STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G029	A. BUILDING _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHLEENS RESIDENTIAL CARE	1505 EAST FIFTH STREET EMMETSBURG, IA 50536

(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
W 000	INITIAL COMMENTS The investigation 71204-C resulted in a determination of Immediate Jeopardy (IJ) on 9/28/17 at 3:00 p.m., based on the facility's failure to provide proper oversight of nursing personnel for adequate coverage and completion of required assessment, follow up, and treatment of wounds. The facility provided a plan to remove the IJ, which included staff training regarding skin care, adequate nursing personnel coverage for insulin dependent clients, and overall oversight of the facility. The IJ was removed on 10/2/17 at 1:45 p.m. Investigation findings resulte in condition-level deficiencies cited at W102 and W318, and standard-level deficiencies cited at W104, W331, W336, W339, and W365.	W 000	POC 12/5/17	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain minimal compliance with Condition of Participation (CoP) Governing Body and Management. The Governing Body failed to provide adequate oversight and operating direction to effectively ensure the health and safety of clients and provide appropriate services and supports in accordance with identified needs. Cross reference W104: Based on observation,	W 102	Administrator and Director of Nursing will develop and/or revise company polices and procedures to ensure the provision of appropriate healthcare services to meet identified client medical needs. These policies will include but not limited to: Insulin Policy & Procedures, Quarterly Nursing Assessments Policy & Procedures, Pressure Ulcer Policy & Procedures, and Administration of PRN Medications Policy and Procedures. Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 12/5/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharreen Mason	Administrator	10/30/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1 interviews and record review, the Governing Body failed to provide adequate oversight and operating direction to ensure the health and safety of clients. The facility failed to ensure provision of appropriate staff, supports, and services to meet client needs. Cross reference W318: Based on observations, interviews, and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Health Care Services. The facility failed to consistently provide adequate care and oversight to ensure provision of appropriate health care services to meet identified client medical needs. Cross reference W331: Based on interviews and record review the facility failed to provided adequate nursing services to meet client needs. The facility failed to ensure appropriately licensed and trained invidivudals consistently administered insulin injections as ordered. Cross reference W336: Based on interviews and record review the facility failed to consistently ensure completion of quarterly nursing assessments. This affected 15 of 15 clients living in the home. Cross reference W339: Based on observation, interviews and record review the facility failed to provided adequate nursing services and oversight in accordance with client needs. The facility failed to adequately identify and address development of a pressure ulcer. The facility failed to ensure documentation of medication treatments, communicate treatments being utilized, complete and update changes on the nursing care plan and failed to follow general nursing practices	W 102	(Cross Ref: W331) SEE W 331 FOR CORRECTIONS (Cross Ref: W336) SEE W 336 FOR CORRECTIONS (Cross Ref: W339) SEE W 339 FOR CORRECTIONS	

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W 104	Continued From page 3 When interviewed on 9/28/17 at approximately 2:00 p.m. the Administrator explained the use of the green foam applied over the seat of the wheelchair on 7/31/17. She explained when she did the investigation on 9/26/17 regarding an open area behind the right knee she checked the wheelchair and the green pad was off. It was in the clients' room and she did not know when it had been removed. She reapplied the green foam to the wheelchair seat. She denied any documentation or notification to the staff regarding the green foam and that it should remain on the wheelchair. She also denied documentation in the clients' record of the additional foam to assist the clients' knee to heal. Thus, Client #1's wheelchair lacked the needed padding to heal the first area of skin breakdown. See W339 for additional information. 2. When interviewed on 9/28/17 at 2:00 p.m. the Program Coordinator/Certified Med Aide confirmed she administered insulin on the weekends when nursing did not come to give it. She was not sure how many weekends this occurred but guessed she worked 2-3 weekends the last year. She confirmed she gave six shots a day between the two clients receiving insulin. She acknowledged she had informed the DON of giving the insulin because no one had shown up to do it. She admitted this was beyond the scope of her job duties. She admitted she forged the DON's initials after she gave the injections. When interviewed on 10/2/17 at 1:00 p.m. CMA B reported she administered insulin on the weekends. She thought she probably did the injections three times on the weekends. She	W 104	104 #1 Con't All Admin Personnel; Admin/QIDP, Director of Nursing, Program Coordinator, LPN will continue to utilize the Communication Book (located at the Nurse's Station) to notify staff of any changes or concerns regarding residents. QIDP will also document in the QIDP notes any concerns and changes to a resident's treatment and/or care plan. Responsible Persons: Admin/QIDP, Director of Nursing, Nursing Personnel, Program Coordinator. Date of Completion: 10/27/17 W 104 #2 The Nursing On Call Policy & Procedures was revised to include administration of insulin and the stipulation that any time a CMA is on call a member of the Nursing Personnel must be scheduled to administer insulin A disclaimer was also included which states " under no circumstance is a CMA allowed to administer insulin to any resident of this facility". Responsible Person: Admin/QIDP Date of Completion: 10/2/17 The Director of Nursing developed and implemented an On Call Schedule to ensure adequate Nursing coverage for insulin administration when CMAs are schedule for Medication Passes. The schedule will be developed per month and copies will be given to the Administrator and all Nurses and CMAs. A copy of each months schedule will be posted at the Nurses's Station for staff to reference. Responsible Persons: Director of Nursing, Admin/QIDP Date of Completion: 9/29/17	

