	3:37 p.m.

The medication administration audit revealed Accuchecks scheduled at 7:30 a.m. and 12:00 p.m., but only performed at 3:38 p.m.

The Health Status Note of 6/14/17 at 12:52 p.m., revealed the resident's AM blood sugar measured 183 and no AM insulin administered. A late entry at 7:50 p.m. documented a "HI" blood sugar and staff contacted the physician.

During observation on 6/14/17 at 2:25 p.m., Staff

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F 281	Continued From page 25 D, RN, prepared medications for Resident #5. Staff D took the following medication cards labeled "morning" out of the medication cart: calcitriol 0.25 mcg, clopidogrel 75 mg, lisinopril 20 mg, metformin 500 mg, metoprolol succinate ER 50 mg, nexium DR 40 mg, and potassium 10 meq. Staff D punched each medication out of the bubble pack on the card, and placed the medication into a med cup. Staff D dispensed one aspirin 325 mg from a stock medication bottle kept in the medication cart. Staff D then administered medications to Resident #5. During an interview on 6/14/17 at 12:40 p.m., Staff D reported a number of the residents' morning medications were not administered, so she administered morning and noon medications together. Staff D reported she did not know why morning medications were not passed, but thought the previous nurse had gotten behind in work. During an interview 6/14/17 at 4:05 p.m., Resident #5 expressed concern about not receiving medications at the prescribed times. Resident #5 stated he/she never knew when he/she would get medications, and it took staff awhile to administer them. The resident reported if he/she supposed to get medications around 8 p.m., often times he/she had not received medications until 11:30 p.m. The resident reported his/her blood sugars measured low at times because s/he received too much insulin within a short period of time. During an interviews on 6/14/17 at 4:15 p.m., the Director of Nursing (DON) reported when medications administered late, staff filled out an incident report and staff notified the physician and	F 281		

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F 281	Continued From page 26 family. The DON stated she expected staff ask for help when they had gotten behind passing medications. The Administrator, during the same interview, acknowledged they had identified a problem with staff administering medications late. The Administrator stated she had set up additional staff training the week of 6/20/17 to go over policy specific information and the basics of medication pass. During an additional interview on 6/15/17, at 9:45 a.m., the Administrator stated the facility had no policy on medication pass times and the computer system set up medication administration times. During an interview 6/15/17 at 10:00 a.m., the MDS Coordinator stated she entered orders in the computer and assigned medication pass times, according to the options in the computer system. The medication timeframes included: 6:30 -11:00 a.m., 11:00 am-2 p.m., 4 - 6:30 p.m., and 7 - 11:00 p.m. The MDS Coordinator stated medications needed to be administered during the timeframes set up. If the system designated a specific time for medication pass, for example, 6 a.m., 2 p.m., or 10 p.m., then staff had one hour before or after that time to administer the medication or the medication was considered late. The facility's Medication Administration Procedure dated 1/13 instructed staff to verify and compare the pharmacy label of the drug to the MAR prior to medication administration. The principles for medication administration included the right medication, the right resident and the right time. b. Review of the Physician Order Summary	F 281		

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F 281	Continued From page 27 Report dated 5/9/17 revealed the following order: a. Accu checks 4 times a day and call doctor if less than 60 or greater than 400. Review of the MAR dated 5/1/17 through 5/31/17 revealed Accuchecks were not completed per order on 5/4 lunch, 5/14 HS, 5/20 lunch and 5/24 lunch. The following blood sugars included abnormal results: 5/1 HS-469, 5/15 HS-479, 5/20 HS-517, 5/27 AM-56, 5/28 evening-550 and 5/31 AM-55. Staff failed to notify the physician. Review of the MAR dated 6/1/17 through 6/30/17 revealed Accu check the following abnormal results: 6/3 HS-536, 6/4 lunch-435, evening-530, HS-999, 6/6 AM 434, evening-521, 6/9 HS 58, 6/16 lunch 410, 6/17 AM 564 and lunch 407. Staff failed to notify the physician. 2. The MDS assessment dated 6/12/17 for Resident # 6 documented diagnoses that included heart failure, hypertension, renal (kidney) disease, dementia, depression and chronic lung disease. The MDS revealed the resident scored 15 out of 15 on the brief interview for mental status (BIMS) test, which indicated intact memory and cognition. On a numeric rating scale of 1 to 10 the resident rated the worst pain over the last 5 days at 7. According to the MDS the resident received scheduled pain medication regimen, as needed pain medications and non-medication interventions. The resident's care plan, updated on 2/22/17, directed staff to administer medications as ordered. a. Review of the physician's order dated 6/6/17,	F 281		

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F 281	Continued From page 28 revealed the resident's physician prescribed the following medications: Albuterol-ipratropium (for breathing) 2.5 mg - 0.5 mg/3 milliliter (ml) three times a day (TID) Bumetanide (a diuretic) 1 mg (1 ½ tabs) with breakfast and lunch Calcitriol (supplement) 0.25 mcg qd Carvedilol (for heart and blood pressure) 6.25 mg BID Clopidogrel 75 mg qd Lactobacillus (for digestive problems) 1 tab TID Memantine (for dementia) 10 mg BID Omeprazole (for stomach acid) 20 mg BID Prednisone (a steroid)10 mg qd Sertraline (an antidepressant) 100 mg qd Vancomycin (an bacterial antibiotic) 250 mg four times a day (QID) at 5 am, 11 am, 5 p.m., and 11 PM. Nystatin (to treat fungus infection) 1 teaspoon (tsp.) QID Symbicort (for COPD) 2 puffs BID The MAR dated 6/14/17 listed the following AM medications administered by Staff D: Albuterol-ipratropium 2.5 mg - 0.5 mg/3 ml - AM and lunch dose Bumetanide 1 mg (1 ½ tabs) - AM and lunch dose Calcitriol 0.25 mcg Carvedilol 6.25 mg Clopidogrel 75 mg Lactobacillus 1 tab - AM and lunch dose Memantine 10 mg Omeprazole 20 mg Prednisone 10 mg Sertraline 100 mg Vancomycin 250 mg - 7 a.m. and 11:30 a.m. dose Nystatin 1 teaspoon (tsp.) Symbicort (for COPD) inhaler 2 puffs	F 281		

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F 281	Continued From page 29 Artificial tears 2 drops both eyes - AM and lunch dose Each medication card had a label which indicated medications administered in the "morning" or "noon". The following medications had a "morning" label: bumetadine 1.5 mg, carvedilol 6.25 mg, vancomycin 250 mg, calcitriol 0.25 mcg, clopidogrel 75 mg, lactobacillus 1 tab, memantine 10 mg, omeprazole 20 mg, prednisone 10 mg, and sertraline 100 mg. Additional cards had a "Noon" label for the following medication: vancomycin 250 mg, lactobacillus 1 tab and bumetadine 1 mg (1.5 tabs). During observation on 6/14/17, at 12:12 p.m., Resident #6 propelled him/herself in a wheelchair toward the nurse's station. Resident #6 yelled, "Staff C, I'd like to have my pills." The resident stated s/he had not had morning medications. Staff C said he knew and walked toward the opposite hallway of where the resident sat. During observation on 6/14/17, at 12:40 p.m., Staff D, RN administered artificial tears 2 drops to Resident #6's eyes. At 12:42 p.m., Staff D gave the resident a symbicort inhaler. The resident took 1 puff then took another puff after his/her receiving their oral pills. At 12:43 p.m., Staff D prepared medications for Resident #6. Staff D took the following medication cards out of the medication cart: carvedilol 6.25 mg, vancomycin 250 mg, bumetadine 1.5 tabs (1.5 mg), calcitriol 0.25 mcg, clopidogrel 75 mg, floranex 1 tab, memantine 10 mg, omeprazole 20 mg, prednisone 10 mg, sertraline 100 mg, and noon medications: bumetadine 1.5 tabs (1.5 mg), floranex 1 tab, and	F 281		

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F 281	Continued From page 30	F 281		

vancomycin 250 mg. Staff D punched each medication out of the bubble pack on the card, and placed the medication into a med cup. Staff D administered medications to the resident. At 12:52 p.m., Staff D administered an ipratropium/albuterol nebulizer treatment.

The Medication Administration Audit report dated 6/14/17 revealed the scheduled medication times and the times staff administered the following medications:

Medication	Time scheduled	Time Administered
Bumetanide 1 mg (1 ½ tabs)	7:30 a.m.	12:33 p.m.
Bumetanide 1 mg (1 ½ tabs)	12:00 p.m.	12:36 p.m.
Calcitriol 0.25 mcg	7:30 a.m.	12:34 p.m.
Carvedilol 6.25 mg	7:00 a.m.	12:28 p.m.
Clopidogrel 75 mg	7:30 a.m.	12:34 p.m.
Lactobacillus 1 tab	7:30 a.m.	12:34 p.m.
Lactobacillus 1 tab	12:00 p.m.	12:36 p.m.
Memantine 10 mg	7:30 a.m.	12:34 p.m.
Omeprazole 20 mg	7:30 a.m.	12:35 p.m.
Prednisone 10 mg	7:30 a.m.	12:35 p.m.
Sertraline 100 mg	7:30 a.m.	12:36 p.m.
Vancomycin 250 mg	7:00 a.m.	12:29 p.m.
Vancomycin 250 mg	11:30 a.m.	12:30 p.m.

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Nystatin 1 tsp. 7:00 a.m. 12:52 p.m.
Symbicort inhaler 2 puffs 7:30 a.m. 12:36 p.m.
Artificial tears 2 drops 7:30 a.m. 12:33 p.m.
Albuterol-ipratropium 7:30 a.m. 12:52 p.m.
2.5-0.5 mg/3ml

Review of the Web MD and Micromedex Drug Information for bumetanide and vancomycin revealed if the resident missed a dose of the medication, to skip the dose if it is almost time for the next dose and a regular dose schedule is resumed. Do not double dose the medication.

b. The resident's care plan dated 6/13/17 directed staff to administer analgesia per orders and to give analgesia 1/2 hour before treatments or care as needed. The care plan also directed staff to evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. The care plan directed to monitor/record/report to nurse any signs/symptoms of non-verbal pain: changes in breathing, mood/behavior, eyes, face or body. The care plan also directed to monitor/record/report to nurse resident complaints of pain or requests for pain treatment.

Review of the Order Summary Report dated 6/1/17 through 6/30/17 revealed the following medications ordered for pain:
a. Norco 7.5-325 mg (milligrams) (hydrocodone-acetaminophen give 1 tablet 4 times a day for moderate pain; mild pain related

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F 281	Continued From page 32 to low back pain. b. Norco tablet 7.5 mg give 1 tablet every 3 hours as needed for moderate pain; mild pain related to low back pain. c. Morphine sulfate 20 mg/ml give 0.25 ml every 1 hour as needed for shortness of breath. Observation on 6/23/17 at 12:40 PM revealed Staff C, RN passed the morning medications to the resident. He handed the resident a paper cup with pills and immediately left the resident's room. Staff C failed to watch and ensure the resident took the medications and failed to assess the resident's pain. Staff C also failed to document the medication administration in the MAR. The observation also revealed the resident had increased anxiety. During an interview with the resident on 6/23/17 at 12:40 AM he/she stated first time today he/she received any medications. Resident #6 stated s/he needed breathing medication and had pain pain all over. The surveyor reported the resident's interview with the Administrator and at 1:00 PM Staff S, RN administered a breathing treatment to the resident. During an interview with Staff C on 6/23/17 at 1:15 PM he stated the resident had medication also scheduled at noon and he planned to wait until later this afternoon to administer it. 3. The MDS assessment dated 5/3/17 for Resident # 7 recorded diagnoses that included paraplegia, neurogenic bladder and diabetes. The MDS revealed the resident scored 15 out of 15 on the brief interview for mental status (BIMS) test.	F 281		

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F 281	Continued From page 33 The care plan dated 1/17/17 instructed staff to administer the resident's medications as ordered. Review of the physician's order summary report dated 6/2017 revealed the physician prescribed aspart (Humalog) insulin 20 units SQ TID, aspart insulin per sliding scale QID based upon the resident's blood sugar and oxybutynin (for bladder spasms) 5 mg TID. The MAR dated 6/1-6/20/17, listed the following medications administered on 6/14/17 during lunch: aspart insulin 20 units SQ, aspart 4 units SQ for a blood sugar reading 156, oxybutynin 5 mg PO. During observation 6/14/17 at 2:35 p.m. Staff D prepared and administered oxybutynin 5 mg PO and Humalog 24 units SQ to Resident #7. The Medication Administration Audit report dated 6/14/17 revealed the scheduled medication times and the times staff administered the following medications: Medication Time scheduled Time Administered Aspart insulin 20 units SQ 7:30 a.m. 10:43 a.m. Aspart insulin 20 units SQ 12:00 p.m. 2:48 p.m. Aspart sliding scale 7:30 a.m. 10:43 a.m. Aspart sliding scale 12:00 p.m. 2:48 p.m. Oxybutynin 5 mg PO 12:00 p.m. 2:37 p.m. 4. The MDS assessment dated 4/21/17 for Resident # 8 documented diagnoses of heart failure, hypertension (high blood pressure),	F 281		

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F 281	Continued From page 34 pneumonia, septicemia (blood infection) and diabetes. The MDS revealed the resident had a BIMS score of 11 out of 15, indicating moderate cognitive and memory impairment. The care plan dated 4/11/17 directed staff to administer medications as ordered. a. Review of the physician's order summary report dated 6/2017 revealed the physician prescribed the following: Benzonatate (for respiratory failure) 100 mg TID Cephalexin (an antibiotic) 250 mg qd Diltiazem (for blood pressure) 30 mg every 8 hrs Gabapentin (for muscle weakness) 100 mg TID Midodrine 5 mg before meals Novolog insulin per sliding scale before meals (5 units for blood sugar 151-200) The Medication Administration Record (MAR) dated 6/1-6/30/17 listed the following medications administered at "lunch" by Staff D on 6/14/17: Benzonatate 100 mg Cephalexin 250 mg Gabapentin 100 mg Midodrine (for low blood pressure) 5 mg Novolog insulin 5 units for blood sugar 192 The MAR revealed Staff E, Licensed Practical Nurse, documented the resident not at the facility for the 8:00 a.m. dose of diltiazem 30 mg, and the next dose as scheduled at 4:00 p.m. The manufacturer drug resource revealed aspart insulin should not be used in larger or smaller amounts or for longer than recommended and a meal should be eaten within 5-10 minutes after insulin administeration. When the resident missed a dose, no extra insulin should be	F 281		

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F 281	Continued From page 35 administered to make up the missed dose. b. During observation on 6/14/17 at 1:30 p.m., Staff D prepared medications for Resident #8. Staff D took the following medication cards labeled "morning" out of the medication cart: benzonatate 100 mg, gabapentin 100 mg, and midodrine 5 mg, and dispensed the medications into a cup. Staff D dispensed cephalexin 250 mg from the medication card labeled noon, and diltiazem 30 mg from the medication card labeled 8 a.m. Staff D administered the medications to the resident. At 1:40 p.m., Staff D obtained the resident's blood sugar. The blood sugar was 192. Staff D took an open, unlabeled bottle of novolog insulin from the medication cart, and drew up 5 units of insulin. A date of 5/21 had been written on the bottle. Staff D administered the insulin to the resident. The Medication Administration Audit report dated 6/14/17 revealed the scheduled medication times and the times staff administered the following medications: Medication Time scheduled Time Administered Benzonatate 100 mg 7:30 a.m. & 12:00 p.m. 11:28 a.m. & 1:32 p.m. Cephalexin 250 mg 12:00 p.m. 1:32 p.m. Diltiazem 30 mg 8:00 a.m. 11:27 a.m. Gabapentin 100 mg 12:00 p.m. 1:32 p.m. Midodrine 5 mg 11:00 a.m. 1:27 p.m. Novolog insulin 5 units 8:00 a.m. & 11:00 a.m. 11:28 a.m. & 1:43 p.m. (per sliding scale for blood sugar 151-200)	F 281		

