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	165441	A. BUILDING _____ B. WING _____	C 12/06/2017

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SUNNY VIEW CARE CENTER	410 N W ASH DRIVE ANKENY, IA 50023

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F 000	INITIAL COMMENTS Amended on February 14, 2018, following the IDR decision. ds Correction date 1/3/18 The following deficiencies relate to the investigation of complaint #72459. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000	The Facility denies that the alleged facts as set forth constitute a deficiency under interpretation of Federal and State law. The preparation of the following plan of correction does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of correction prepared was executed soley because the provision of State and Federal law required it.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure complete ongoing skin assessments were completed for two of six residents reviewed. (Resident #2 & #3) The facility census was 88 residents. Findings include: A Skin Assessments policy dated 2017 indicated the following: a. The purpose had been to ensure residents received proper assessments of their skin,	F 684	F684- Without waiving the foregoing statement, the Facility states that respect to resident #2 and resident #3, and all other similarly situated residents, Nurses were educated on 1-2-18 in regards to policy of followng weekly skin assessments and expected documentation of such assessments. The Director of Nursing and/or her designated representative will monitor for compliance through the facilities quality assurance program on a monthly basis. Unit Managers will conduct random audits to ensure ongoing compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/08/2018

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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maintained skin integrity and steps taken to ensure proper treatment and follow-up had been taken for residents with skin concerns.

b. The policy had been that each resident received weekly skin assessments and all concerns addressed by the facility and the resident Physician.

c. The hot charting information should have included the following:

1. Type of assessment.
2. Date and time of assessment.
3. Name and title of the individual completing the assessment.
4. Any change in resident's condition.
5. Condition of the skin (size, stage, type, color, location, odor, drainage and etc)
6. The treatment type (if applicable)
7. How the resident tolerated the treatment (if applicable)
8. Any problems or concerns related to the condition of the skin or treatment.
9. If the resident refused the treatment and why.

1. An Admission Record form dated 10/20/17 at 2:48 p.m., indicated Resident #2 had diagnosis that included anemia and peripheral vascular disease (PVD).

The MDS assessment dated 10/19/17, indicated the resident required extensive assistance of staff with bed mobility, transfers, dressing, toilet use and hygiene and as non-ambulatory.

A Care Plan with focus areas dated 10/20/17 indicated the resident was at risk for skin breakdown and wheel chair bound. The focus areas included the resident required the assistance of 2 staff for transfers.

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Observation of the residents room on 12/5/17 at 3:25 p.m., revealed no plastic insert on the lower side rail closest to the door on the residents bed.

A Skin Condition Report form dated 11/7/17 indicated the resident received a C shaped skin tear to the right outer calf that measured 3.0 centimeters (cm) by 1.0 cm with a depth of 0.1 cm and a small amount of drainage. The follow up assessments included:

a. 11/8 - 3.0 cm by 1.0 cm by 0.1 cm deep - red and a stable condition.
b. 11/9 - 3.0 by 1.0 by 0.1 deep - red and dry condition.
c. 11/10 - 3.0 by 1.0 by 0.1 deep - red and healing.
d. 11/11 - 3.0 by 1.0 by 0.1 deep - red around the scabbed curve but dry with a small amount of bloody drainage.
e. 11/12 - 3.0 by 1.0 by 0.1 deep - red around the scabbed curved area and no progress documented.
f. 11/13 and 11/14 - no assessment or progress of the area documented.
g. 11/17 - 3.2 by 1.0 - a hard dry scab with no progress documented.
h. 11/24 - 2.8 by 1.0 - a hard scab with no progress documented.
i. 12/1 - 2.0 by 0.5 - dry scab with no progress documented.

A Skin Condition Report form dated 11/14/17 indicated the resident received an unidentified bleeding area that measured 0.5 cm by 0.5 cm with no depth documented. The follow up assessments included:

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a. 11/15 = 2.4 by 0.8 - red moist skin tear with no progress documented.
b. 11/16 - 2.4 by 0.8 - red skin tear with no progress documented.
c. 11/17 - 2.3 by 0.8 - red open skin tear with no progress documented.
d. 11/18 - 2.2 by 0.9 - red open area with no progress documented.
e. 11/19 - no assessment or progress of the area documented.
f. 11/20 - 2.2 by 0.8 - red open area with no progress documented.
g. 11/21 - 2.0 by 0.5 - red and healing area.
h. 11/22 - 2.0 by 0.5 - red and dry area no progress documented.
i. 11/24 - 2.0 by 0.5 - red and dry area with no progress documented.
j. 12/1 - 1.0 by 0.3 - dry scab with no progress documented.