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W 102	Continued From page 2 regarding charting. Cross reverence W365: Based on interviews and record review, the facility failed to ensure staff consistently maintained client medication administration records (MAR), as evidenced by staff failure to document administration of PRN (as needed) medications in accordance with facility policy and procedures.	W 102	(Cross Ref: W365) SEE W 365 FOR CORRECTIONS W 104 #1	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the Governing Body failed to provide adequate oversight and operating direction to ensure the health and safety of clients. The facility failed to ensure provision of appropriate staff, supports, and services to meet client needs. This affected 3 of 4 clients involved in the investigation of #71204-C (Client #1, #2 and #3) and potentially affected all clients residing in the facility (15 of 15) Finding follows: 1. Record review on 9/27/17 revealed a Medical Incident completed by the Director of Nursing (DON). The DON described the open wound found behind Client #1's right knee on 7/28/17. The Administrator completed an investigation on 7/31/17. She noted the bottom of the wheelchair seat was hard. A green pad was placed over the hard seat to protect the clients' knee and give the "sore time to heal without adding more pressure on it."	W 104	All residents and their Care Plans will be reviewed at the schedule monthly meetings or in-services. Admin/QIDP will continue to use the current Training Verification Form which all staff are required to sign, signifying that they have been trained and understand all aspects of the training or meeting. Admin/QIDP will implement a Meeting Binder to be kept at the Nurse's Station which will contain typed meeting notes from each meeting/in-service for staff to review and initial. This will ensure that all staff are aware of the information discussed at the meeting. It will also be available for staff to reference when questions arise. Admin/QIDP and Director of Nursing will implement a Care Plan Binder to be kept at the Nurse's Station which will contain all resident's current Care Plans for staff to reference. Director of Nursing will be responsible for keeping the binder up to date with each resident's most recent care plan. When changes are made to a resident's care plan the Director of Nursing will place an updated copy of the care plan in the communication book for all staff to review and sign. The signed copy will then be placed in the residents file.	