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F 281	Continued From page 36 c. Review of the Order Listing Report dated 5/19/17 revealed orders for continuous oxygen at 2 L (liters) per nasal cannula. Observation on 6/14/17 at 3:45 PM revealed the resident sat in the wheelchair in his/her room. Oxygen on at 5 L per nasal cannula. At 3:50 PM family entered the room and lowered the oxygen to 2 L. Observation on 6/21/17 at 5:15 PM revealed Staff D, RN completed pressure wound treatment. The resident lay in bed and oxygen tubing on the floor and s/he had no oxygen administered. On 6/22/17 at 2:35 PM the resident sat in the recliner with no oxygen administered. During an interview with the DON on 6/22/17 at 3:10 PM she identified the resident had an order for oxygen continuously and the oxygen had not been discontinued. She place the oxygen on at 2 L per nasal cannula. 5. The MDS assessment dated 2/7/17 documented Resident #1 had diagnoses that included dementia, malnutrition, depression, anxiety and schizophrenia. The same MDS documented a BIMS score of 0 which indicate severe cognitive and memory impairment and required the assistance of two staff for completion of activities of daily living (ADL's). The care plan problem dated 6/13/16 identified the resident uses psychotropic medications related to the diagnoses of depression, schizoaffective disorder bipolar type and behavior management and directed staff administer medications as ordered.	F 281		

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F 281	Continued From page 37 The resident re-admitted to the facility on 5/17/17 after inpatient geriatric psychiatric treatment. The Physician Transfer Order Report dated 5/17/17 for Resident #1 directed staff to administer Vitamin D3 (vitamin supplement used in the treatment of depression) 50,000 units (u) every morning. Review of the Progress Notes revealed entries completed 6/3, 6/6, 6/7, 6/10, 6/11/17 by Staff B, certified medication assistant (CMA) that documented she gave Vitamin D3 5,000 u as ordered. A physician facsimile dated 6/6/17 documented staff requested clarification of the Vitamin D3 dosage because the staff thought Vitamin D3 available in 400 u or 1,000 u tablets. The physician replied the Vitamin D3 does come in 50,000 u doses and again wrote and order for cholecalciferol (Vitamin D3) 50,000 u daily. An unidentified staff member noted the order on 6/7/17. A Non-Covered Medication Notification from the pharmacy revealed the facility would accept financial responsibility for this medication on 6/8/17. Review of the medication blister pack which contained the Vitamin D3 tablets revealed it had been filled by the pharmacy on 6/8/17. A Progress Notes entry completed by Staff A, RN, on 6/13/17 documented the resident had not been receiving the Vitamin D3 50,000 u as ordered on 5/17/17 and clarification of dosage request would be sent to the physician. A physician facsimile dated 6/13/17 again requested clarification of the Vitamin D3 dosage. During interview on 6/14/17 at 2:35 PM, Staff A	F 281		

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F 281	Continued From page 38 stated she passed medications on 6/6/17 and noted the resident did not have a Vitamin D3 card so she sent the clarification to the physician as the facility only had 400 u and 1,000 u stock tablets. She thought the 50,000 u dose seemed high. She stated she did not know which staff had been administering to this resident. Observation of the medication blister pack at 3:00 PM revealed 4 tablets administered from the card which would indicate the correct dosage administered starting 6/11/17. During interview on 6/14/17 at 5:20 PM Staff B stated she administered five 1,000 u tablets to the residents on the days she passed medications because she had checked the chart and thought the order read 5,000 u and the 50,000 u dose may have been a typographical error. 6. The MDS assessment dated 5/5/17 documented Resident #2 had the diagnosis of diabetes mellitus. The same MDS documented a BIMS score of 14 which indicates intact cognition and also documented the resident received daily insulin injections. The care plan problem updated 5/12/17 identified the resident had the potential for altered nutrition related to the diabetes mellitus and directed staff to administer medications daily and monitor for signs and symptoms of adverse reactions. a. The Order Summary Report signed 5/16/17 directed staff administer insulin Detemir solution 15 u SQ 2 times a day. The June, 2017 MAR directs staff to administer the Detemir at 7:00 AM and 20:00 (8:00 PM).	F 281		

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CASA DE PAZ HEALTH CARE CENTER	2121 WEST 19TH STREET SIOUX CITY, IA 51103

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F 281	Continued From page 39 Review of the June, 2017 documentation of Detemir administration revealed the following: 6/1 - 7:00 AM dose administered at 12:02 PM 6/5 - 7:00 AM dose not administered 6/13 - 7:00 AM dose administered at 9:06 AM 6/15 - 8:00 PM dose administered at 23:02 (11:02 PM) 6/1/6 - 7:00 AM dose administered at 8:52 AM 6/18 - 8:00 PM dose administered at 23:20 (11:20 PM) 6/19 - 7:00 AM dose administered at 10:19 AM 6/20 - 7:00 AM dose administered at 8:39 AM 6/21 - 7:00 AM dose administered at 9:20 AM 6/23 - 7:00 AM dose administered at 8:35 AM 6/24 - 7:00 AM dose administered at 10:58 AM b. The Order Summary Report signed 5/16/17 directed staff to administer insulin Aspart solution SQ per sliding scale (based on the resident's blood sugar reading) before meals and at bedtime using the following guidelines: If blood sugar is 111-150 - 2 u, 151-200 - 4 u, 201-250 - 6 u, 251-300 - 8 u, 301-350 - 12 u, 251-400 - 16 u, 401 or > administer 20 u and call the physician. Review of the June, 2017 MAR for Insulin Aspart revealed the following: 6/2 - 7:00 AM insulin for blood sugar reading of 163 administered at 10:58 AM and the 4:00 PM insulin for blood sugar reading of 183 administered at 6:37 PM 6/3 - 11:00 AM insulin for a blood sugar reading of 118 administered at 12:12 PM and the 4:00 PM insulin for a blood sugar reading of 138 administered at 5:10 PM 6/6 - 4:00 PM insulin for a blood sugar reading of 142 administered at 5:55 PM 6/7- No blood sugar done or insulin administered	F 281		

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F 281	Continued From page 40 at 7:00 AM. The 8:00 PM scheduled insulin for a blood sugar reading of 122 administered at 12:31 AM on 6/8 6/10 - 4:00 PM insulin for a blood sugar reading of 137 administered at 6:50 PM and at 8:00 PM insulin for a blood sugar reading of 138 administered at 8:34 PM both by Staff C 6/11 - 11:00 AM insulin for a blood sugar reading of 124 administered at 12:53 PM 6/13 - 7:00 AM insulin for a blood sugar reading of 122 administered at 9:05 AM 6/15 - No blood sugar result for 4:00 PM and 8:00 PM documented and that no insulin was required 6/16 - 7:00 AM insulin for a blood sugar reading of 184 not administered until 8:51 AM and 11:00 AM scheduled insulin for a blood sugar reading of 204 administered at 12:23 PM and 4:00 PM insulin for a blood sugar reading of 156 administered 5:26 PM 6/17 - 11:00 AM insulin for a blood sugar reading of 136 administered at 12:41 PM 6/18 - 8:00 PM insulin for a blood sugar reading of 177 administered at 11:18 PM 6/19 - 7:00 AM insulin for a blood sugar reading of 113 administered at 10:18 AM 11:00 AM insulin for a blood sugar reading of 120 administered at 2:06 PM and the 8:00 PM insulin for a blood sugar reading of 177 administered at 11:09 PM 6/21 - 4:00 PM No blood sugar recorded. The time stamp documented at 8:53 PM by Staff D and also that Staff D administered insulin for a blood sugar reading of 143 at 8:50 PM 6/22 - 11:00 AM insulin for a blood sugar reading of 124 administered at 1:21 PM During interview on 6/21/17 at 10:10 AM the DON stated sliding scale insulin dosages cannot be charted until a blood glucose reading is	F 281		

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F 281	Continued From page 41 documented on the electronic MAR. Therefore, the time of the insulin administration is the time the blood glucose level was completed. Sliding scale insulin dosage is based on blood sugar readings before meals, so many of the dose of insulin were administered based on a blood glucose done after the resident has eaten. The manufacturer drug resource revealed Aspart insulin not used in larger or smaller amounts or for longer than recommended, and a meal eaten within 5-10 minutes after the insulin administered. When the resident missed a dose, no extra insulin administered to make up the missed dose. The posted dining room meal times are breakfast:7:30-9:00 AM, lunch 11:00 AM-12:30 PM and supper from 5:30-6:30 PM. 7. The MDS assessment dated 4/20/17 documented the pertinent diagnosis of diabetes mellitus for Resident #3. The same MDS documented the resident received insulin injections 7 of 7 days of the assessment period. The care plan problem dated 11/22/15 and revised on 10/26/16 identified the resident has a potential for alteration in nutrition related to the diagnosis of diabetes mellitus and directed staff perform blood glucose checks as ordered by the physician with the goal for the resident to has no signs and symptoms of high or low blood sugars through 8/10/17. The resident re-admitted to the facility from the hospital on 6/6/17. The After Visit Summary dated 6/6/17 directed staff to administer insulin Aspart 8 u plus the following sliding scale protocol 3 times daily before meals: if blood sugar is 111-150-2 u,	F 281		

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F 281	Continued From page 42 151-200 4 u, 201-250 6 u, 251-300 8 u, 301-350 12 u, 251-400 16 u, 401 or > administer 20 u and call the physician. The June, 2017 MAR directed staff administer the sliding scale amount only before meals. A new order had not been entered on the MAR to include the 8 u 3 times a daily before meals as ordered upon return the facility on 6/6/17. Review of the location of administration report for June, 2017 MAR for Resident #3 revealed the following: 6/6 - 5:00 PM dose for a blood sugar reading of 228 administered at 9:26 PM 6/7 - 7:30 AM dose for a blood sugar reading of 295 administered at 11:53 AM and 12 Noon dose for a blood sugar reading of 295 administered at 1:22 PM 6/9 - 5:00 PM dose for a blood sugar reading of 295 administered at 8:17 PM 6/10 - 12 noon dose for a blood sugar reading of 386 not administered until 2:08 PM and 5:00 PM dose for a blood sugar reading of 227 not administered until 8:49 PM 6/13 - 5:00 PM dose for a blood sugar reading of 158 administered at 8:55 PM 6/14 - 7:30 AM dose for a blood sugar reading of 174 administered at 11:26 AM, the 12 noon dose for a blood sugar reading of 16 administered at 2:58 PM 6/15 - 5:00 PM dose for a blood sugar reading of 258 administered at 10:30 PM 8. The electronic clinical record listed diagnoses of unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, diabetes mellitus and hypertension for Resident #4. The partially completed admission Minimum Data Set (MDS) documented the resident's	F 281		

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F 281	Continued From page 43 weight as 257 pounds and did not document the resident's height. The assessment documented the resident required a feeding tube and that s/he received 51% or > of total calories and 501 cubic centimeters (cc) or greater of fluid per day via the feeding tube. The care plan problem dated 6/2/17 and revised on 6/13/17 identified the resident has impaired speech, has a feeding tube and is unable to take anything by mouth (NPO). Observation of medication administration for Resident #7 on 6/21/17 at 11:35 AM revealed Staff C prepared the following medications for administration through the resident's feeding tube: potassium chloride 10% solution (a supplement) - 15cc colace 50 mg/5 cc solution (stool softener) - 10cc hydralazine (to relax blood vessels) - 50 mg folic acid 1 mg (a supplement) amlodipine (for blood pressure) 10 mg metoprolol (to reduce the heart's workload) 100 mg Staff D crushed the 4 tablet medications and added water to them and administered them and the liquid medications during administration of the resident's tube feeding. Review of the MAR revealed the resident has orders for loratadine 10 mg as well as thiamine 100 mg scheduled for administration at that time. Observation revealed Staff D failed to administer these 2 medications but signed them off as administered on the electronic MAR at this time. During interview at 11:55 AM Staff D confirmed he administered only the 6 medications observed	F 281		

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F 281	Continued From page 44 and had not administered any more since the observation. 9. According to the MDS assessment dated 3/6/17, Resident #14 had diagnoses that included peripheral vascular disease, anxiety disorder, depression, psychotic disorder, Gillian-Barre syndrome, borderline personality disorder and pseudobulbar affect. The MDS identified the resident had a BIMs score of 15 which indicated intact cognition. According to the MDS the resident required limited assistance with bed mobility, dressing and toilet use. The care plan dated 3/31/17 directed staff to apply ice or heat to affected areas as needed and to monitor for effectiveness of pain medications and update the physician of any unrelieved or uncontrolled pain as needed. Review of the Physician orders dated 5/19/17 revealed the order for methyl topical analgesic 5% patch on am and night, may leave on for only 8 hours to right shoulder or upper right arm 2 times a day for right arm pain. On 10:00 AM to 6:00 PM and 9:30 PM to 5:30 AM. Review of the MAR dated 6/1/17 through 6/30/17 revealed the following orders not administered as ordered. a. Methyl topical analgesic 5% patch on AM and night for 8 hours not administered 6/10/17 and 6/15/17 AM dose. b. Miralax powder 17 gram 1 times daily not administered 6/10/17. c. ferrousul 28 mg daily not administered 6/10/17. d. Fluticasone propionate 50 mcg 2 sprays in each nostril daily not administered 6/4/17 or 6/10/17.	F 281		

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F 281	Continued From page 45 e. Gabapentin 800 mg 3 times a day not administered 6/10/17 at lunch. f. Tramadol 50 mg 100 mg 3 times a day not administered 6/10/17 at lunch. g. Refresh tears 1 drop in both eyes 4 times a day not administered 6/4/17 or 6/10/17 in AM or lunch. h. Pain rated a 10 on a scale of 0 to 10 on 6/10/17 at 2:00 PM. Review of the Progress Notes dated 6/15/17 at 1:48 PM revealed methyl topical analgesic 5% patch on AM and night not available. Observation of 6/15/17 at 2:00 PM revealed medication patch located on the resident's right shoulder. During an interview with the resident on 6/15/17 at 2:00 PM he/she stated thought she had removed the medication patch this morning due to burning. He/she further stated no longer burning. During an interview with Staff I, CMA on 6/15/17 at 2:50 AM she stated they had contacted the pharmacy about the patches and not received at this time. She also stated the resident normally takes the patch off and brings it to staff but Staff I told him/her to keep it on today. She further stated the resident likes the patch on all the time and would have behaviors they could not control. 10. According to the MDS assessment dated 4/3/17 Resident #15 had diagnoses that included diabetes mellitus, anemia, neurogenic bladder, hyponatremia and depression. The MDS identified the resident had a BIMs score f 13 which indicated intact cognition. According to the	F 281		