During interview on 12/4/17 at 12:55 p.m., the resident indicated the 2nd skin tear occurred when the resident scrapped their right leg on the bottom part of the side rail, that had no plastic protector in the circle. Observation at the time revealed no plastic insert in the circular area on the bottom portion of the side rail closest to the door.

On 12/6/17 at 1:20 p.m., Staff A, Licensed Practical Nurse, LPN conducted an interview with the resident at which time the resident indicated they received the second skin tear from the side rail closest to the door as she reached down and touched the side rail and said from the circle thing that does not have a cap on it.

During interview on 12/6/17 at 1:35 p.m., Staff L, Certified Nursing Aide, CNA indicated the skin

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tear on 11/14 would have occurred when staff transferred the resident from bed to wheel chair. Staff L confirmed the resident as alert and oriented.

3. The MDS assessment dated 9/1/17, indicated Resident #3 had diagnosis that included anemia, heart failure, hypertension and muscle weakness and required extensive assistance of staff with bed mobility, transfers, locomotion, dressing, personal hygiene and was non-ambulatory.

A Care Plan with focus areas initiated 8/17/17 indicated the resident required assistance with all activities of daily living since a recent hospitalization for hip surgery and at risk for skin breakdown related to impaired cognition, impaired physical mobility and incontinence. The interventions included the following:

a. Wheel chair used for mobility and propelled by staff.
b. Required 2 staff assistance and a front wheeled walker (FWW) and/or a hoyer lift device for transfers.
c. Geri sleeves to arms and lower extremities as allows
d. Ace wraps from toe to knee (hand written and not dated)

A Skin Condition Report form dated 10/2/17 indicated the resident received 2 skin tears on his/her right outer calf one area that measured 1.5 centimeters (cm) by 1.5 cm with no depth documented and the other area that measured 1.0 cm by 1.0 cm with no depth documented. The report failed to identify the 2 separate areas. On 10/3 through 10/7 the facility only measured

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one area and it had been unknown which area. On 10/8 and 10/16 the facility measured two areas but failed to identify which area. On 10/9 the facility measured one unidentified area. On 10/23 the facility healed area #1 however that area was never been identified and measured the second area at 1 cm by 1 cm scabbed area with no progress documented. The rest of the assessments documented:

a. 10/30 - no assessment of the area had been present.
b. 11/6 - 2.0 by 1.5 - scabbed area and healing.
c. 11/13 - no assessment of the area had been present.
d. 11/20 - 1.5 by 1.5 - scabbed area with no progress documented.
f. 11/27 - 2.0 by 0.7 - open ST with no progress documented.
g. 12/4 - 2.0 by 0.5 - red areas with no progress documented.

A Skin Condition Report form dated 10/9/17 indicated the resident received a 1.0 centimeters(cm) by 1.0 cm skin tear to the left calf. Further measurements included:

a. 8/10 - 1.0 by 0.5 - a dry scabbed area with no progress documented.
b. 8/11 - 1.0 by 0.5 - scabbed area with no progress documented.
c. 8/12 - 1.0 by 0.5 - scabbed area with no progress documented.
d. 8/13 - 1.0 by 0.3 - brown scabbed area with no progress documented.
e. 8/14 - 1.0 by 0.3 - scabbed area with no progress documented.
f. 8/15 - 1.0 by 0.3 - scabbed area and healing.

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g. 8/16 - no assessment of the area present.
h. 8/28 - 1.3 by 1.1 - brown scab with pink surrounding tissue.
i. 9/4 - 1.0 by 0.1 - pink scab and healing.
j. 9/11 - 1.0 by 0.1 - dry scab and healing.