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W 104	Continued From page 4 admitted it was beyond the scope of her duties. When interviewed on 10/2/17 at 12:50 p.m. the Administrator reported she had been aware of the CMAs administering subcutaneous injections for a couple months. She directed the nurses to make sure they covered the shifts and assumed it never happened again. She denied documentation or any follow-up regarding the problem being resolved. See W331 for additional information. 3. Record review on 9/28/17 revealed Client #1's most recent Physical Therapy evaluation, dated 7/6/17, included the following recommendation: "Due to poor to no wt (weight) bearing, so 100% of pts (patients) weight lifted by staff, recommend hoyer sling lift for this client, for client and staff safety." The PT evaluation was noted by the Director of Nursing (DON) on 7/6/17 at 11:30 a.m. Observation on 9//27/17 at 4:00 p.m. revealed two staff transferred Client #1 from the wheelchair to the bed. Licensed Practical Nurse (LPN) B confirmed the client required a two person transfer. When interviewed on 10/3/17 at 10:45 a.m. the Administrator reported they looked for a lift to be used for several clients, if needed. They were also checked costs and the Administrator of the building evaluated cost reports. She confirmed a lift had not been ordered, but she had spoken with the Administrator of the building with in the last week. She denied any documentation regarding this request or any other discussions about the lift recommended for Client #1, since 7/6/17.	W 104	W 104 #2 Con't Scheduling Policy & Procedures will be revised to include an area strictly for Nursing Services. The Policy will include the administration of insulin, the role of CMAs and a contingency plan for coverage if no Nurse's are available. Kathleen's is contracted with Grapetree, their services will also be added to our policy and procedures. Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 12/5/17 W 104 #3 QIDP will review all Professional recommendations within 30 days of receipt. QIDP will document all progression or lack of progression towards recommendations. QIDP will also document reasons as to why IDT chose not to follow recommendations. IDT will meet weekly (at a minimum monthly) and each resident will be reviewed; medical, behavioral, professional recommendations, etc. IDT notes will be typed and all members of the IDT will sign said notes. Notes will then be placed in the IDT Meeting Notes Binder, located in the Administrator's Office. Responsible Person: Admin/QIDP, Director of Nursing, Nursing Personnel, Program Coordinator Date of Completion: 10/27/17	

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W 104	Continued From page 5 See W159 for additional information.	W 104		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Health Care Services. The facility failed to consistently provide adequate care and oversight to ensure provision of appropriate health care services to meet identified client medical needs. Findings follow: Cross reference W331: Based on interviews and record review the facility failed to provided adequate nursing services to meet client needs. The facility failed to ensure appropriately licensed and trained invidivudals consistently administered insulin injections as ordered. Cross reference W336: Based on interviews and record review the facility failed to consistently ensure completion of quarterly nursing assessments. This affected 15 of 15 clients residing in the facility. Cross reference W339: Based on observation, interviews and record review the facility failed to provided adequate nursing services and oversight in accordance with client needs. The facility failed to adequately identify and address development	W 318	(Cross Ref: W331) SEE W 331 FOR CORRECTIONS (Cross Ref: W336) SEE W 336 FOR CORRECTIONS (Cross Ref: W 339) SEE W 339 FOR CORRECTIONS	

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W 318	Continued From page 6 of a pressure ulcer. The facility failed to ensure documentation of medication treatments, communicate treatments being utilized, complete and update changes on the nursing care plan and failed to follow general nursing practices regarding charting. Cross reference W365: Based on interviews and record review, the facility failed to ensure staff consistently maintained client medication administration records (MAR), as evidenced by staff failure to document administration of PRN (as needed) medications in accordance with facility policy and procedures.	W 318	W 318 (Cross Ref: W 365) SEE W 365 FOR CORRECTIONS	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to provide adequate nursing services to meet client needs. The facility failed to ensure appropriately licensed and trained in consistently administered insulin injections as ordered. This affected 2 of 3 sample clients (Client #2 and #3). Findings follow: 1. When interviewed on 9/28/17 at 10:30 a.m. Habilitation Training Aide (HTA) A denied seeing nurses on the weekends. The HTA reported insulin given on the weekends by Certified Medication Aide (CMA) A. In an interview with HTA B on 9/28/17 at 10:35 a.m. revealed CMA B administered insulin on	W 331	Admin/QIDP and Director of Nursing will develop an Administration of Insulin Policy & Procedures. Those residents who receive insulin will have individualized insulin procedures added to their medication administration procedures. . Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 12/5/17 SEE ALSO W 104 #2 CORRECTIONS	