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F 281	Continued From page 46 MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident required insulin 7 days of the 7 day assessment period. The care plan dated 4/10/17 directed staff to administer medications daily and monitor for side effects. The care plan also directed staff to monitor for signs/symptoms of hyper/hypoglycemia and update physician as needed. Review of the facsimile dated 5/9/17 revealed the resident receiving levemir (insulin) 14 units 2 times a day. The physicians order included Accucheck 2 times a day and call if less than 50 or greater than 300. Review of the facsimile dated 5/23/17 revealed the order for blood sugar checks 3 times a day and parameters to call if less than 58 or greater than 350. Review of the TAR dated 5/1/17 through 531/17 revealed Accuchecks completed 2 times a day 5/10/17 through 5/18/17 prior to resident hospitalization. Staff did not document completing Accuchecks following the order 5/23/17. Review of the TAR dated 6/1/17 through 6/30/17 revealed Accuchecks not completed as ordered.	F 281		
F 309 SS=G	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	F 309		

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F 309	Continued From page 47 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (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, staff interview and review of the policy and procedures, the facility failed to assure timely assessment and intervention for residents with adverse changes of condition for 3 of 22 residents reviewed (Resident #3, #15, #17). The facility identified a census of 56 residents.	F 309		

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F 309	Continued From page 48 Findings include: 1. Resident #3 had a Minimum Data Set (MDS) assessment with a reference date of 4/20/17. The MDS identified the resident had diagnoses that included anemia (low blood count), gastroesophageal reflux disease (GERD), seizure disorder, diabetes mellitus and Alzheimer's disease. The same MDS documented a Brief Interview of Mental Status score of 3. A score of 3 represented a severe cognitive impairment. The MDS indicated the resident required extensive assistance with bed mobility, transfers, dressing and personal hygiene. The MDS identified the resident as incontinent of bowel and bladder. The Care Plan identified a problem on 11/22/15. The resident had seizure activity and dependent upon staff for completion of activities of daily living skills. and identified the resident had seizure activity and dependent upon staff for completion of activities of daily living. The Progress Notes entry competed by Staff C, registered nurse (RN), on 5/13/17 at 3:46 p.m. documented the resident had 3 episodes of dark liquid emesis. Staff C documented the nurse notified the physician and received direction to give the resident clear liquids if not vomiting and if vomiting continued to send the resident to the emergency room. The Progress Notes entry completed by Staff C on 5/13/17 at 4:30 p.m. documented the resident had another "huge" emesis of very dark fluid. The entry contained no assessment of the resident.	F 309		

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F 309	Continued From page 49 The Progress Notes entry completed by Staff H, RN, on 5/13/17 at 9:15 p.m. documented the resident's medications held due to vomiting earlier in the shift. The resident's bowel tracking record documented the resident had a large loose/diarrhea stool on 5/13/17 at 9:59 PM The Progress Notes entry completed by Staff H on 5/14/17 at 5:02 AM documented the resident is pale in color, warm to touch and has increased confusion and weakness. The resident's temperature recorded at 101.4 degrees, pulse 90, blood pressure 140/40 and blood sugar 430. The resident's abdomen was firm and distended with bowel sounds sluggish and the resident complained of pain in the abdomen. Staff H notified the physician and received an order to send the resident to the emergency room by non-emergent ambulance. The resident left the facility at 5:40 AM. The After Visit Summary dated 5/22/17 documented the diagnoses of severe sepsis (a life-threatening condition that arises when the body's response to infection causes injury to it's own tissue and organs) due to pneumonia and urinary tract infection (UTI) and an ileus (lack of movement in the intestines that can lead to a build-up and potential blockage). The resident returned to the facility on 5/22/17. During interview on 6/20/17 at 2:35 PM Staff C stated he did not know why he did not send the resident to the hospital after he had the order to send the resident if vomiting continued. He stated he believed he assessed the resident but acknowledged he did not document it. Staff C	F 309		

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F 309	Continued From page 50 stated the resident had a history of gastrointestinal bleeding. During interview on 6/22/17 at 9:40 AM Staff H stated she did not know that the resident had vomited after Staff C had obtained the order to send the resident to the hospital if vomiting occurred. She did hold the resident's medications because she knew that she had vomited the day before she came on duty. Staff C told her the resident had vomited several times but did not assess the resident until right before she sent the resident to the hospital as the certified nursing assistants (CNA's) did not report anything unusual with the resident. Staff H stated she looked in on the resident while passing early morning medications and noted the s/he did not appear to be his/her usual self. The facility's Clinical Change of Condition Management policy dated 6/2015 directed the following: Overview: The Interdisciplinary team strives to identify and manage all resident/patients that are experiencing a change of condition. Daily observation and communication is important in identifying changes in a resident/patient that requires further investigation. Daily observation includes but is not limited to changes in: participation in daily routines physical assessment (i.e. cardiovascular, respiratory, mental status, neurological) behavior mobility comfort level response to medications	F 309		

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F 309	Continued From page 51 Clinical care management includes routine assessment, evaluation, response to changes in clinical condition and communication with resident/patients and/or families/responsible parties. Procedure: 1. Assess the resident/patient clinical status when a change in condition is identified. This may include but is not limited to: vital signs lung sounds pulse oximetry (blood oxygen level) bowel sounds skin color, turgor, temperature pain 2. Review the resident/patient medical record including but not limited to: primary diagnosis and medical history lab work medication changes changes in nutritional status advanced directives allergies 4. contact the physician and provide clinical data and information about the resident/patient condition. Document notification and physician response in the resident/patient medical record. Initiate any new physician orders. 5. Document on the Change of Condition Data Collection Tool. 6. Document resident/patient condition and location on the 24 hour report.	F 309		

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F 309	Continued From page 52 The Clinical Programs Manual Documentation policy dated 6/2015 directed the following: 1. Document all information on the Change of Condition Data Collection Tool unless otherwise indicated. 2. Complete evaluation of the resident/patient change of condition. Evaluation of conditions may include, but are not limited to: Abdominal pain, discomfort, distension to assess abdominal palpation, bowel sounds, quantity and description of vomit/diarrhea, hemocult if possible blood. The Progress Notes entry competed by Staff G, RN, on 6/1/17 at 21:19 (9:19 PM) documented the resident vomited up all medications but had no other emesis this shift. The clinical record contained no assessment of the resident by Staff G regarding the episode of vomiting. The Progress Notes entry completed by Staff dated 6/2/17 at 13:55 (1:55 PM) documented the resident had an extra-large dark coffee-ground emesis and a large soft dark stool at 4:30 AM. The resident's temperature was 99.2 degrees, pulse 96, respirations 28 and blood pressure 148/80 and the resident felt cool and sweaty and blood glucose measured 435. Staff E notified the physician and sent the resident to the hospital at 5:35 AM. the Progress Notes entry dated 6/2/17 at 8:30 PM documented the resident admitted to the intensive care unit (ICU) with the diagnosis of gastrointestinal bleeding. The resident returned to the facility on 6/6/17. The Progress Notes entry completed by Staff O, licensed practical nurse(LPN) from a temporary	F 309		

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F 309	Continued From page 53 staffing agency, on 6/12/17 at 12:56 PM documented the resident assessed and noted to have bowel sounds present in all 4 abdominal quadrants and no abdominal distension. The Progress Notes entry dated completed by Staff P, RN from a temporary staffing agency, on 6/15/17 at 8:41 AM documented the night nurse reported to her the resident had a coffee-ground emesis (indicative of gastrointestinal bleeding). Staff P held the resident's morning dose of aspirin 81 milligram (mg). Staff P assessed the resident and found the resident's heart rate elevated at 108, and the resident complained of tenderness with abdominal palpation. The physician ordered the resident to be seen in the emergency room. The Progress Notes entry completed by Staff G on 6/15/17 at 5:52 PM documented the resident readmitted to the facility for hospice care for the diagnosis of gastrointestinal bleeding. During an interview on 6/24/17 at 6:40 PM Staff O (licensed practical nurse-agency) stated the resident had the coffee-ground emesis right before her shift ended on 6/15/17, but not sure what time it would have been. Staff O stated she went to the resident's room and Staff D, registered nurse, was already there so she left the facility. She did not chart anything on the resident because it was time for her to go, but reported it to Staff P (registered nurse-agency). Contact with facility staff on 6/24/17 at 7:00 PM documented Staff D on vacation and not able to be reached at this time. Review of the resident's clinical record revealed no documented assessment by Staff D or Staff P on 6/15/17 prior to transfer to the hospital.	F 309		

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F 309	Continued From page 54 2. Resident #17 had a MDS with a reference date of 3/25/17. The MDS identified the resident had diagnoses that included a fracture and multiple sclerosis (neurological disorder). The MDS identified the resident had a BIMs score of 15. A score of 15 represented no cognition impairment. According to the MDS, the resident required extensive assistance with bed mobility, dressing and personal hygiene and total dependence with transfers and toilet use. According to the MDS, the resident had no wounds but required the application of ointments and medications. The Care plan dated 1/10/17 directed staff to monitor residents skin daily with cares and with showers and update physician of any changes in residents skin integrity as needed. The care plan also directed staff to perform weekly skin assessments per facility policy. Review of the Physician Visit document dated 5/4/17 identified the resident had a non- healing surgical wound. Review of the Skin Grid for All Other Skin Impairments dated 4/26/17 revealed a lower right leg surgical wound had the following measurements: a. 4/26/17 - 1.4 cm by 1.0 cm by 0.3 cm had moderate drainage and yellow bed wound. b. 5/3/17 - 2.2 cm by 1.4 cm by 2.2 cm scant amount yellow drainage and yellow wound bed c. 5/10/17 - 2.0 cm by 1.2 cm by 2.2 cm scant clear drainage and yellow wound bed. d. 6/1/17 - 2.3 cm by 1.5 cm scant clear drainage with yellow wound bed. e. 6/14/17 - 2.2 cm by 1.1 cm wound.	F 309		

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F 309	Continued From page 55 The facility failed to assess the wound on a weekly basis. Review of the Physician Orders dated 7/10/17 revealed the following orders: a. iodoform packing change daily for wound care. b. redress right ankle 2 times a day, remove idoform, prefer 1/8 inch - 1/4 inch gently pack wound, 4 by 4's, wrap with Kerlix and ace wrap until wound clinic seen. c. right lower leg use Santyl (debriding agent) ointment wrap with Kling daily. Review of the TAR dated 5/1/17 through 5/31/17 revealed the following orders not documented administered: a. iodoform packing change daily for wound care: 5/20, 5/24, 5/2, and 5/30/17. b. mupirocin ointment 2% to left ankle ulcer topically daily, cover with Mepilex and wrap with ace wrap: 5/20, 5/24, 5/2, and 5/30/17. c. remove idoform, gently pack wound, 4 by 4's, wrap with Kerlix and ace wrap to right ankle 2 times a day: 5/13-AM, 5/20-AM & PM, 5/23-PM, 5/24-AM & PM 5/25-AM, 5/26-AM & PM and 5/27-5/29/17 PM. Review of the TAR dated 6/1/17 through 6/30/17 revealed the following orders: a. Mupirocin Ointment 2% to left ankle ulcer topical 1 time a day for left ankle wound cover with Mepilex and wrap with ace wrap. The treatment not documented completed on: 6/3, 6/6, 6, 6/9-6/13, 6/16, 6/17, 619 or 6/20/17. 4. Resident #15 had a MDS (minimum data set) dated 4/3/17 Resident #15 had diagnoses that included diabetes mellitus, anemia, neurogenic bladder, hyponatremia and depression. The MDS	F 309		

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F 309	Continued From page 56 identified the resident had a BIMs score of 13. The score of 13 represented no cognitive impairments. According to the MDS, the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The MDS identified the resident had surgical wounds present and required surgical wound care and application of ointments and dressings to the feet. The Care Plan dated 5/16/17, directed staff to administer treatments per physician and/or wound clinic orders. Review of the Braden Scale dated 4/21/17 revealed the resident at low risk for the development of pressure ulcers. Review of the Hospital Visit Summary dated 5/22/17 revealed the resident admit on 5/16/17 for ulcer of the left foot incision and drainage and removal of external fixator on 5/18/17 and osteomyelitis. Orders include: a. right foot wound care 2 times a day: remove old dressing. Clean with 10 ml (milliliters) normal saline. Pat dry with sterile 4 by 4 gauze. Apply mupirocin (bactroban) 2 % ointment. Place a non-adherent dressing. b. left post thigh every other day and as needed if dressing loosens or becomes soiled: 1) cleanse area with normal saline and pat dry. 2) cover the area with Mepilex foam with border. c. Vancomycin HCL (antibiotic) 1000 mg and sodium chloride 1500 mg IV (intravenous) daily Review of the Physician Verbal Orders dated 5/23/17 revealed the order to cleanse the left and right foot wounds with normal saline, apply bactroban 2% ointment, cover with non-adherent dressings and wrap with king and ace wraps daily	F 309		

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F 309	Continued From page 57 and as needed. The Hospital facsimile dated 6/15/17 revealed the order to leave dressings intact and call office if need dressing changes. Left heel-leave dressing intact and OK to change right heel dressing. Review of the Order Summary Report dated 7/10/17 revealed the order for Vancomycin HCL solution reconstituted use 1 gram intravenously daily for infection and meropenem solution reconstituted 1 gram intravenously every 12 hours for wounds. Review of the Telephone Orders dated 4/11/17 revealed the following orders: a. Left heel (lower leg) apply Betadine soaked 4 by 4's, ABD, Kerlix and ace wrap up to the knee daily. b. Right heel ulcer apply Betadine , cover with 4 by 4's, ABD, Kerlix and ace wrap up to knee daily. Review of the Physicians Order dated 5/28/17 revealed the order for Santyl to open wounds, sorbart to left heel and cover with nuprilix, change daily and as needed. Apply Betadine to the right 5th toe and deep dressing on with ace wraps. Review of the Skin Grid for All Other Skin Impairments revealed the following wound measurements: a. identified 5/22/17 5th toe right foot: 5/14/17- 1 cm by 1 cm; 6/14/17- 1 cm by 1 cm. b. diabetic ulcer night great toe: 5/3/17- 0.8 cm by 0.3 cm scabbed ; 5/14/17- 0.6 cm 0.3 cm scabbed. c. lateral right foot open crater; 5/22/17- 5 cm by 5 cm depth 0.5 cm. 6/14/17-5 cm by 5 cm depth 0.5 cm.	F 309		