A Skin Condition Report form dated 10/9/17 indicated the resident received a 4.0 centimeters(cm) by 4.0 cm open area over a previous bruise. Further measurements included:

a. 10/9 - 4.0 by 4.0 - with no appearance or progress documented.
b. 10/10 - 4.0 by 4.0 - with no appearance or progress documented.
c. 10/11 - 3.5 by 2.5 - with no appearance documented and the progress as healing.
d. 10/12 - 3.5 by 2.5 - with no appearance documented and the progress as healing.
e. 10/13 - 3.5 by 2.5 - with no appearance documented and the progress as healing.
f. 10/14 - 3.3 by 2.4 - with no appearance or progress documented.
g. 10/15 - 3.0 by 0.5 - area slightly moist with a superficial yellow wound bed with no progress documented.
h. 10/16 - 3.0 by 0.4 - area with a yellow wound bed and healing.
i. 10/23 - 3.0 by 0.4 - scabbed area and healing.
j. 10/30 - no assessment of the area present.
k. 11/6 - 1.0 by 0.5 - scabbed area and healing.
l. 11/13 - no assessment of the area present.
m. 11/20 - 0.5 by 0.2 - scabbed area with no progress documented.
n. 11/27 - area healed.

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A Skin Condition Report form dated 10/29/17 indicated the resident received a skin tear to the right inner lower extremity that measured 1.5 cm. by 3.5 cm with a general appearance of open, scabbed edges and a red moist center. Further measurements included:

a. 10/30 - 1.5 by 3.5 - with no appearance documented and the progress stable.
b. 10/31 - 1.5 by 3.5 - with no appearance or progress documented.
c. 11/1 - 1.5 x 3.5 - with no appearance or progress documented.
d. 11/2 - no assessment of the area present.
e. 11/3 - 1.5 by 1.7 - area a dried scab with red and dry surrounding tissue and no progress documented.
f. 11/4 - 1.5 by 1.7 - scabbed area with no progress documented.
g. 11/5 - 1.5 by 1.5 - scabbed area with no progress documented.
h. 11/6 - 1.2 by 1.7 - scabbed area with no progress documented.
i. 11/13 - no documentation on the area present.
j. 11/20 - 1.2 by 1.5 - scabbed area with no progress documented.
k. 11/27 - 2.0 by 0.5 cm - scabbed area with no progress documented.
l. 12/4 - 2.5 by 0.3 - a red, open and weeping area with no progress documented.

A Skin Condition Report form dated 11/17/17 indicated the resident received a skin tear to his/her left lower extremity that measured 6.5 cm by 3.5 cm and 2.0 cm deep with serosanginous drainage and tissue exposure caused by a side rail. The facility staff then placed steri strips. Further measurements included:

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F 684	Continued From page 8 a. 11/18 - 6.5 by 3.5 and 2.0 cm deep and draining - no further appearance or progress documented. b. 11/19 - 6.5 by 0.2 - with no appearance or progress documented. c. 11/20 - 6.5 by 0.2 - with no appearance or progress documented. d. 11/21 - 6.5 by 0.2 - with no appearance or progress documented. e. 11/22 - 6.5 by 0.2 - with no appearance documented and healing. f. 11/23 - 6.5 by 0.2 - with no appearance or progress documented however the resident complained of pain. g. 11/24 - 6.5 by 0.2 - with no signs and symptoms of infection and stable. h. 11/27 - 6.0 by 2.5 - with no appearance or progress documented. i. 12/5 - 5.5 by 0.3 - area red and surrounded by multiple bruises and no progress documented.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to provide adequate supervision to ensure against hazardous side rails and wheelchair foot pedals	F 689	F 689- Without foregoing the following statement, the Facility states that with respect to resident #3 and Resident #2, and all other similary situated residents, side rails were assessed and end caps were replaced on rails on or before 12-6-2017. Maintenance will ensure ongoing that end caps or other devices are in place on rails when applicable.	

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which caused tears to the skin of Resident #2 and Resident #3. The sample consisted of 6 residents and the facility reported a census of 88 residents.