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W 331	Continued From page 7 weekends because she (CMA B) "was a CMA". Record review on 9/28/17 identified obvious changes to the Medication Administration Record (MAR) from weekend days and weekday initials. The documentation differences included: Staff A (licensed practical nurse) initials always appeared in blue ink. LPN A admitted on 9/28/17 she always used blue pens to chart (unless she did not have blue). On the weekend, chartings of the Certified Med Aids A and B, the initials were in black ink along with black ink initials of either LPN A or the DON in black ink. When interviewed on 9/28/17 at 7:30 a.m. the DON reported she or LPN A always came in on the weekends to administer insulin to Client #2 and Client #3. On 10/2/17 at 12:15 p.m. the DON acknowledged she did not notice someone writing down her initials on the MAR over a weekend. She denied instructing CMAs to give the insulin, but did report communication problems when the CMAs would switch with an LPN and there would not be coverage available for a nurse to give the insulin. She thought the problem began in July and August. She did not recall the CMAs talking to her about this. She did not know if the Administrator was aware of the issue. When interviewed on 9/28/17 at 7:05 a.m. LPN A reported she or the DON came to the facility to administer insulin if the med passer was a CMA. She said it was usually the DON because she lived in town. She stated she did not document her time in the facility, as it did not take very long. She denied signing her initials after a weekend a CMA would have worked. When interviewed on 10/2/17 at 11:30 a.m. LPN A acknowledged a problem with nursing availability for administration	W 331		

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W 331	Continued From page 8 of insulin on the weekends. She did not know how long it had been a problem. She reported she did notice her initials being forged, and was aware the two CMAs administered insulin. When interviewed on 9/28/17 at 2:00 p.m. the Program Coordinator/Certified Med Aide confirmed she administered insulin on the weekends when nursing did not come to give it. She was not sure how many weekends this occurred but guessed she worked 2-3 weekends the last year. She confirmed she gave six shots a day between the two clients receiving insulin. She acknowledged she had informed the DON of giving the insulin because no one had shown up to do it. She admitted this was beyond the scope of her job duties. She admitted she forged the DON's initials after she gave the injections. When interviewed on 10/2/17 at 1:00 p.m. CMA B reported she administered insulin on the weekends. She thought she probably did the injections three times on the weekends. She admitted it was beyond the scope of her duties. When interviewed on 10/2/17 at 12:50 p.m. the Administrator stated she had been aware of the CMAs administering the subcutaneous injections for a couple months. She informed the nurses to make sure they covered the shifts and assumed it never happened again. The Administrator was unable to provide documentation or any follow-up regarding the problem being resolved.	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a	W 336		

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W 336	Continued From page 9 quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to consistently ensure completion of quarterly nursing assessments. This affected 15 of 15 clients living in the home (Clients #1-Client #15). Findings follow: Record review on 10/3/17 revealed Client #1's last quarterly nursing assessment completed 3/23/17. Additional review on 10/3/17 revealed clients' most recent quarterly nursing assessments completed as follows: a. Client #2: 3/16/17. b. Client #3: 4/6/17. c. Client #4: 3/23/17. d. Client #5: 6/2/17. e. Client #6: 3/23/17. f. Client #7: 3/30/17. g. Client #8: 4/6/17. h. Client #9: 3/9/17. i. Client #10: 3/2/17. j. Client #11: 3/23/17. k. Client #12: 5/3/17. l. Client #13: 4/27/17. m. Client #14: 5/3/17. n. Client #15: 3/23/17. When interviewed on 10/3/17 at 11:15 a.m. the Director of Nursing confirmed quarterly nursing assessments had not been appropriately completed, as scheduled, for all 15 clients residing in the facility.	W 336	Admin/QIDP and Director of Nursing will develop a Quarterly Nursing Assessment Policy & Procedures. Admin/QIDP will sign off on all Quarterly Assessments once completed. QIDP will monitor due dates and completion dates for all resident's Quarterly Nursing Assessments using the 2017 Quarterly Nursing Assessment Form. Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 12/5/17	