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F 309	Continued From page 58 d. left lateral distal leg above ankle 5/22/17-1.8 cm by 0.8 cm,5/30/17-1.8 by 0.8 cm, 6/14/17 2.0 by 0.9 cm scabbed. c. left medial foot at great toe base debridement site: 5/22/17- 5.2 by 2.2 by 0.1 cm, 5/30/17-4.5 cm by 2.8 cm by 1 cm , 6/14/17- 3 cm by 3 cm. d. left Achilles tendon posterior heel 5/30/17- 11 cm by 4 cm, 6/14/17- 11 cm by 4 cm. e. left lateral foot: 5/22/17- 2.4 by 0.9 cm by 0.3 cm, 5/30/17- 2.4 by 0.8 cm by 0.2 cm, 6/14/17- 2.0 cm by 0.6 cm. f. right Achilles: 5/3/17- 1.0 cm by 1.0 cm, 5/30/17- 5 cm by 2 cm, 6/14/17- 4 cm by 2 cm. g. left foot bottom- 5/3/17, 12 by 11 cm by 0.2 cm, 5/21/17- 14 cm by 11 cm, 5/30/17- 15 cm by 12 cm, 6/14/17- not measured and wound covered entire bottom of foot with granulation present. Order to not remove dressings from 5/6/17 through 5/18/17. Review of the TAR dated 5/1/17 through 5/31/17 identified the following orders not documented as completed: a. right ulcer apply Betadine soaked 4 by 4. Cover with Kerlix. Apply 4 inch ace to foot and 6 inch to leg up to knee daily: 5/4 & 5/5/17. b. left lower leg Betadine soaked 4 by 4's, ABD, Kerlix, ace wrap to knee daily. 4 inch ace to foot and 6 inch ace to leg up to knee: 5/4 & 5/5/17. c. Wound care left post thigh every other day and as needed: cleanse area with normal saline and pat dry. Cover area with Mepilex foam with border: 5/24 through 5/31/17. d. Mupirocin ointment 2%. Apply to affected area topically 2 times a day: 6:00 AM- 5/23 through 5/31/17 and 2:00 PM- 5/24, 5/26 and 5/31/17. d. Rooke boots to both feet at all times every shift: 6:00 AM 5/29/17 and 5/31/17, 2:00 PM 5/26/17, 10:00 PM 5/23, 5/25, 5/27 and 5/30/17.	F 309		

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F 309	Continued From page 59 Review of the TAR dated 6/1/17 through 6/30/17 revealed the following orders not documented completed: a. left & right heel: Santyl to open wounds. Sorbact to left heel. Cover with nuprilix daily and as needed. Wrap with Kling and cover with ace wrap: 6/1, 6/3 and 6/9/17. b. right foot, 5th digit apply Betadine to toe daily: 6/1, 6/3, 6/9 and 6/17/17. c. left posterior thigh cleanse with normal saline and pat dry, cover area with Mepilex foam with border every other day and as needed: 6/6, 6/10, 6/12, 6/16/17. d. Mupirocin ointment 2%. Apply to affected area topical 2 times a day: 6:00 AM-6/1, 6/3 and 6/6/17. 10:00 PM- 6/1/17. to left heel. e. Continue to change right heel dressing at facility. Cleanse, apply Santyl, sorbect mesh, cover with nonadhesive Mepilex, wrap with Kling and ace wrap daily and as needed: 6/16 and 6/17/17. Review of the Progress Notes dated 5/31/17 at 3:28 PM revealed the resident returned per facility van from the physician office with a reminder to change the foot dressings every day as his/her wound desiccating (drying and or separation of a skin lesion).	F 309		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR 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	F 312		

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F 312	Continued From page 60 by: Based on clinical record reviews, observations and resident and staff interviews, the facility failed to assure all residents receive necessary services to maintain grooming, oral care and personal hygiene for 4 of 22 residents sampled (Residents #3, 4, 6 and 13). The facility identified a census of 56. Findings include: 1. The electronic clinical record listed diagnoses of unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, diabetes mellitus and hypertension for Resident #4. The resident had no completed admission MDS (minimum data set) assessment. The care plan problem dated 6/13/17 identified the resident newly admitted to the facility and s/he had a head injury with left side weakness, is dependent upon staff to complete ADL's and has a feeding tube. The care plan directed staff to transfer the resident with an EZ stand lift and 2 assistants but did not address any resident personal care or bathing preference. Observation on 6/21/17 at 10:00 AM revealed the resident lay in bed watching TV. The resident shook the surveyor's hand upon introduction. Observation revealed the resident with very long jagged fingernails with debris under them and a hospital band on his/her left wrist dated 6/18/17 as well as a pink hospital band on the right wrist. The resident had unkempt hair and mustache and their beard needed to be trimmed. The resident's oral cavity appeared dry and their teeth had crust on them in the front.	F 312		

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F 312	Continued From page 61 Observation on 6/22/17 at 4:05 PM revealed the resident seated in a recliner. The resident's fingernails and toenails remained long and jagged and debris under the fingernails. The resident's toenails extended over the end of their toes with large peeling calluses on each great toe. The resident still wore the hospital bands on each wrist. The resident turned on his/her call light and Staff M, CNA, entered the room. Staff M stated the resident had a shower earlier today and asked the resident if it felt good. The resident's oral cavity appeared dry and teeth had dried secretions on them. The resident said "yes" when asked if s/he had natural teeth. Review of the bathing record for Resident #3 from 5/19/17 (date of facility admission) through 6/19/17 revealed the resident received a bath on 5/22, 5/29, 6/5 and 6/12. 2a. The MDS assessment dated 4/20/17 documented Resident #3 had diagnoses that included Alzheimer's disease, seizure disorder, depression and Non-Alzheimer's dementia. The same MDS documented a Brief Interview of Mental Status score of 3 which indicates severe memory and cognitive impairment. The resident required the assistance of 2 staff with dressing, hygiene, bathing and toilet use. The care plan problem dated 8/25/16 identified the resident as dependent upon staff for completion of activities of daily living (ADL's) and directed to assist the resident with dressing, grooming and personal hygiene daily, assist with oral hygiene twice daily and identified the resident has dentures but will refuse to let staff remove them, monitor resident jewelry choice to ensure proper fit to avoid injury or compromise. Another	F 312		

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F 312	Continued From page 62 care plan problem identified the resident will "play" in bowel movements and at times, would put his/her hands in the mouth and directed staff to monitor fingernails for rough edges and alert nurse if nails need to be cut or filed to avoid scratching self. Observation on 6/16/17 at 11:00 AM revealed the resident seated in an adapted wheelchair in the front lounge area. The resident sat with their eyes closed and mouth gaped open. Resident #3 had dried crust on their lips and upper teeth. Resident #3 wore a hospital band on the left wrist and had a 2 x 2 gauze sponge taped to the inner side of the same wrist. The hospital band indicated a date of 6/15/17. At 11:10 AM, the resident awoke and watched TV. Resident #3 had a ring on the right ring finger that is very soiled and crusted. The resident reached out for the surveyor's hand and observation revealed his/her hand had an odor, with long and jagged fingernails with debris under the nails and polish that is worn off. The resident's hair appeared greasy. Observation on 6/16/17 at 2:25 PM revealed the resident lay in bed with eyes closed and their mouth open. The resident had a dry oral cavity with teeth and lips coated with dried secretions. The resident's fingernails remained long, jagged and with debris under the nails, especially on the right hand. The ring on the right hand remained dirty and crusted. The resident still wore the hospital band and had 2 x 2 gauze dressing taped to the inner left wrist. Observation on 6/20/17 at 10:45 AM revealed the resident seated in a wheelchair in the front lounge. The resident's hair appeared greasy and	F 312		

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F 312	Continued From page 63 their fingernails remained long, jagged and soiled. The resident's ring on the right hand remained soiled and crusted and s/he had an odor to his/her hands. The hospital band dated 6/15/17 still on the left wrist. The resident's oral cavity looked dry with crusted secretions on their teeth and resident's lips were dry During interview on 6/23/17 at 9:40 AM Staff J, certified nursing assistant (CNA) stated she is the facility's bath aide but she often gets pulled to assist with care on the floor and had recently been on vacation. She reviewed the bathing record for Resident #3 from the computer and verified the resident received only 1 bath (on 6/8/17) in the period of 6/5 - 6/19/17. 2b. Observation on 6/23/17 at 9:50 AM revealed Staff L, CNA and Staff R, CNA provided incontinent care for Resident #3. Staff rolled the resident to his/her left side, revealing incontinence of urine. Staff cleansed the resident's groin area and turned him/her to the left side and removed the incontinent brief. Staff cleansed the peri-rectal area and then cleansed the rectal area. Staff failed to cleanse the right or left buttocks and applied ointment to excoriated areas on the right and left buttock. Staff then applied a new brief . Observation on 6/23/17 from 10:00 AM through 3:40 PM revealed Resident #3 remained in his/her wheelchair in the dining room and front television area. During an interview with Staff L, CNA on 3/23/17 at 2:00 PM she stated they had not provided incontinent care for the resident and did not know if the afternoon shift would lay him/her down in before supper.	F 312		

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F 312	Continued From page 64 Review of the Policy and Procedure titled Bowel and Bladder Continence Management dated 4/13 directed staff to do the following: a. Separate the labia with 1 hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. b. Use a clean wash cloth/wipe and rinse thoroughly from front to back c. Pat the area dry with a bath towel. d. Position the resident to expose the anal area. e. Clean rinse and dry the anal area, starting at the posterior vaginal opening and wiping from front to back. 3. According to the MDS assessment dated 2/23/17, Resident #13 had diagnoses that included peripheral vascular disease, hypertension, hyperlipidemia and depression. The MDS identified the resident had a BIMs score of 13 which indicated intact cognition. The resident required the assistance of one staff with bed mobility, bathing and dressing and the assistance of 2 staff with transfers and toilet use. According to the MDS the resident had 1 healed pressure ulcer and 2 venous and arterial ulcer present. The care plan dated 2/28/17 directed staff to monitor residents skin daily with cares and with showers and update the medical doctor of any changes in residents skin integrity. Review of the documentation titled Bathing dated 5/31/17 through 6/23/17 revealed staff bathed the resident as follows: a. Week 1 - 6/7/17 b. Week 2 - 6/16/17 c. Week 3 - 6/21/17 and 6/23/17	F 312		

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F 312	Continued From page 65 During an interview on 6/23/17 at 1:50 PM, Resident #13 stated most of the time he/she gets a bath 1 times a week. Sometimes he/she will get a bath 2 times a week and is very lucky then. 4. According to the MDS assessment dated 6/12/17 Resident #6 had diagnoses that included coronary artery disease, heart failure, renal insufficiency, dementia, anxiety disorder, depression and chronic obstructive pulmonary disease. The MDS identified the resident had a BIMs score of 15 which indicated intact cognition. According to the MDS the resident required assistance with bed mobility, transfers, walking, dressing, toilet use personal hygiene and bathing. The care plan dated 6/13/17 directed staff to assist with shower/shampoo per resident's preference as scheduled. Review of the Bathing Task Record dated 6/5/17 through 6/15/17 revealed bathing completed on 6/8/17 only.	F 312		
F 314 SS=K	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	F 314		

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F 314	Continued From page 66 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and review of the policy and procedures, the facility failed to assure all residents with pressure ulcers receive appropriate care and services to promote healing, prevention of infection and prevent new ulcers from developing for 5 of 5 residents reviewed. Due to lack of services for the identification, assessment, identification, prevention of wound development and interventions to promote healing, this placed an immediate jeopardy situation for residents at risk and residents with pressure ulcers (Residents #7, #8, #11, #13 and 16). The facility identified a census of 56 residents. Findings include: 1. Resident #7 had a Minimum Data Set (MDS) assessment with a reference date of 5/3/17. The MDS identified the resident had diagnoses that included viral hepatitis (liver disorder), paraplegia (loss of motor and sensory sensation of lower extremities), diabetes mellitus (metabolic disorder causing abnormal blood sugar levels), chronic obstructive pulmonary disease (lung disease) and peripheral vascular disease (condition of narrowing vessels of the lower extremities). The same MDS documented a Brief Interview of Mental Status (BIMS) score of 15. A score of 15 represented no cognitive problems. The MDS indicated the resident depended upon staff for transfers, used a wheelchair for mobility, required	F 314		

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F 314	Continued From page 67 extensive assistance of two staff members for bed mobility, dressing, toileting and personal hygiene. The MDS indicated the resident had a colostomy (surgical opening in abdomen into colon for collection of stool into a sealed bag) and an indwelling catheter (tube into bladder to drain urine into a bag). The MDS identified the resident had 3 unstageable pressure ulcers present on admission. The admission MDS dated 12/20/16 documented the resident had an admission date of 12/14/16 with 3 Stage III pressure ulcers and the largest 1 measured 6 cm x 6 cm x 2.4 cm. The Care Plan problem initiated 1/16/17 and revised on 4/5/17 identified the resident had ulcers on his/her ischial tuberosities (lower buttocks), coccyx and buttock that were present on admission. The care plan further identified the areas are long standing ulcers that are unresolved due to the resident's non-compliance with treatments and refusal to lay down or reposition side to side. The care plan directed the resident only be up for 1 hour at a time, to follow facility protocol for treatment of injury, administer treatments per direction of the physician, follow-up with the wound clinic per schedule, monitor resident's skin condition daily with care and treatments and update the physician of any changes in resident's skin integrity, complete weekly skin assessments per facility policy and to monitor/document location, size and treatment of skin injury and report abnormalities such as failure to heal, signs and symptoms of infection, maceration, etc. to the physician. The care plan also directed a Dolphin mattress on the bed per physician order and a pressure reduction cushion in the wheelchair. The Results Details report dated 1/27/17	F 314		

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F 314	Continued From page 68 documented the resident verified as Methicillin-resistant staph Aureus (MRSA) positive via nasal swab and Vancomycin-resistant enterococci (VRE) positive per rectal swab on 1/19/17. The Skin Grid for Pressure Ulcers documented the following measurements of the coccyx pressure ulcer: On 5/3/17- full thickness wound measuring 6 cm x 5 cm x 2.0 cm with moderate amount of yellow drainage with tissue type G(granular)/S(slough) and wound bed color R (red)/Y(yellow) with no odor. On 5/10/17-full thickness wound measuring 6 cm x 5 cm x 2 cm with moderate amount of serosanguinous drainage with granular wound bed that is red in color with no odor. The next assessment dated 6/2/17 documented a full thickness wound which measured 23.5 cm x 14 cm x 2.0 cm with moderate amount of serosanguineous drainage with a granular wound bed red in color with no odor. On 6/14/17- full thickness wound measuring 14 cm x 8 cm x 2 cm with moderate amount of serosanguineous drainage with a granular wound bed red in color with no odor. The Skin Grid for Pressure Ulcers documented the following measurements of the right ischial area: On 5/3/17-full thickness wound measuring 13.0 cm x 6.0 cm x 1.8 cm with a moderate amount of yellow drainage with granular and slough tissue	F 314		

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F 314	Continued From page 69 present in the wound base that is red and yellow in color with no odor. On 5/10/17-full thickness wound measuring 13.0 cm x 6.0 cm x 1.8 cm with a moderate amount of yellow drainage with granular and slough tissue present in the wound base that is red and yellow in color with no odor. The next assessment dated 6/2/17 documented a full thickness wound with a moderate amount of serosanguineous drainage with granular wound base red and yellow in color with no odor. The assessment contained the statement that all areas were measured but are not documented on the form or in the Resident Progress Notes. On 6/14/17-full thickness wound measuring 13.0 cm x 6.0 cm x 3.0 cm with a moderate amount of serosanguineous drainage with granular wound base red and yellow in color with no odor. The Skin Grid for Pressure Ulcers documented the following measurements of the left ischial area: On 5/3/17-full thickness wound measuring 13.0 cm x 5.0 cm x 2.0 cm with a moderate amount of yellow drainage with granular and slough tissue present in the wound base that is red and yellow in color with no odor. On 5/10/17-full thickness wound measuring 13.0 cm x 5.0 cm x 2.0 cm with a moderate amount of yellow drainage with granular and slough tissue present in the wound base that is red and yellow in color with no odor. The next assessment dated 6/2/17 documented a full thickness wound with a moderate amount of	F 314		