Findings include:

1. A document titled Admission Record, dated 10/20/17, identified Resident#2 had diagnosis that included anemia (Low number of healthy red blood cells in the body) and peripheral vascular disease (Condition of blood vessels that lead to narrowing and hardening of the arteries).

Resident #2 had a MDS (Minimum Data Set) assessment, with a reference date of 10/19/17. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15. A score of 6 identified the resident had cognitive problems. The MDS indicated the resident required extensive assistance of staff members for bed mobility, transfers, dressing, toilet use and hygiene. The MDS identified the resident as not ambulatory.

A Care Plan with focus areas dated 10/20/17 identified the resident as wheelchair bound. The interventions directed the staff the resident could propel self a short distance but staff assist for all other mobility. The interventions indicated the resident required 2 staff for transfers. The Care Plan identified the resident at risk for skin breakdown related to impaired cognition, incontinence and a history of pressure ulcers. The interventions included and directed staff to monitor skin weekly per protocol, during showers and when providing cares; Report any areas of concern to the nurse.

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The Nurse's Notes dated 11/7/17 at 1:00 a.m. indicated the resident had a right lower extremity skin tear area. The nurse cleansed the area with normal saline and covered the area with Telfa The nurse documented a ½ "C" skin tear that the resident thinks she hit on the wheelchair pedal when being put to bed.

The Skin Condition Report dated 11/7/17 indicated a 3 cm (centimeter) by 1 cm by .1 cm depth and located on the right outer calf. The report described the area as a "C" shaped skin tear with a small amount of drainage. The Skin Report indicated assessments daily from 11/9 through 11/12/17 and then on 11/17/17, 11/24/17 and 12/1/17. The last report on 12/1/17 indicated the area measured 2 cm by 0.5 cm and scabbed.

The Quality Assurance Condition Report dated 11/7/17, identified an intervention for staff to remove the wheelchair foot pedals with all transfers.

The Skin Condition Report dated 11/14/17, identified another skin tear which measured .5 cm by .5 cm and bleeding. The cause of the skin tear was from transferring to a wheelchair. On 11/15/17 the area measured 2.4 by 0.8. The report indicated on 12/1/17, the area measured 1 cm by 0.3 cm and scabbed.

The Quality Assurance Condition Report identified the area on the right lower leg and next to the old previous skin tear. The intervention initiated was to pad the wheelchair.

The Skin Condition Report dated 12/3/17 identified a skin tear located on the right upper extremity that measured 2.0 by 2.0 cm and full

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thickness. The report identified the cause of the skin tear was the resident had increased anxiety with the transfers and had fragile skin. The intervention to prevent further skin tears directed the staff to apply Geri Sleeves to the resident's arms and to monitor anxious behaviors for 1 week for possible medication review.

Observation on 12/5/17 at 3:25 p.m. identified no plastic insert on the lower side-rail, closest to the door.

On 12/4/17 at 12:55 p.m., the resident indicated the 2nd skin tear occurred when she scrapped her right leg on the bottom part of the side rail without a plastic protector in the circle. An observation at the same time revealed no plastic insert in the circular area on the bottom portion of the side rail closest to the door.

On 12/6/17 at 1:20 p.m., observation identified Staff A, Licensed Practical Nurse (LPN), conducted an interview with the resident. The resident stated she received the 2nd skin tear from the side rail closest to the door as she reached down and touched the side rail and stated from this circle thing that does not have a cap on it.

On 12/6/17 at 1:26 p.m., Staff A was interviewed and confirmed the above stated document.

On 12/6/17 at 1:35 p.m., Staff L, Certified Nursing Assistant (CNA) was interviewed and stated the skin tear would have occurred when staff transferred the resident from the bed to the wheel chair. Staff L stated she didn't notice anything until she saw blood on the resident's pants. The staff member confirmed the resident as alert and

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oriented. Staff L stated the resident knew what was going on around her and she knew her (Staff L) by name.

On 12/6/17 at 1:42 p.m. Staff M, Licensed Practical Nurse (LPN) was interviewed and stated when the 2nd skin tear occurred the resident had a Band-Aid over the 1st skin tear. The staff member confirmed the resident as alert and oriented.