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W 339	Continued From page 10	W 339	Nursing will continue to monitor the wound 2 times per week (per wound nurse instructions) or as needed and will document in Nurse's Notes and on the Pressure Skin Report. Pictures of the area will be taken and placed on the server at minimum one time per week to document the progression of healing. Resident will continue to see the Wound Nurse as ordered and Nursing Personnel will follow through with treatment ordered. Responsible Persons: Director of Nursing, Nursing Personnel Date of Completion: 9/25/17 Admin/QIDP will continue to monitor the healing process of the wound and will document accordingly in the QIDP notes. Admin/QIDP will visualize the area at minimum weekly. Admin/QIDP will continue to monitor the Nurse's Notes and Pressure Skin Report to ensure timely and accurate charting and will document in QIDP Notes. Resident's treatment and progress will be reviewed at minimum weekly, during IDT and documented in the IDT Meeting Notes. Responsible Persons: Admin/QIDP, Director of Nursing, Nursing Personnel, Program Coordinator Date of Completion: 9/27/17	
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide adequate nursing services and oversight in accordance with client needs. The facility failed to adequately identify and address the development of pressure ulcers. The facility failed to ensure documentation of medication treatments, communicate treatments being utilized, complete and update changes on the nursing care plan and failed to follow general nursing practices regarding charting. This affected 1 of 3 sample clients (Client #1). Findings follow: 1. Client #1 had a physical exam completed on 12/21/16. The exam report identified the resident's diagnosis included: cerebral palsy (abnormal motor function), severe mental retardation, lower extremity edema, scoliosis (curvature of the spine), history of anorexia (eating disorder), enlarged thyroid (gland) and hiatal hernia (upper part of stomach pushes through diagram). On 9/27/17 at 4:30 p.m. observation identified an open area behind Client #1's right knee. The area measured 2 cm x [by] 1.5 cm x 0.5 cm with tan exudate in the wound. The surround area appeared red. No active bleeding observed. The area behind the left knee also was covered with	W 339		

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W 339	Continued From page 11 Telfa (dressing) and measured 1 cm x 1.5 cm x 0. The linear area appeared slightly swollen with surround redness. Photographs were obtained from both the right and left and right areas. The Centers for Medicare and Medicaid Services (CMS) identify the following stages of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Record review on 9/27/17 revealed a Medical Incident, completed by the Director of Nursing (DON) 7/28/17, noted an injury to the back of Client #1's right knee. Under medical treatment, the DON documented the following: No active drainage noted. Measuring 1.0 centimeters (cm) x 0.5 cm (L x W) (length x width) and 0.3 cm depth. Cleansed. Bacitracin applied. Covered with Telfa and secured with Mediplex tape. A 24 hour update documented by the DON on 7/29/17 at	W 339	Bathing Policy was revised to include skin checks to ensure that staff are visualizing and inspecting the integrity of the residents skin for any changes that would need to be addressed by the Nursing Personnel for further assessment, medical interventions and monitoring. Responsible Persons: Admin/QIDP, Director of Nursing, Program Coordinator Date of Completion: 9/28/17 Bath Sheets were revised to include an area to document that a skin check was completed. Included on the form is also instructions on reporting any skin issues to Nursing Personnel immediately. Responsible Persons: Admin/QIDP, Director of Nursing, Program Coordinator Date of Completion: 9/29/17 Emergency Staff Training occurred on 9/29/17, topics covered included; resident skin checks, reporting of injuries or areas of concern, follow-up procedures, documenting of skin checks, completing medical incident reports and bathing procedures. All staff were required to sign the Training Verification Form. Policies were also reviewed and copies given to staff; Physical Neglect and Suspected Abuse Policy, Copyof Medical Incident Report, and Incident of Unknown Origin Policy & Procedures. Staff were required to review all policies and sign acknowledgment forms for each. Responsible Persons: Admin/QIDP, Director of Nursing, Program Coordinator Date of Completion: 9/29/17	

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	16G029	A. BUILDING _____ B. WING _____	C 10/05/2017