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F 314	Continued From page 70 serosanguineous drainage with granular wound base red and yellow in color with no odor. The assessment contained the statement that all areas were measured but are not documented on the form or in the Resident Progress Notes. On 6/14/17-full thickness wound measuring 13.0 cm x 5.0 cm x 3.0 cm with a moderate amount of serosanguineous drainage with granular wound base red and yellow in color with no odor. The facility's Skin and Wound Care Management Documentation policy dated 6/2015 directs the grid to be completed weekly until area healed; more frequent documentation may be indicated based on changes in condition of the wound. During an interview on 6/20/17 at 2:35 PM Staff C, RN, stated there had been a lapse in weekly skin assessments because the former Director of Nursing (DON) used to complete them but she left in mid-May 2017. The Progress Notes from the Wound Clinic dated 6/15/17 documented the resident's coccyx ulcer measures 7.7 cm x 12 cm x 2.8 cm, the right ischial ulcer measures 10.4 cm x 4.3 cm x 3.9 cm with a small secondary ulcer that measured 2 .0 cm x 1.8 cm x 01. cm. The left buttock ulcer measured 7.7 cm x 4.7 cm x 3.6 cm. The report documented all areas were selectively debrided and there were some more necrotic areas that were small and debrided as well. The hospital Progress Notes dated 6/15/17 documented the resident's wound culture identified positive for proteus mirabilis, staphylococcus group B and Corynebacterium species.	F 314		

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F 314	Continued From page 71 The resident's clinical record contained no wound clinic documentation since 4/27/17. The surveyor obtained wound clinic Progress Notes dated 5/11/17, 5/25/17 and 6/15/17. The Treatment Administration Record (TAR) for June, 2017 directed staff cleanse the sacrum/coccyx, buttock ulcers with normal saline, and apply Dakin's soaked gauze and cover with gauze and ABD pad 2 times per day and to cleanse the right and left ischial spine ulcers with normal saline and apply a hydrocolloid dressing every 3 days and as needed (PRN). Observation on 6/22/17 at 10:55 AM revealed Staff D, registered nurse (RN), entered the resident's room with supplies to complete the resident's wound treatments. Observation identified a 1,000 cc (cubic centimeters) open bottle of normal saline which contained approximately 800 cc. The bottle contained no date of opening. The label on the bottle documented it delivered by the pharmacy on 6/5/17 and the manufacturer's label identified the bottle as single use only as it contained no bacteriostatic and to discard the unused portion. Staff D placed a red (biohazard) garbage bag on the resident's bed and washed her hands and put on gloves. The resident turned to lie on the left side. The wounds were not covered by ABD pads, but had a disposable incontinent pad over it that contained a large amount of foul drainage yellow/green and red in color with a foul odor. Observation revealed no hydrocolloid dressings on the right and left ischial spines. Staff D removed the packing from the resident's wound and then used her right gloved hand to open the resident's bedside table drawers and removed an unopened roll of Kling gauze. Staff D then	F 314		

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F 314	Continued From page 72	F 314		

opened the package of gauze and folded into layers and placed on the bed next to the resident who remained lying on the left side. Staff D then removed her gloves and poured normal saline and Dakin's solution into 2 different cups. Staff D then removed an open package of 4 x 4 gauze from the resident's drawer and then put on gloves. Staff D placed several 4 x 4 gauze pads into the normal saline cup and then cleansed around and into the wound and scrubbed back and forth over the wound bed with the gauze sponges. The wound contained slough tissue between 10:00 and 2:00 and a depth of approximately 3 cm with some undermining in the area. The wound covered the entire coccyx, both buttocks, right and left ischial regions with an adjacent area approximately half-dollar in size with superficial depth, yellow wound base and viable red edges. Staff D continued to cleanse the wound with a back and forth motion over all areas. Staff D then removed her gloves, tore the package of 4 x 4 gauze so she could obtain them more easily, put on clean gloves and then place 4 x 4 gauze into the cup containing the Dakin's solution. Staff D then placed the soaked gauze in the undermined wound edges and then changed her gloves. She then dried the skin around the ulcer with 4 x 4 gauze, changed her gloves, opened the packages of ABD pads and unfolded them and applied skin prep all the way around the wound. Staff D then placed the 2 ABD pads over the wound except for the half-dollar size are on the right ischium. Staff D then use paper tape to secure the ABD pads in place and taped directly over the exposed right ischium ulcer. The tape did not stick to the open skin. Staff D then took a 4 x 4 dry gauze sponge and folded it in half and placed it directly over the right ischium and then taped over it all the dressing edges to reinforce

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F 314	Continued From page 73 them and taped over the seam of the ABD pads to keep them intact. Wearing the same gloves. Staff D then assisted Staff K, CNA to pull the resident on the bath blanket to the middle of the bed. Staff D removed her right glove, carried supplies to the treatment cart and carried the biohazard bag with the soiled dressings in it to the soiled utility room down the hall. Staff D placed the biohazard garbage in the regular garbage bin and removed the left hand glove. Staff D then went to the treatment cart, obtained the keys from her pocket, unlocked the cart and put away supplies and then went back to the soiled utility room to wash her hands. Observation revealed the resident lay on a Dolphin FIS (fluid immersion simulation) bed. The bed had a fitted sheet on it and Staff L, CNA placed a bath blanket folded into fourths and 2 washable incontinent pads side-by side with the seam between the 2 pads running from head to foot of the bed so the resident's lower back, buttock and upper thighs would rest on them when in bed and assisted the resident to lay on his/her back. The manufacturer's (Joerns) guidelines directed the staff to do the following: Page 12. Recommended Linen: Special linens are not recommend for the Dolphin FIS therapy mattress there is no need for a bottom sheet as the therapy pad should be covering the therapy cells at all times. The patient should never by lying or sitting directly on the therapy cells. Based on a patient's specific needs, the following linens may be utilized: Draw or slide sheet or aid in positioning and to	F 314		

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F 314	Continued From page 74 further minimize friction and shearing. Incontinence barrier pad for patients incontinent of urine and/or stool and patient's with heavily draining wounds. Add top sheet, blanket and/or bedspread as needed for patient comfort. Keep the amount of padding between the patient and the therapy mattress or specialty surface at a minimum for optimum performance. Placing excessive pads or sheets between the patient and the therapy mattress or specialty surface may negatively impact performance. The facility's Infection Prevention Two-Tier Transmission Based Precautions: Standard Precautions policy dated 3/2015 directed the following: Procedure: Handwashing 1. Wash hands after touching the following whether or not gloves are worn: blood body fluid contaminated items excretions secretions 2. Wash hands promptly: after gloves removed between resident/patient contact as indicated to avoid transfer of microorganisms to other resident/patient or environments between tasks and procedures on the same resident/patient to prevent cross-contamination of different body sites Gloves 3. Apply clean gloves before touching mucous membranes or non-intact skin 4. change gloves between tasks and procedures	F 314		

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F 314	Continued From page 75 on the same resident/patient after contact with material that may contain high concentration of microorganisms 5. remove gloves promptly after use, before touching non-contaminated items and environmental surface, and before going to another resident/patient 6. Wash hands promptly to avoid transfer of microorganisms to other residents/patients or environment. During interview on 6/22/17 at 2:10 PM Staff D stated she cannot apply hydrocolloid dressings to the right and left ischial spines as the wounds have become "one big wound" and unable to get the dressing to adhere. She stated the resident goes to the wound clinic and they are aware that it is all one ulcer now. She stated she did not apply the dressing as ordered on 6/17 and planned to document this in the Progress Notes but got busy and did not complete it. She stated she has not contacted the wound clinic to get the hydrocolloid dressing discontinued. Staff D stated the nurse on Shady Lane is really busy and often does not have enough time to complete all the treatments. She does not sign off that it has been completed; she leaves the box blank. During interview on 6/20/17 at 2:35 PM Staff C, RN stated he has had days where ordered treatments have not been completed for all residents. He has gone to do treatments on residents and found the dressings on the resident dated 2 days before. Staff C stated he has, on occasion, signed off treatments as completed when he did not do them.	F 314		

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F 314	Continued From page 76 During interview on 6/22/17 at 12: 15 PM the resident stated his/her wound treatment does not get done 2 times a day on a consistent basis. The resident stated she/he reported this to the wound care doctor each time she/he goes and the doctor has said he can tell it is not being done as ordered. Review of the June, 2017 TAR revealed the resident's sacral/coccyx ulcer treatment not signed off as completed in the evening on 6/9 and 6/13 and in the morning on 6/1 and 6/10. 2. Resident #11 had a MDS with a reference date of 4/26/17. The MDS identified the resident had diagnoses that included neurogenic bladder, diabetes mellitus, anxiety disorder, depression and chronic obstructive pulmonary disease (lung disease). The MDS identified the resident had a BIMs score of 15. A score of 15 represented no cognitive problems. According to the MDS the resident required extensive assistance with bed mobility, locomotion, dressing, toilet use and total dependence with transfers. The MDS identified the resident had 1 unstageable pressure area present upon admission and had diabetic foot ulcers. The resident required the use of a pressure reducing device for chair and bed, turning/repositioning program and nutrition or hydration intervention to manage skin problems. The Care Plan dated 2/22/17 directed staff to encourage and assistance with frequent repositioning while in bed and wheelchair. Monitor/document location, size and treatment of skin injury and report abnormalities, failure to heal, signs/symptoms of infection and maceration to the physician. Pressure reduction cushion to wheel chair.	F 314		

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F 314	Continued From page 77 Review of the History and Physical dated 6/29/17 indicated the resident had an infected left heel diabetic ulcer and chronic coccygeal ulcer. The hospital record identified the resident had positive MRSA. Orders included antibiotic therapy of daptomycin 2 mg every 24 hours for 6 weeks and ertapenem 1 gram every 24 hour IV. Review of the Order Listing Report dated 6/1/17 through 6/30/17 indicated the following orders: " Cleanse sacrum with soap and water, then blot dry, then pack 1 inch Kling roll gauze into opening and cover with unrolled Kerlix gauze to create a large dry gauze pad type dressing. Change every 8 hours for wound care. " Irrigate left foot ulcer with 50 cc 1/4 strength Dakin's solution, dry well, pack ulcer with wet to dry 1/4 inch Nugauze plain, dress with Xeroform, fluff and Kerlix. Change daily for left foot ulcer. Review of the Skin Grid for Pressure Ulcers identified a Stage III coccyx pressure ulcer present on admission. The measurements for the wound documented as follows: On 5/3/17-1.5 cm by 1.3 cm with depth of 2 cm. Tunneling 11 o'clock to 2 o'clock 4.7 cm On 5/10/17-1.5 cm by 1.3 cm with depth of 3 cm. Tunneling 11 o'clock 6.5 cm to 2 o'clock 7 cm. On 6/2/17 1.3 cm by 0.6 cm with depth of 3.7 cm. Tunneling 11 o'clock to 2 o'clock 4 cm. On 6/14/17 1 cm by 1 cm with depth of 6 cm. Tunneling 11 o'clock 6 cm & 2 o'clock 6 cm. The facility failed to assess the resident's wounds	F 314		

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F 314	Continued From page 78 on a weekly basis. Review of the TAR dated 6/1/17 through 6/30/17 revealed the following treatments not documented completed: Coccyx wound cleanse with Dakin's solution and pack tunneling with gauze impregnated with bacitracin. Cover with ABD every 12 hours- 6/7 AM, 6/9 AM & PM, 6/10 AM, 6/13 AM 6/15 AM & PM. Left heel cleanse with normal saline, apply betadine, non-adherent dressing and wrap with Karli 2 times a day and as needed. 6/6 AM 6/7 AM 6/9 AM & PM, 6/10 AM 6/13 PM and 6/15 AM & PM. Observation on 6/30/17 at 3:35 PM identified the acting DON (Director of Nursing) complete wound care for the resident. The wounds measured with the following results: Left heel ulcer-5.4 cm by 4.8 cm and depth 1.4 cm Coccyx ulcer-0.5 by 0.5 with 4 by 6 cm macerated moist tissue surrounding wound and depth 2.2 cm. During an interview with Staff J, CNA on 6/22/17 at 1:30 PM, she stated there had been several times no dressing was present on the resident's wounds. Staff J stated the resident did not want to get out of bed if no dressing was on wound. Staff J stated she tells the nurses when no dressing is present and Staff D, RN has told her she could not complete it and did not have time.	F 314		

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F 314	Continued From page 79 During an interview with Staff D, RN on 6/15/17 at 11:30 AM, she stated if staff didn't get into the resident's room and it's too late, he/she will not allow the dressing changes. Staff are unable to do treatments until after the medications are passed [administered]. During an interview with the resident's family on 6/27/17 at 8:45 AM she/he stated the resident's dressings were found to not be in place and not always changed. The family member stated the resident did develop an infection in the wound on the foot. Some of the nurses ensure the dressing changes are done and some refuse to do it. 3. According to the MDS dated 2/23/17 Resident #13 had diagnoses that included peripheral vascular disease, hypertension, hyperlipidemia and depression. The MDS identified the resident had a BIMs score of 13 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. According to the MDS the resident had 1 healed pressure ulcer and 2 venous and an arterial ulcer present. The MDS identified the resident required pressure reducing device for chair, pressure reducing device for bed, application of nonsurgical dressing, ointments/medication and applications of dressings to the feet. The Care Plan dated 2/28/17 directed staff to do the following interventions: derma savers to bilateral lower extremities, elevate bilateral feet at all times when in bed, encourage and assist with frequent repositioning, heel boots on bilateral (both) feet, lotion to feet, heels off mattress at all times, monitor skin daily with cares and with showers and updated medical doctor of any	F 314		

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F 314	Continued From page 80 changes in resident's skin integrity as needed, pressure reduction mattress to bed and cushion to wheelchair and skin assessment per facility policy, treatments per wound clinic or physician orders. Review of the Braden Scale dated 2/28/17 identified the resident had a total score of 16 which identified the resident at a low risk for developing pressure sores. Review of the Physician Orders dated 5/8/17 included Cefdinir (antibiotic) 300 mg 2 times a day and doxycycline hyclate (antibiotic) 100 mg 2 times a day for positive MRSA (Methylin Resident Staphaureous) in the wound for 14 days. The Physician Orders dated 5/30/17 identified the order for Ampicillin (antibiotic) 500 mg 4 times a day for positive wound culture to the left heel until 6/13/17. Review of the wound clinic notes dated 5/3/17 indicated the right calcaneus pressure ulcer acquired 1/17/17 measured 4.4 cm by 1.5 cm with depth of 0.2 cm. The wound clinic classified the wound as a Stage III pressure area with slough and a medium amount serosanguineous (blood and serous fluid) red brown exudate. The wound bed had granulation (new connective tissue) tissue in the amount of (medium) 34% to 66% and red, pink, friable in quality. The necrotic area size (small) with 1-33% adherent slough (dead tissue). The note included a pressure ulcer acquired 12/15/16 to the left lateral foot. The wound measured 0.6 by 0.5 cm with depth of 0.2 cm classified as a Stage III. Review of the Skin Grid for Pressure Ulcers dated 5/10/17 revealed the left heel had pressure	F 314		

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F 314	Continued From page 81 areas with the following measurements: On 5/10/17 0.6 cm by 0.3 cm with no drainage and granulation tissue present and would bed pink. On. 6/1/17 6.5 cm by 2.5 cm with minimal serosanguineous drainage and pink wound bed. On 6/14/17 7.4 cm by 4.5 cm with minimal serosanguineous drainage, granulation tissue and pink wound bed. Review of the Skin Grid for Other Skin Impairments dated 5/3/17 revealed the lateral left foot wound identified on 12/15/16 and had the following measurements: On 5/3/17- 0.6 cm by 0.5 cm with depth 0.2 cm no drainage. On 5/10/17- 0.5 cm by 0.3 cm with depth 0.1 cm had no drainage. On 6/1/17- 1 cm by 0.5 cm with depth 0.2 cm, scant amount serous drainage and wound bed pink. On 6/14/17- 0.7 cm by 0.7 cm no depth, serous drainage and wound bed pink. Review of the Skin Grid for Other Skin Impairments dated 5/3/17 identified the right calcaneus wound identified on 1/17/17 had the following measurements: On 5/3/17 4.4 cm by 1.5 cm with 0.2 depth had moderate serous sanguineous drainage and slough and red/yellow wound bed. On 5/10/17- 4.2 by 1.3 with depth 0.1 moderate sero-sangenous drainage with granulation and pink wound bed. On. 6/1/17 4.5 cm by 1.6 cm moderate amount sero-sangenous drainage with granulation and pink wound bed. On 6/14/17 4.5 cm by 2 cm and no depth. drainage, tissue and wound bed color not	F 314		

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F 314	Continued From page 82 assessed. Review of the Weekly Skin Sweep dated 5/3/17 to current, revealed the skin assessments completed on 5/3/17, 5/10/17, 6/1/17 and 6/14/17. The document failed to identify new skin impairment and failed to complete weekly. Review of the Wound Clinic Patient Instructions document dated 5/10/17 identified an order for the left and right heel and left lateral foot to cleanse the wounds with normal saline, apply Dakin's 0.125% and cover with gauze, kling and tape. The order for the 3rd and 4th web space included a treatment of Betadine (antiseptic) 2 times a day. Review of the Physician Clinic Sheet dated 6/14/17 indicated the order for the foot dressings must be changed daily. The Patient Instructions revealed the order for right and left heel apply Santyl and cover with white foam. The left lateral foot included apply Dakin's 0.125%. The left 3rd and 4th webspace included the order to paint with Betadine daily, apply white foam between the 3rd and 4th toe and change daily. Review of the Wound Clinic Patient Instructions dated 6/21/17 included the following order for the right and left heel and left lateral foot: apply Santyl, apply Dakin 0.125% soaked gauze and then ABD dressing and roll gauze 2 times a day. Review of the TAR (Treatment Administration Record) dated 5/1/17 through 5/31/17 indicated an order to cleanse the left lateral foot and right heel with normal saline. Apply Dakin 0.125% soaked gauze, 4 by 4 and wrap with Kling 2 times a day. The TAR also identified the order to	F 314		

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F 314	Continued From page 83 cleanse the left 3rd and 4th toe web spaces with normal saline and apply Betadine 2 times a day. The treatment not documented on the following: 6:00 AM-5/20, 5/23-5/26, 5/28-5/31/17. 2:00 PM-5/12, 5/17, 5/20, 5/23, 5/24, 5/26 and 5/31/17. The TAR also identified the order to cleanse the left heel with normal saline, apply Dakin's 0.125% soaked gauze 2 times a day. (AM and hour of sleep) The treatment not documented on the following: a. AM-5/20, 5/23-5/26, 5/28-5/31/17. b. Hour of sleep-5/23, 5/26/17. The TAR dated 6/1/17 through 6/22/17 revealed the order for the left and right heel 6/8/17 through 6/22/17: cleanse with normal saline, apply Santyl then cover with foam dressing and cover with gauze, Kling and tape daily. The left lateral foot order 6/8/17 through 6/22/17 directed to cleanse with normal saline, apply Dakin, cover with gauze, Kling and tape daily. The treatment not documented completed: 6/9,6/16, 6/17, 6/18 and 6/21/17. Observation on 6/23/17 at 1:50 PM revealed Staff S, RN completed a wound treatment on the resident's pressure ulcers. The left lateral foot wound measured 1.5 cm by 3 cm. The right calcaneous measured 2 cm by 4 cm. The left lateral heel measured 8 cm by 5 cm. She cleansed the left lateral wound and left heel with normal saline. She applied Santyl with a gloved hand to the left lateral wound and used the same gloved hand to apply Santyl to the left heel. She applied a 4 by 4 inch gauze square soaked with Dakin's and ABD dressing and Kling. She cleansed the right calcaneus wound with normal	F 314		

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F 314	Continued From page 84 saline, applied Santyl to the wound and a Dakin soaked dressing. She then applied an ABD dressing and Kerlix. She disinfected the treatment cart. On 6/23/17 at 1:30 p.m., Resident #13 was interviewed and stated the wound treatment had not been completed 2 times a day as ordered and the wound clinic wrote the facility a note about it. The dressing changes are now 1 time a day. The resident stated the dressings are not changed on Friday, Saturday or Sunday (6/16, 6/17, 6/18/17). The resident stated he could smell his/her feet and refused to get out of bed on Monday until a nurse assisted with the wounds. The resident stated the DON (Director of Nursing) did come to the room and change the dressings after he/she asked. During an interview with the Wound Clinic ARNP on 7/5/17 at 8:00 AM, he stated the resident's wound on the left calcaneous increased on size from 2.35 cm by 1.2 cm by 0.1 cm to 7.6 cm by 4.8 cm by 0.4 cm. The facility failed to follow the ordered treatment and the decline could have been potentially prevented considerably. He further stated the resident completely realizes on staff and has no family that advocates for him/her. 4. Resident #8 had a MDS with a reference date of 4/21/17. The MDS identified the resident had diagnoses that included heart failure, hypertension (elevated blood pressure), pneumonia (lung infection), septicemia (infection), diabetes mellitus, and chronic obstructive pulmonary disease (lung condition). The MDS identified the resident had a BIMs score of 11. A score of 11 represented the resident had	F 314		

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F 314	Continued From page 85 a moderate cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, dressing, toilet use and total dependence with transfers. The MDS identified the resident had impairments on both sides of the lower extremities. According to the MDS the resident had no risk of developing pressure ulcers and had no pressure ulcers since the last assessment. The Care Plan dated 4/11/17 directed staff to monitor/document location, size and treatment of skin injury and report abnormalities, failure to heal, signs/symptoms of infection and maceration. The Care Plan also directed staff to use a pressure reduction cushion to the wheelchair and an air mattress to the bed. Staff also directed to assist the resident with repositioning frequently throughout each shift and as needed and to provide treatments per physician orders. Review of the Physician Telephone Order dated 5/30/17, directed the nurse to apply Mepilex and change 3 times a week and as needed every Monday, Wednesday and Friday to the left heel blister. Review of the Skin Grid for Pressure Ulcers dated 5/18/17, indicated the back left heel with 8.5 cm by 4 cm blister intact and dark purple in color. Review of the Skin Grid for Pressure Ulcers dated 5/18/17 identified the outer left heel with 9 cm by 3 cm blister intact and dark purple in color. Observation on 6/28/17 at 8:05 PM revealed Staff T, RN and Staff L, LPN completed wound care for the resident. The left heel measured 6 cm by 7.3	F 314		

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F 314	Continued From page 86 cm with open area of 3.6 cm by 1.1 cm. The right heel measured 3.1 cm by 2.4 cm. During an interview with the Wound Clinic ARNP on 7/5/17 at 8:00 AM, he stated the resident had family report several times the wound care not treated per physician's order. The advocate ensured the treatments completed. He further stated some residents did not have advocates to speak for them. 5. Resident #6 had a MDS with a reference date of 6/13/17. The MDS identified the resident had diagnosis which included peripheral vascular disease (narrowing of vessels of the lower extremities), diabetes mellitus, arthritis and sciatica (condition of the sciatic nerve). According to the MDS, the resident had a BIMs score of 15 which indicated no cognitive problems. The MDS identified the resident required limited assistance with bed mobility, transfers, dressing and toilet use. According to the MDS the resident was not assessed to have pressure ulcers. The MDS identified the resident required use of pressure reducing device for chair and bed and application of dressing to feet with or without topical medications. The Care Plan dated 6/9/14 directed staff to provide a pressure reduction surface in the bed and wheelchair. The Care Plan failed to identify skin impairment or wound care. Review of the Braden Scale dated 6/12/17 indicated the resident at low risk for the development of pressure ulcers. Review of the hospital x-ray report dated 6/1/17 indicated a soft tissue ulcer medial to the 1st	F 314		

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F 314	Continued From page 87 metatarsal joint. There is focal osteopenia (bone loss density) and apparent mild destructive change within the 1st metatarsal head (bone behind the big toe), suggesting osteomyelitis. The impression included focal osteopenia mild destruction in the 1st metatarsal head, a finding consistent with osteomyelitis (bone infection). Review of the Hospital Podiatry Consult (physician orders) dated 6/2/17 identified the following wounds: Ulceration to the medial hind foot completely granular base with no acute signs of infection such as drainage, purulence, cellulitis, ascending lymphangitis, probing, tracking or undermining. Prior to and after debridement, the ulceration measured 1.1 by 1.0 by 0.1 cm. The area identified etiology pressure. Ulceration to the plantar aspect of the 1st metatarsal head had extensive hyperkeratotic tissue prior to debridement. There was no acute signs of infection noted. Following debridement, the ulceration measured 1.2 by 0.8 by 0.1 cm. The area identified etiology pressure. The full thickness ulceration located to the plantar aspect of the right 1st metatarsal head and medial hind foot bandaged with Betadine, 4 by 4, Kerlix and ace bandage. The resident to be in a post operative shoe at all times with ambulation. The dressings are to be changed daily in a similar manner. The note directed the staff the resident needed to follow up with the physician in the office, 1 week after discharge. Review of the Order Summary Report dated 6/1/17 through 6/30/17 revealed the order for daily wound care directions to right foot wounds 1	F 314		

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F 314	Continued From page 88 time daily: a. Betadine to both ulcerations on right foot. b. Cover with 4 by 4 [gauze] c. Wrap with Kerlix (do not bandage to tight). k. Wrap with ACE wrap bandage. (do not bandage to tight) Review of the TAR dated 6/1/19 through 6/30/17 revealed the order for wound care to wounds on the right foot 1 time daily: a. Betadine to both ulcerations on right foot. b. Cover with 4 x 4 [gauze] c. Wrap with Kerlix. d. Wrap with ACE wrap bandage. The wound care effective on the TAR on 6/12/17 and documented completed on 6/13/17 and 6/14/17. Review of the Progress Notes dated 6/6/17 at 9:23 PM revealed documentation the resident had no skin issues noted except the right foot had an ace wrap on it from the hospital. On 6/16/17 at 7:13 AM the resident discharged home with family per his/her request. During an interview with Staff C, RN on 6/20/17 at 2:40 PM he stated the areas had hard eschar. He further stated he never saw open wounds that he remembered. The resident had orders for wrap and Kling and if he took it off and looked at it he would of documented it somewhere. During an interview with the DON on 6/8/17 at 9:00 AM, she stated the medical record did not contain assessments of the wound on the right foot. During an interview with the Physician on 6/20/17 at 11:00 am he stated the resident had a recent	F 314		

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F 314	Continued From page 89 hospitalization for ulcers but had been discharged. The resident had an appointment at his office on 6/12/17. The resident did not come to the appointment. According to the facility they told them they forgot to write down the time. He further stated the resident at risk for amputation. Note: At the time of the complaint investigation, the complaint was coded at a "K", immediate and serious jeopardy. By 7/3/17, the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "G" level. The implemented measures were: An assessment of all residents determined 7 residents with wounds. Each wound was assessed and physicians were updated on current status of wounds on 7/1/17. On 7/3/17, all licensed nursing staff received a wound inservice about the policy and procedures of wound care and gave a successful return demonstration on wound care techniques. As of the 7/12/17 exit date, the facility continued to need to: The Director of Nursing or designee will continue to monitor wounds on a weekly basis and ensure weekly assessments and treatments are completed. Continue to monitor Care Plans to ensure interventions are implemented in order to promote healing. Continue to provide inservices to licensed staff about wound care. Continue to monitor the staff to ensure the facility policy and procedures for skin and wound care are followed.	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE PAZ HEALTH CARE CENTER	2121 WEST 19TH STREET SIOUX CITY, IA 51103

(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 315	Continued From page 90	F 315		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 315		

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F 315	Continued From page 91 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and facility policy review, the facility failed to assure catheter care to minimize the chance of urinary tract infections (UTI) for 2 of 3 residents sampled with indwelling catheters (Residents #6 and #7. The facility identified a census of 56. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 5/3/17, documented diagnoses that included neurogenic bladder, viral hepatitis, diabetes mellitus and paraplegia for Resident #7. The same MDS documented the resident required the assistance of two staff with toilet use and personal hygiene. The assessment documented Resident #7 required an indwelling catheter for urinary elimination and a colostomy for bowel elimination. The care plan problem, revised on 2/17/17, identified the resident has a suprapubic catheter and is at risk for infections related to it. The care plan instructed staff to manage the resident's catheter care and to monitor for signs and symptoms of UTI. Observation on 6/22/17 at 11:37 AM revealed Staff K and L, certified nursing assistants (CNAs) assisted the resident with personal care. Staff K opened and closed the resident's colostomy bag to release air with her gloved hands and then removed those gloves but did not wash her hands before donning another pair of clean gloves. Staff K then handled the resident's catheter tubing and cleansed each of the resident's groin areas with disposable cloths. Staff K then took	F 315		

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F 315	Continued From page 92	F 315		

another disposable wipe and handled and cleansed around the insertion site of the suprapubic catheter and the catheter itself wearing the same soiled gloves. Observation revealed the insertion site and catheter itself crusted with dried drainage. Staff K continued to touch the catheter to remove the drainage, as well as crusted drainage on the resident's mons area and then took a clean disposable wipe and cleansed the resident's inner labial area. Observation revealed the catheter remained crusted with drainage. Staff K removed her gloves and washed her hands and wiped up and down on the suprapubic catheter to clean it.

The facility's Suprapubic Catheter Care procedure dated 1/13 directed the following:

Point # 4 - Wash hands and apply gloves.
Point # 7 - Gently cleanse area and approximately 3 inches of the catheter with soap/water or cleanser. Start at the stoma and work outward. Hold and support catheter and avoid tension or unnecessary movement.
Point # 8 - Gently rinse area (if using soap/water) making sure all soap is removed.
Point # 14 - Remove gloves and wash hands.
2. According to the MDS assessment dated 6/12/17, Resident #6 had diagnoses that included coronary artery disease, heart failure, renal insufficiency, obstructive uropathy, dementia, anxiety disorder, depression and chronic lung disease. The MDS identified the resident had a BIMs score of 15 which indicated intact memory and cognition. According to the MDS, the resident required the assistance of 2 staff with toilet use and the assistance of one with personal hygiene. The MDS identified the resident required an indwelling catheter.