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W 339	Continued From page 12 9:00 p.m., documented and noted the following: Decreased redness noted on surrounding skin. Area measuring 0.7 x 0.3 and 0.2 depth. Area cleansed, Bacitracin (antibiotic treatment) applied and covered with Telfa. Secured with Medi-pore tape. Further record review revealed the client's Nurses Notes documented the following: On 7/28/17 at 8:50 p.m. Staff reports blood noted to soaker pad on wheelchair. Noted to have open area to back of right knee. No active drainage noted. The area measured. Cleansed and Bacitracin applied and covered with Telfa. Secured with Medi-pore tape. No outward signs of pain noted. Skin assessment sheet initiated. This note was signed by the DON. On 7/28/17 at 9:10 p.m. 24 hour F/U (follow up) - Decreased redness noted to surrounding skin. Area cleansed, Bacitracin applied. Covered with Telfa and secured with tape. Will continue to monitor. Signed by the DON. On 9/19/17 at 6:30 a.m. the area resolved. No further treatment required. Initiated thigh high TED (thromboembolic disease-compression stockings to prevent blood clot formation) stockings at this time. The Nurse's Notes was signed by Staff A (Licensed Practical Nurse). Continued record review revealed Non-Pressure Skin Condition Records that noted the following: On 7/28/17 an open area to the posterior (back) right knee, characterized as intact, surrounding skin reddened, not changed. Continue Treatment. Measured length 1.0 cm	W 339	The Incident of Unknown Origin Policy & Procedures was revised to include more detailed instructions for reporting injuries, the necessary follow-ups that are to be done by the Nursing Personnel, Admin/QIDP and instructions on how to complete the Medical Incident Report. Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 10/2/17 The Medical Incident Report was revised to include an area to document when the injury is resolved. A signature line was also added for the Admin/QIDP to sign to verify that the injury has been resolved. Responsible Persons: Admin/QIDP, Director of Nursing, Nursing Personnel Date of Completion: 10/3/17 Staff training completed on 10/5/17, topics covered and reviewed were; resident skin checks, revised Medical Incident Report, communication book, new Meeting Notes Binder, new bathing schedule that was recommended by the Wound Nurse & reason for it, 2-10 Nursing/CMA coverage all staff were required to sign the Training Verification Form. Responsible Persons: Admin/QIDP, Director of Nursing, Nursing Personnel, Program Coordinator Date of Completion: 10/5/17	

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W 339	Continued From page 13 (centimeters) x width cm 0.5 x depth 0.3. The Progress Notes documented: Area cleansed and Bacitracin applied, covered with non-stick Telfa and secured with tape. The DON signed this entry. On 7/29/17, the measurements were noted as length 0.7 cm x width 0.3 cm and depth 0.2 cm. Area noted as not changed. Progress notes documented the area as cleansed and Bacitracin applied. Bacitracin applied. Covered with non-stick Telfa and secured with tape. This entry signed by the DON. On 8/4/17 the measurements were noted to be length 0.6 cm x width 0.3 cm x depth 0.2 cm. Area noted as improved. Progress Notes documented the area continues covered with non-stick Telfa and Bacitracin applied to surrounding skin. A scant amount of serous drainage noted. The DON signed this entry. . On 8/11/17 the measurements noted as length 0.4 cm x width 0.2 cm x depth 0.2. The area noted as improved. The Progress Notes identified the nurse covered the area with Telfa after left open to air to dry after bath. No outward signs of pain noted and afebrile (without fever). This entry was signed by the DON. On 8/18/17 the measurements were noted as length 0.4 cm x width 0.1 x depth 0.1 cm. The area noted as improved. Progress Notes identified the day bath changed to every other day on 8/17/17. Area continues covered with non-stick Telfa, secured with tape, TED hose held and (not applied) on 8/14/17." This entry signed by the DON.	W 339	Due to the influx of Medical Incident Reports a binder was developed and implemented for all Medical Incident Reports to be placed in for staff to review and reference. This will ensure that injuries are not being documented and reported a second or third time. Responsible Persons: Admin/QIDP, Director of Nursing, Nursing Personnel Date of Completion: 10/5/17 Repositioning Forms were developed for those residents unable to reposition themselves independently throughout the night . This will ensure that residents are being repositioned every two hours which will aide in the prevention of pressure areas that could lead to pressure sores/ulcers. Responsible Persons: Admin/QIDP, Director of Nursing, Program Coordinator Date of Completion: 11/1/17 Resident data sheets have been revised to include an area for documentation of skin checks. This will ensure that skin checks are getting done even on days when a resident has no bath. Responsible Persons: Admin/QIDP, Program Coordinator Date of Completion: 11/1/17	

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W 339	Continued From page 14 On 8/25/17 the measurements noted to be: length 0.3 cm x width 0.1 cm x depth 0.1 cm. Area noted as improved. Comments documented: TED hose remain off. Area remained normal in color. No drainage noted. Afebrile and area covered with Telfa and secured with tape. The entry signed by the DON. On 9/1/17 the measurements noted to be: length 0.2 cm, x width 0.1 cm depth 0. Comments noted: Area remained free from s/s (signs and symptoms) of infection. Continue to cover area with Telfa for protection. Staff A signed this entry. On 9/15/17 the measurements noted to be: length 0.1 cm x width 0.1 cm. Comments noted: Area scabbed over. No s/s of infection. Remains covered with Telfa. TED hose remain off. Entry signed by Staff A. On 9/19/17 the measurements noted to be: length 0 cm x width 0 x depth 0. Comments noted: Area resolved. Thigh high TED hose initiated. Entry signed by Staff A. Record review identified Client #1's physician orders included: Bacitracin Ointment 500 Units/ GM (gram). Orders directed to apply topically to open or affected areas BID (twice a day)/ PRN (as needed) until clear may repeat. (See W365 for additional information) When interviewed on 9/28/17 at 10:45 a.m. the DON stated she documented on the Medical Incident report initially and at the 24 hour follow-up. She completed a non-pressure skin assessment at the time it was noticed and weekly thereafter. She denied a policy regarding documentation of prolonged skin assessments. She explained the nurses met weekly to discuss	W 339	Policy and Procedures will be developed and implemented for dealing with pressure sores/ulcers. Included in Policy & Procedures will be; Prevention, Diagnosis, Assessment, Stages of, Medical Interventions, Special Professional Interventions, Documentation,Treatment and other Professional recommendations, such as Dietary. Responsible Person: Admin/QIDP, Director of Nursing Date of Completion: 12/5/17 Training will be provided to all personnel at Kathleen's ICF/ID from a licensed WCON to educate personnel on how pressure ulcers develop, how to identify pressure ulcers, stages of pressure ulcers, and how to prevent ulcers. Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 12/8/17	

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W 339	Continued From page 15	W 339		

verbally any issues. She informed LPN A of the Bacitracin treatment. She said if she would pass the information to the other staff it would be by a note or on the communication log at the nurse's station.

Record review on 9/28/17 revealed lack of any documentation at the nurses station or communication log regarding the treatment of Client #1's wound behind his/her right knee.

When interviewed on 9/28/17 at 1:20 p.m. the Administrator stated staff were trained to check the skin during bathing and notify nursing if problems occurred. She denied any documentation or training or a policy/procedure to indicate this was expected/completed.

Record review on 9/28/17 revealed Client #1's Nursing Care Plan undated. The plan instructed staff to check the client's skin at least once daily, apply Ted hose, elevate legs and reposition at least every 2 hours. The Nursing Care Plan lacked any indication of a skin wound, changes with TED hose, or interventions for staff to be aware of. The Care Plan lacked nursing direction for staff to maintain skin integrity, cleanliness or be alert to any unusual alarming symptoms which could have occurred.

Review of the communication log at the nursing area identified a note on 9/19/17 from LPN A communicated as: (Client #1) now has thigh high TED hose. Any questions see nursing.

Continued record review revealed no documented assessment of the area from 9/19/17, after initiation of the TED hose, until 9/25/17, when the area was again noted to be

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W 339	Continued From page 16 open. On 9/28/17 at 10:45 a.m. the DON was interviewed and explained on 9/25/17, during the p.m. shift, and Staff B (licensed practical nurse) telephoned the DON. Staff B informed her of Client #1's open area behind the right knee. Staff B sent the DON a picture of the area. DON checked with LPN A via phone to find out if she knew anything about the open area. LPN A denied knowledge of the area. LPN B explained the area opened when the TED hose were removed that evening. The client did not have a fever and the area not actively bleeding. The DON told Staff B to cover the area. Record review on 9/28/17 identified a Nurses Note dated 9/25/17 at 8:25 p.m. and written by the DON. The note indicated she received a telephone call from Staff B that while staff removed the TED hose on the right leg, a skin tore from area behind the right knee and the area opened. The client had no elevated temperature and skin surrounding the area had a reddened appearance. Area covered with ABD and serosanguinous (yellow or pink watery) drainage noted. The documentation failed to note the entry as a "late entry." When interviewed on 9/28/17 at 10:45 a.m. the DON confirmed she was not present at the facility on 9/25/17, but wrote the note the following day. Also on 9/26/17 she documented: At 6:45 a.m. the area to the back of the right knee measured 1.1 cm (centimeters) x 0.4 cm with 0.3 cm depth. Skin surrounding is reddened in appearance. Active drainage noted. No outward signs of pain noted. Skin assessment sheet initiated.	W 339		