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F 315	Continued From page 93 The resident's care plan dated 6/13/17 documented the presence of a Foley (urinary catheter) and directed staff to monitor the Foley for kinks or leakage and to monitor/record/report to physician signs/symptoms of urinary tract infection. Staff directed to empty Foley every shift and as needed and provide catheter cares every shift. Review of the Progress Notes dated 5/6/17 at 11:23 AM revealed the order for Macrobid due to dark foul urine an pain. Observation on 6/22/17 at 2:00 PM revealed the resident sat in the recliner in his/her room. The Foley catheter urine bag and tubing sat directly on the floor. At 3:00 PM the Foley catheter urine bag and tubing continued to sit directly on the floor. The urine bag did not have a covering. Review of the Policy and Procedure titled Catheter Care dated, 1/13, directed staff to do the following: Point #18 - Position catheter and drainage bag below the level of the resident to facilitate flow of urine. Hang drainage bag on the bed frame, not on the bed rails Position drainage bag from view or cover with a privacy bag.	F 315		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 322		

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F 322	Continued From page 94 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, observations, interviews, facility policy review and professional reference reviews, the facility failed to assure residents with feeding tubes receive appropriate treatment and services to prevent complications and to meet the resident's nutritional and fluid requirements for 1 of 2 current residents sampled with feeding tubes (Resident #4). The facility identified a census of 56. Findings include: 1. The electronic clinical record listed diagnoses of unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, diabetes mellitus and hypertension for Resident #4. The partially completed admission Minimum Data Set (MDS), dated 5/19/17, documented the resident's weight as 257 pounds, did not document the resident's height and identified the	F 322		

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F 322	Continued From page 95 resident received 51% or > of their total calories and 501 cubic centimeters (cc) or greater of fluid per day through a feeding tube. The care plan problem dated 5/26/17 identified the resident has a potential for alteration in nutrition related to history of alcohol abuse, intracranial bleed and open areas and directed to monitor for signs and symptoms of aspiration and dehydration and for the registered dietician to review resident nutritional issues and make recommendations as needed. Another care plan problem dated 6/2/17 and revised on 6/13/17 identified the resident with impaired speech, s/he had a feeding tube and could not take anything by mouth (NPO). a. The Patient Discharge Instructions dated 5/19/17 directed staff to administer 360 cc of Glucerna 1.2 formula followed with a 200 cc water flush 5 times daily through the resident's feeding tube and also documented the resident's weight as 275 pounds on 5/17/17. The Progress Notes completed by Staff D, RN (Registered Nurse) on 5/19/17 at 12:15 PM documented the resident admitted to the facility. An entry by Staff D on 5/19/17 at 5:28 PM documented the on-call physician contacted with a request to change the resident's feeding formula from Glucerna 1.2 to Jevity 1.5. The physician gave the order as requested and Staff D documented the facility would have the dietician compare the Jevity 1.2 to see which is better. The Enteral Nutrition Data Collection Tool completed by the facility's dietician consultant on 5/23/17 documented the resident's current tube	F 322		

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F 322	Continued From page 96 feeding formula as 360 cc of Jevity 1.5 and documented no other nutritional data or assessment. the Summary stated the dietician would complete the assessment with height and weight but current orders would provide 113 grams (g) protein, 2700 calories, 1,440 cc of free water with additional 1,000 cc of water flush for a total of 2,440 cc of fluid. During interview on 6/20/17 at 1:56 PM Staff Q , certified nursing assistant (CNA) stated the facility's dietician's last day was 6/14/17. She knows the facility has hired a new one but not sure when s/he will start. During interview on 6/15/17 at 2:45 PM Staff G, pool staff RN, stated the facility had no Jevity 1.5 available for the resident's tube feedings scheduled for 5:00 PM and 9:00 PM scheduled feedings. She contacted the administrator who told her she would try and find some. She stated there were cans of Jevity 1.2 on the resident's counter so she used them for both feedings but did not obtain an order to do so. The Progress Notes completed by Staff H, RN on 6/11/17 at 12:38 AM documented the physician gave an order to use Jevity 1.2 formula until Jevity 1.5 could be ordered. Review of the June, 2017 MAR revealed Staff D documented the 12 noon, 5:00 PM and 9:00 PM feedings on 6/14/17 as a 9 which is the code for "other/see Nurse's Notes". Review of the Progress Notes revealed no entry made by Staff D regarding the notation. During interview on 6/16/17 at 10:15 AM, Staff D stated she thought that she had documented she	F 322		

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F 322	Continued From page 97 administered either Glucerna 1.2 or Osmolite 1.2 instead of Jevity 1.2 because there was none available. She thought she administered Glucerna 1.2 as the resident had a order previously for it. During interview on 6/22/17 at 9:00 AM the Director of Nursing (DON) presented a facsimile order signed by the physician 6/12/17 to change the resident's enteral formula back to Glucerna 1.2 at the request of the facility. The DON stated there is no Progress Notes entry why the change had been requested and there is no nurse signature on the facsimile sent to the physician on 6/8/17. She stated she found the order in a pile of papers to be filed and order had not been implemented but will do so today. The surveyor requested information from the registered dietician for the State of Iowa regarding changing of enteral formulas. The following information was communicated by email: "An assessment of what the formula provides compared to the estimated needs would be important to ensure needs are being met. Changing formulas, without adjusting the rate and/or free water can result in differences in the total calories, protein and free water received, which in turn could result in a deficit or excess of these components. Formulas vary on the osmolality. High osmolarlity products draw water into the gut and can cause osmotic diarrhea. Fiber content, and the type of fiber vary from product to product which can impact bowel function-either positively or negatively. The type and content of fiber desired can vary based on an individual's need".	F 322		

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F 322	Continued From page 98 According to ClinCalc.com: Selecting an Appropriate Formulation-the selection of the appropriate tube feed formulation is a very patient-specific decision. The following factors play a role in choosing a formulation: macronutrient complexity, protein content, volume, disease-specific formulas (some products are designed for specific disease states such as ARDS/ALI, hepatic impairment, renal impairment and diabetes), fiber content. For complicated patients, consider consultation with a registered dietician for recommendations regarding appropriate enteral feeding formulas and supplements. b. Observation of enteral feeding for Resident #4 on 6/21/17 at 11:35 AM revealed Staff C, RN, poured an unmeasured amount of Jevity 1.5 formula into a drinking cup and set the unused portion aside and the opened another can and poured some of it into another cup. Each can contains 240 cc. Staff C did not clean the tops of the cans or shake the cans prior to opening. Staff C had a graduate which contained 200 cc of water. Staff C checked the resident's feeding tube for gastric residual and none returned. Staff C then mixed 2 liquid medications into each cup of formula and added 140 cc of water to the cups of formula and the cup of crushed medications and administered them through the resident's feeding tube using a 60 cc syringe. After administration of the formula and medications Staff C flushed the feeding tube with the remaining 60 cc of water. Staff D noted he still had formula remaining in a can he intended to use the full amount. Staff C then attached the 60 cc syringe barrel to the resident's feeding tube	F 322		

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F 322	Continued From page 99 and administered the remaining formula and flushed the tube with 20 cc of water he measured in the graduate. After completion of the resident's feeding the surveyor asked Staff C to measure the amount of formula left in the can he had set aside. The amount measured 130 cc. The resident's feeding order is for 360 cc and Staff C acknowledged the resident received only 350 cc and stated "it's close". Observation on 6/22/17 at 4:05 PM revealed the resident told Staff M, CNA that s/he felt hungry. Staff M alerted the nurse. Observation at 4:40 PM revealed Staff D, RN took a drinking cup and measured 120 cc of water into the cup and observed the cup to see how far up the cup it went and then discarded the water. Staff D stated he did this to see where the 120 cc limit would be on the cup so he could pour 120 cc of formula into it. Staff D obtained two 240 cc cans of Glucerna 1.2 from the resident's closet. He shook them slightly, opened them and poured formula into the cup he previously measured the water into to visualize the limit and then measured 200 cc of water into a graduate. Staff D checked the resident's feeding tube for gastric residual and none returned. He attached the 60 cc syringe barrel to the feeding tube and poured in formula alternating with water. He flushed the feeding tube with the remaining 100 cc of water after the formula had been administered. The labels of both the Jevity 1.5 can and Glucerna 1.2 cans direct the following: Shake well. Clean top of container thoroughly before opening. The facility's Enteral Feeding policy revised 5/16 directs the following:	F 322		

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F 322	Continued From page 100 Point # 9. Evaluate the placement of feeding tube. Instill 10-20 cc of air onto the feeding tube while simultaneously auscultating (listening) over the left upper quadrant of the abdomen with a stethoscope to validate air movement in the stomach. Aspirate 2-10 ml of gastric contents and re-instill.	F 322		
F 323 SS=E	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. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 101 Based on observation, staff interview and facility policy review, the facility failed to lock the medication cart when unattended by staff for 1 of 2 staff observed during medication pass. Additionally, based on observation and interview, the facility failed to secure used needles and lancets to prevent the spread of infection to cause injury. The facility also failed to secure portable oxygen tank to prevent injury. The facility reported a census 56 residents. Findings include: 1. During observation of medication pass on 6/14/17 at 12:24 p.m., Staff C, Registered Nurse (RN), removed a blood sugar machine from the medication cart parked in the hallway, and took the machine into Resident #10's room. Staff C left the medication cart unlocked, and his backside faced the doorway. After Staff C obtained Resident #10's blood sugar reading, he returned to the medication cart, cleaned the machine and placed the machine back in the top drawer of the medication cart. Staff C obtained an insulin pen and prepared the medication for the resident. During the observation, Resident #9 sat in a wheelchair by the medication cart and requested a pain pill. Staff C acknowledged Resident #9, then took the insulin medication into Resident #10's room and administered the medication to the resident. Staff C left the medication cart unlocked and unattended. The unlocked drawer of the medication cart contained bubble packs, bottles and vials of medications for residents who resided on the 2nd floor at the facility. During an interview on 6/14/17 at 4:15 p.m., the Director of Nursing (DON) reported staff left	F 323		

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F 323	Continued From page 102 medication carts unlocked and they had addressed the problem, but the problem continued. The Administrator reported setting up additional staff training during the week of 6/20/17 to review policy and procedures, and the basics of medication administration The Medication Administration Procedure, dated 1/13, instructed: Point #14 - Never leave the medication cart open and unattended. An In-Service Training for staff held on 5/25/17 revealed medication carts must be locked and not left unattended. Staff C had attended the training. 2. Observation of an unattended medication cart parked to the side of the nursing desk on 6/23/17 at 1:50 PM revealed an overfull sharps container on the side of the medication cart with 3 used insulin needles accessible. The top of the cart contained a two-handled resident drinking cup that contained used insulin pen needles and used lancets as well as a paper straw cover and a soiled alcohol pad. The nurse consultant alerted to the observation and she removed the cup and stated she would have the sharps container changed right away. 3. According to the MDS (Minimum Data Set) assessment dated 4/21/17 Resident #8 had diagnoses that included heart failure, hypertension, pneumonia, septicemia, diabetes mellitus and chronic lung disease. The MDS identified the resident had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. According to the MDS, the resident required the assistance of 2 with bed mobility, dressing and toilet use. The	F 323		

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F 323	Continued From page 103 MDS identified the resident had shortness of breath with exertion and laying flat and s/he required oxygen therapy. Review of the Order Listing Report dated 5/19/17 revealed direction to administer oxygen at 2 liters per nasal cannula continuously. Observation on 6/22/17 at 2:35 PM revealed the resident sat in the recliner in his/her room. The portable oxygen tank stood unsecured on the floor next to the sink. During an interview with the DON on 6/22/17 at 2:35 PM she stated she expected staff to secure oxygen tanks and she removed the oxygen tank from the resident's room.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. BUILDING _____ B. WING _____	C 07/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE PAZ HEALTH CARE CENTER	2121 WEST 19TH STREET SIOUX CITY, IA 51103

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F 431	Continued From page 104 (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to label a resident's medication with identifying information for 1 of 9 residents observed during medication pass (Resident #8). The facility reported a	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 105 census 56 residents. Findings include: During observation of medication pass on 6/14/17, at 1:38 p.m., Staff D, Registered Nurse, looked through the medication cart but could not locate insulin for Resident #8. At 1:40 p.m., Staff D removed a vial of novolog insulin from the top drawer of the medication cart. The novolog insulin bottle had no label that identified which resident the medication belonged to. The insulin bottle had a date of 5/21 written on the bottle. Staff D drew up 5 units of insulin into an insulin syringe, replaced the bottle in the top drawer of the medication cart and then administered the insulin to Resident #8. During an interview 6/14/17, at 1:42 p.m., Staff D reported she used the unlabeled novolog insulin bottle as a stock emergency bottle. Staff D reported staff used the stock emergency bottle for multiple residents who took novolog insulin and staff used the stock bottle whenever a resident ran out of their own medication. Staff D stated the resident may have had another bottle of insulin in the refrigerator, but she did had not checked. During an interview 6/14/17, at 4:30 p.m., the Director of Nursing (DON) reported she expected medications labeled with the resident's name and the medication name. The DON stated insulin bottles and pens are single resident use. On 6/14/17, at 4:40 p.m., the DON confirmed the lack of a resident name on the novolog insulin bottle opened on 5/21 and she discarded the unlabeled vial of insulin.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 106 During an interview 6/15/17, at 9:45 a.m., the Administrator stated the facility had no medication handling or storage policy. The Administrator stated it was a standard of practice for medications to be labeled.	F 431		

4. Maintenance Director/designee will conduct weekly rounds to ensure beds are in proper working order.
   DON/designee will review new orders daily Mon-Fri to verify all orders for appointments are schedule and transportation arranged.
   Maintenance Director will report monthly to facility QAPI committee on preventative maintenance, monthly repairs and equipment needing to be replaced.
   DON/designee will present to monthly QAPI meeting the monthly transportation schedule, any missed appointments and corrective actions implemented if an appointment was missed.

Compliance date is 7/27/17

F273D It is the facility practice to conduct a comprehensive assessment within 14 calendar dates after admission.

1. Resident #4 had the 14-day Admission assessment completed on 7/5/17.
2. MDS RN consultant visited facility the week of 7/3/17 and 7/10/17. Missing/over-due 7/10/17 assessments were completed by RN as of 7/13/17.
3. Administrator in-serviced MDS nurse on 7/10/17 regarding current status of assessments, plan to complete assessments timely and communication if assessments cannot be completed in required time frame.
4. MDS nurse will present to QAPI meeting monthly x 3 months regarding status of assessments completed during the preceding month to ensure on-going compliance.

Compliance date is 7/27/17

F274D It is the facility practice to complete a significant change reassessment within 14 days after the facility has determined a change in a resident's physical or mental condition.

1. Res #1 had a significant change reassessment completed on 7/4/17.
2. Current residents were audited by RN the week of 7/3/17 and 7/10/17 to identify any missing or overdue significant change reassessments. All current residents' assessments were completed and current as of 7/13/17.
3. Administrator in-serviced MDS nurse on 7/10/17 regarding current status of assessments, plan to complete significant change re-assessments timely and communication if assessments cannot be completed in required time frame.
4. MDS nurse will present to QAPI meeting monthly x 3 months regarding status of re-assessments completed during the preceding month to ensure on-going compliance.

Compliance date is 7/27/17

F276D It is the facility practice to assess residents using the quarterly review instrument not less than once every 3 months.