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W 339	Continued From page 17 Review of the Pressure Skin Condition Report dated 9/26/17 revealed documentation by the DON of 1.1 x 1.4 with a depth of 1.3 cm. The comment section indicated the surrounding skin reddened in appearance. Wound bed pink with visible tendon and a Dr. appointment made for that morning. Record review on 9/28/17 revealed a consult with the physician from 9/26/17 and documented a subcutaneous abscess of posterior R (right) knee. Read x-ray of right knee. Referred to a general surgeon and to check CBC (Complete Blood Count) and antibiotics were ordered. When interviewed on 10/2/17 at 2:10 p.m., the general surgeon revealed the area did not require surgical intervention. The surgeon stated the client was referred to a wound nurse. Record review on 10/3/17 revealed a wound nurse consultation at 10:35 a.m. that day. The doctor's orders and progress notes documented the following: Initial evaluation and treatment for full thickness ulcer to RT (right) popliteal space (behind right knee). Patient has had this ulcer since 9/25/17 when it re-opened. Quite possibly even if the wound had sealed over there was still infection in the sealed over wound. Have seen this happen in my time in my experience. The ulcer measured 1.0 cm x 1.0 cm x 0.4 cm depth. There is granulation tissue (new connective tissue and shows signs of healing) noted in the base of the ulcer. The periwound (skin around open area) clean and intact. Is finishing course of ATB (antibiotic), but culture had numerous organisms with one of the organisms being a bacteria called Staphylococcus Aureus (staph aureus). The staff re-cultured the ulcer with this	W 339		

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W 339	Continued From page 18 visit (used swab and obtained drainage). Recommendation: Discontinue Triad cream to right popliteal ulcer (behind knee). Switch to silver calcium alginate, cover with Mepilex foam, and change 2 times per week on bath days and as needed if dislodged. Decrease baths to 2 times a week. Follow-up appointment on 10/10/17 at 10 a.m.	W 339		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff consistently maintained client medication administration records (MAR), as evidenced by staff failure to document administration of PRN (as needed) medications in accordance with facility policy and procedures. This affected 1 of 1 client (Client #1) identified with a skin ulcer in #71204-C. Finding follows: See W 331 for additional information Record review on 9/27/17 revealed a Medical Incident report completed on 7/28/17. The report described an open area behind Client #1's knee measured 1.0 cm (centimeters) x 0.5 cm (LxW) (length x width) and 0.3 depth. The Director of Nursing (DON) documented she cleansed the area and applied Bacitracin and covered the area. Record review of the MAR revealed no indication of Bacitracin ointment application in July, August	W 365	A policy for Medication Administration will be developed and implemented. Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 12/5/17 Admin/QIDP and Director of Nursing will develop Policy & Procedures for the administration of PRN medications. Director of Nursing will review all resident's medication administration records at a minimum weekly to ensure accurate documentation. Admin/QIDP will revise current MAR to include a date for results, if they are occurring 24 hours after administration as would be the case for ointments, eye drops and ear drops. Responsible Persons: Admin/QIDP, Director of Nursing Date of Completion: 12/5/17	

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W 365	Continued From page 19 or September 2017. When interviewed on 9/28/17 at 10:45 a.m. the DON confirmed she failed to document the use of Bacitracin on Client #1's skin wound behind his/her right knee. She added she or Licensed Practical Nurse (LPN) A completed the Bacitracin daily from 7/28/17 to 8/11/17, with neither of them documenting on the MAR. She acknowledged she failed to follow the medication policy. Interview with LPN A on 9/28/17 at 2:00 p.m. confirmed administration Bacitracin topical ointment during the healing of Client #1's skin wound. She confirmed she failed to document the application of the medication per policy.	W 365		