1. Res #13 Quarterly MDS was completed on 7/4/17.
   Res # 14 Quarterly MDS was completed on 7/5/17.
2. Current residents were audited by RN the week of 7/3/17 and 7/10/17 to identify any missing or overdue quarterly MDS. All current residents' assessments were completed and current as of 7/13/17.
3. Administrator in-serviced MDS nurse on 7/10/17 regarding current status of assessments, plan to complete quarterly MDS timely and communication if assessments cannot be completed in required time frame.
4. MDS nurse will present to QAPI meeting monthly x 3 months regarding status of quarterly MDS completed during the preceding month to ensure on-going compliance.

Compliance date is 7/27/17

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.

F157D It is the facility practice to notify resident, responsible party and physicians for residents experiencing a change in condition.

1. Res #22 – RN spoke with resident's sister on 7/13/17 and documented in res medical record.
2. Current residents were audited by DON/designee as of 7/13/17 to ensure no other residents had a change in condition without family/physician notification.
3. Licensed staff were educated by Administrator and DON on 7/13/17 and new staff or new agency staff will continue to be educated prior to their first shift regarding notification of resident, responsible party and physician for changes in condition.
   DON/designee will review 24-hour report and electronic medical record dashboard daily Mon-Fri to identify residents with a change of condition and will audit medical records to ensure notifications have been made and documented. Re-education will be initiated if non-compliance is found.
4. DON/designee will present findings of audits to monthly QAPI meeting for 3 months to ensure on-going compliance.

Date of compliance is 7/27/17

F242D It is the facility practice to honor resident choices related to schedules and health care plans of care- including medication administration times to prevent disruption of sleep.

1. Res #3 – levothyroxine was changed on 6/26/17 to be administered at bedtime per physician order.
2. Current residents' medication administration records were reviewed by RNs on 7/11 through 7/13/17 and all medications ordered routinely before 6AM or after 10 PM were changed to different times per physician orders.
3. Licensed staff were educated by the DON on 7/19/17 regarding the scheduling of routine meds and ensuring medication administration does not interrupt sleep whenever possible based on frequency of medication orders.
4. DON/designee will review all new orders Mon -Fri to verify medications/treatments are ordered at correct times. Any meds ordered for administration before 6AM or after 10PM will be clarified with the physician and changed if possible based on frequency. Weekly Audit by DON/designee.

Date of compliance is 7/27/17.

F246D It is the facility practice to provide services in the facility with reasonable accommodations of individual needs and preferences.

1. Res #16 was discharged from facility on 6/15/17 and no further corrective measures could be implemented.
   Res #8 – bed was replaced with a bed in proper working order on 6/14/17.
2. Maintenance Director made room to room rounds on 7/14/17 to ensure no other beds were need of repair. None found.
   Audit completed of current resident medical records to ensure all ordered appointments were on the transportation calendar. Audit completed 7/13/17.
3. Administrator/DON in-serviced the staff on 7/13/17 regarding reporting equipment in need of repair, ensuring residents are assisted with appointments including being ready on time and having transportation scheduled accurately.

Res # 6 places the catheter bag on the floor – care plan has been updated to reflect this personal choice. Staff offer to move the bag and hang as appropriate during interactions with res. Dignity bag provided to res on 7/13/17.

2. Administrator and RN made walking rounds on 7/13/17 to verify all catheters in use had dignity bags in place and drainage bags were positioned appropriately.
3. Nursing staff in-serviced by Administrator and DON on 7/13/17 regarding appropriate catheter care, procedure for changing gloves, positioning of catheter bags, and using dignity bags.
4. DON/designee will audit catheters weekly to ensure on-going compliance. DON/designee will present findings of weekly catheter audits to monthly QAPI meeting x 3 months.

Compliance date is 7/27/17

F 322D It is the facility practice to provide appropriate treatment and services to residents with NG or G tubes to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore if possible eating skills.

1. Res # 4 height was obtained and entered into electronic medical record on 6/23/17. RD completed an enteral nutrition data collection tool on 6/26/17. On 6/22/17 enteral tube feeding order for Glucerna 1.2 give 360 ml 5Xs QD. Facility has verified formula is in the facility and an adequate stock is maintained to ensure res receives enteral formula as ordered.
2. Facility has no other residents receiving enteral feedings.
3. DON in-serviced licensed staff on proper technique for enteral feedings including proper measuring, cleaning of cans prior to opening, shaking cans prior to opening and discarding any unused formula on 6/23/17. New agency nurses or newly hired licensed staff will continue to be educated on enteral feedings technique before working a shift in the facility.
4. DON/designee will visually observe licensed staff administering enteral feedings to ensure on-going compliance and additional education as indicated. DON/designee will review and new order for enteral feedings to ensure order is accurate, admission has been referred to RD for assessment and formula is available in facility. DON/designee will report on residents with enterals feedings monthly at QAPI x 3 months.

Compliance date is 7/27/17

F323E It is the facility practice to maintain the environment as free of accident hazards as is possible and to ensure each resident receives adequate supervision and assistance devices to prevent accidents.

1. Unsecured O2 was removed by DON on 6/22/17 and resident was switched to O2 concentrator.
   The cup containing the used needles, lancets and debris was immediately removed and disposed of properly and the sharps containers on both med carts and treatment carts were replaced with new, empty containers.
   Licensed staff was immediately in-serviced by DON to keep medication and treatment carts locked at all times when unattended.
2. Administrator and DON began in-servicing licensed staff regarding providing/maintaining safe environment by keeping medication and treatment carts locked whenever unattended, properly disposing of all used sharp devices in approved sharps containers and never leaving unsecured O2 tanks in res rooms.
3. DON/ designee will audit med carts daily at random times to verify they remain locked when unattended.
   Maintenance director/designee will conduct daily walking rounds and complete audit to ensure no unsecured O2 tanks are left in res rooms.
   DON/designee will visually observe med carts daily Mon-Fri to ensure used sharp devices are disposed of properly and to ensure sharps containers are emptied as needed.

Facility utilizing Senior Dental Care a mobile dentistry provider to ensure res can get the dental services they require. Visit scheduled for 7/24/17 and every 4-6 weeks thereafter.

4. Administrator or DON/designee will make weekly observations of resident personal hygiene to include nail care and oral hygiene.
   Baths/showers will be reviewed weekly to ensure schedules were maintained and if baths/showers were missed they were offered on an alternate date. Weekly report will be produced and findings presented to QAPI meeting monthly x 3 months.
   Facility will get reports from podiatrist and dental provider at each visit to ensure services are provided for residents based on needs/requests.

Compliance date is 7/27/17

F314 It is the facility practice to provide necessary treatment and services to residents with wounds to promote healing, prevent infection and prevent new wounds from forming.

1. Res #7, Res #11, Res # 13, Res # 8 – F314 – were assessed by a RN on 6/30/17 and 7/1/17. Wounds were measured and pressure ulcers staged and findings were documented in each medical record. Treatment plans were reviewed to ensure appropriate treatment orders are in place for each wound. Care plans for the res #7, Res #11, Res #13 and Res #8 were reviewed by the RN to verify accuracy related to wound care measures. Attending physicians were updated on current status of wounds on 7/1/17.
   Res #16 (error on 2567 noted as #6) was discharged from the facility on 6/15/17 and no further corrective measures could be implemented.
2. RN will verify daily that wound treatments have been completed as ordered for each resident with wounds. The RN will assess each wound weekly with staging for pressure ulcers and complete wound measurements documented as well as progress of wound in the medical record. Physician will be notified if wound not progressing so appropriate order changes can be implemented.
3. Licensed nursing staff will be educated by RN prior to working in the facility regarding proper infection control practices for wound care, dressing change technique, documentation of wound care and assessment of wound progress. Education will begin immediately on 6/30/17 and continue for all newly hired licensed staff or as newly placed agency nurses are utilized. No licensed staff will be allowed to work a shift unless wound education is provided and return demonstration of proper wound technique and infection control is successfully completed. As of 7/1/17 -5 licensed staff had completed return demonstrations of wound care. Return demonstrations will continue for newly hired or newly placed agency staff prior to working a shift.
4. Administrator and DON/designee will receive a weekly wound report with staging for pressure ulcers, wound measurements and progress of wound.
   DON/designee will audit each resident's medical records with wounds on a weekly basis to ensure weekly measurements, staging if appropriate and a weekly progress note are documented and physician notification is made as clinically indicated.
   DON/designee and interdisciplinary team will review care plans weekly for residents with wounds to ensure updated interventions are recorded/implemented to promote wound healing. DON/designee will present findings of the weekly wound audits to the monthly QAPI meeting including continuing education provided.

Compliance date is 7/27/17

F315 It is the facility practice to provide care to urinary catheters and to prevent infections to the extent possible.

1. Res # 7 had supra-pubic cath site assessed by a RN and stoma area and tubing cleaned on 7/13/17. No s/s infection noted.

Monthly consultant pharmacist report will be reviewed with Admin and DON upon receipt and presented at monthly QAPI report to identify trends and develop performance improvement plans as indicated.

Compliance date is 7/27/17

F309G It is the facility practice to provide the necessary the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

1. Res # 3 has not had any emesis or nausea since 7/13/17.
   Res #17 had missing treatment documentation and missing weekly wound documentation – unable to correct missing documentation.
   Res #15 had missing documentation on the treatment administration record – unable to correct missing documentation.
2. Licensed staff educated by DON and Administrator on 7/20/17 regarding documenting medications, treatments, skin sweeps and weekly wound notes in medical records. Education also included notifying physician when change in condition identified.
3. DON/designee will review nurses' notes, 24 hour reports and electronic records dashboard daily Mon- Fri to identify changes in condition, events requiring physician notification and compliance with documenting meds, treatments, skin sweeps and wound notes. If non-compliance noted immediate re-education will be completed. DON/designee is verifying treatments are completed daily as ordered and documenting the verification.
4. DON/designee will audit weekly skin documentation to ensure wounds are assesses, measured, recorded and physicians notified as indicated. DON will verify electronic signatures for meds and treatments daily via clinical dashboard and will contact any nurse with missing documentation and require they return to facility to make late entry as appropriate.
   DON/designee will review nurses' notes, 24 hour report and clinical dashboard daily Mon-Fri to identify changes in condition or events requiring physician notification and/or nursing assessment and verify documentation is complete. DON will present findings of her audit to monthly QAPI x 3 months. DON/designee will continue educating new licensed staff as they are hired to ensure on-going compliance.

Compliance date is 7/27/17

F 312E It is the facility practice to provide necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

1. Res #4 saw podiatrist at his office on 7/6/17 with orders to return in 3 months. Nail care provided to both hands on 7/6/5/17. CP updated on 7/11/17 to include ADL needs.
   Res #3 hospice provides showers 2 xs week, nail care provided on 7/6/17 and is being monitored routinely through audit. Assisted with oral care during routine ADL care.
   Res #13 receives showers 2 x weekly based on his preferences for day/time. Bath aides are documenting baths/showers daily when given even if shower/bath given on an alternate date.
   Res # 6 receives showers on Mon/Wed/Fri from hospice.
2. Immediate audit conducted on 7/12/17 by assigned department heads to include nail care, oral care and missing baths/showers.
   DON assisted bath aides in interviewing residents to identify resident preferences for day and time of showers/baths – new bathing schedule implemented and C.N.A. electronic documentation platform updated with new days/times on (date).
3. Staff were in-serviced by Administrator and DON on 7/13/17 regarding providing assistance with ADLs to include nail care, oral care, hair care, shaving, bathing or showering based on plan of care and resident preferences.

F279E It is the facility practice to develop a comprehensive care plan for each resident.

1. Res #16 was discharged from the facility on 6/15/17 so no further corrective measures could be implemented.
   Res #17 care plan was updated to reflect bilateral surgical ankle wounds on 7/14/17.
   Res # 18 was discharged on 6/23/17 and no further corrective measures could be implemented.
   Res #14 care plan was updated on 6/21/17 and resolved on 7/1/17.
2. RNs audited care plans for residents in like situations to ensure Care plans are accurate and reflect current status and interventions as of 08/04/2017.
3. MDS nurse in-serviced by Administrator regarding timely of assessments, updates to care plans and documenting changes in condition.
4. DON/designee will review 24-hour report, nurses' notes and electronic clinical dashboard daily MON-FRI to identify clinical issues requiring new or revised care plans. MDS nurse will attend same meeting and will work with interdisciplinary team to ensure CP is updated daily.
   MDS nurse/designee will report to QAPI monthly x 3 month the status of care plans, care plan meeting schedules and any missed opportunities with corrective measures implemented.

Compliance date is 07/27/17

F281F It is the facility practice to provide or arrange for services that meet professional standards of quality and to ensure the services are provided by qualified persons.

1. Res # 5 physician orders for insulin administration were reviewed by RN on 7/12/17.
   Res #6 physician orders for medication reviewed by RN on 7/12/17.
   Res #7 physician orders for medications and insulin reviewed by RN on 7/12/17.
   Res # 8 physician contacted for direction related to med times on dialysis days. New physician orders obtained and MAR changed to reflect new medication administration schedule on 7/13/17.
   Res #1 physician order for Vit D 3 was clarified and correct dosage obtained.
   Res # 2 had missing documentation r/t insulin administration – unable to correct missing documentation.
   Res # 3 had missing documentation r/t insulin administration – unable to correct missing documentation.
   Res #4 had missing documentation r/t medication administration and enteral feedings – unable to correct missing documentation.
   Res #14 is alert & oriented and has very specific requests r/t the application of the topical pain patch. Physician has been contacted as res is requesting the patch to be on at all times but changed 3 xs a day.
   Res #15 is missing documentation r/t results of accu-checks – unable to correct missing documentation.
2. Current residents with insulin orders were reviewed by RN on 7/12 through 7/13/17 to ensure orders complete. Medication orders reviewed and clarified if needed for current residents by RN on 7/12 and 7/13/17.
3. Administrator/ DON in-serviced licensed staff on 7/19/17 regarding following physician orders for completing and documenting accu-checks, medication administration and insulin administration, giving insulin within allotted time frames based on orders, notifying physician according to parameters set forth in the insulin orders and process for completion of med error reports, physician notification and resident/responsible party notification, proper process for handling meds not in facility and ordering new meds and using EDK box for 1st dose as appropriate.
4. DON/designee will review new orders daily Mon- Fri to ensure orders are complete and medications were ordered from pharmacy.
   Education with new licensed staff and new C.M.A.s as they are hired to ensure on-going compliance regarding proper med pass technique, documentation, ordering, transcribing and physician notification and med error reporting process.
   Omni Care will partner with facility to provide on-going monthly med pass observation, med pass education, and increased nursing support from Omni Care clinical services.

4. DON and Maintenance Director will present findings of their audits, education provided and any progressive coaching to the monthly QAPI meeting x 3 months.

Compliance date is 7/27/17

F431D It is the facility practice to ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles.

1. Res #8 the unlabeled insulin was discarded on 6/14/17 and a new insulin was obtained from the pharmacy with the correct label based on physician's order.
2. Medication carts were visually inspected by DON/designee on 6/15/17 to ensure no additional unlabeled medications were in the med carts.
   DON/Administrator provided education to licensed staff regarding proper labels for medications/biologicals and not administering medications if label is missing.
3. DON/designee to visually inspect med carts and complete audit tool to verify no unlabeled/expired medications are stored in med carts.
4. DON/designee will report findings of weekly audits to QAPI meeting for 3 months to identify trends and ensure on-going compliance.

Compliance date is 7/27/17