2. Resident #3 had a MDS assessment with a reference date of 9/1/17. The MDS identified the resident had diagnosis that included anemia, heart failure, hypertension (elevated blood pressure), hereditary and idiopathic neuropathy, asthma (lung disorder), lack of coordination and muscle weakness. The assessment indicated the resident had a BIMS score of 0. A score of 0 identified severely cognitive impairment. The MDS indicated the resident had fluctuating inattention and required extensive assistance of staff for bed mobility, transfers, locomotion, dressing, personal hygiene and non-ambulatory.

A Care Plan with a focus areas initiated on 8/17/17, indicated the resident required assistance with all activities of daily living since his/her recent hospitalization for hip surgery and at risk for skin breakdown related to impaired cognition, impaired physical mobility and incontinence. The interventions directed the staff to do the following:

Wheel chair used for mobility and propelled by staff.

Two staff assistance and a front wheeled walker (FWW) and/or a Hoyer lift (mechanical) device for

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transfers.

Geri sleeves to arms and lower extremities as allowed.

Ace wraps from toe to knee (hand written and not dated).

A document titled Quality Assurance Condition Report dated 9/11/17 at 8:15 a.m. indicated the resident received a skin tear to her right outer calf that measured 2 cm by 2.0 cm, no depth, dried blood present and staff had been unable to approximate the area (position the skin together).

The Quality Assurance Condition Report dated 9/12/17 at 9:00 p.m. indicated the resident received a skin tear to her left calf.

On 12/6/17 at 10:43 a.m. Staff C, Certified Medication Aide (CMA) was interviewed and stated when herself and Staff D, Certified Nursing Assistant (CNA) transferred the resident to bed she hit her leg on the bed but not the side rail. The staff noticed the area when they positioned the resident in bed so they reported it to the nurse who assessed the area and said the area had already been present it just re-opened.

On 12/6/17 at 2:42 p.m., Staff E, Licensed Practical Nurse (LPN) indicated she had been unaware if the resident hit her leg or not but the above stated area had been scabbed and just re-opened.

According to a form titled Witness Statements form dated 12/2/17 at 8:15 a.m., Staff H, CNA documented she removed the resident's geri sleeve from the resident's weeping and swollen

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leg and observed the skin tear.

A Quality Assurance Condition Report form dated 10/29/17 at 7:30 p.m. indicated the resident received a Skin tear to her right lower extremity that measured 1.5 cm by 3.5 cm, with no depth and with red, moist scabbed edges.

A Skin Condition Report form dated 11/17/17 indicated the resident received a skin tear to her left lower extremity that measured 6.5 cm by 3.5 cm and 2.0 cm deep with serosanguinous drainage and tissue exposure caused by a side rail. The facility staff then placed steri-strips to close the wound.

The Nurse's Notes dated 11/17/17 at 7:15 p.m. contained the following documentation:
A new 6.5 by 3.5 by 2.0 cm skin tear found to the left inner calf observed. The resident wore geri sleeves and had on pants. The resident's left calf hit the side rail while positioned in bed. The area was cleansed, 5 steri strips applied and covered with gauze. Wool to cover side rails and wheel chair legs initiated.

On 12/5/17 at 1:40 p.m., Staff J, CNA, was interviewed and stated herself and Staff I, CNA transferred the resident from a wheel chair to bed while the resident wore leg protectors and pants. As the staff members sat the resident on the edge of the bed, the resident yelled out in pain. The staff members then laid the resident down in bed and she noticed fluid on the resident's pants and bed. This staff member stayed with the resident as Staff I informed the nurse. The staff member confirmed she knew the area came from the side rail because the skin tear had been at the same height and the rail had a jagged edge

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on the circle part of the rail that pointed towards the foot of the resident's bed and the skin tear tore down like the exposed circle on the rail. The staff member confirmed she felt along the rail and felt the jagged edges.

On 12/5/17 at 4:34 p.m., Staff I CNA, confirmed herself and Staff J pivot transferred the resident from the wheelchair to bed and sat her on the edge of the bed. Staff J supported the resident's upper body while she swung the resident's legs onto the bed. The staff member stated once they put the resident in bed, she complained of pain, however, the resident didn't voice complaints while in the wheelchair. The staff members then lifted the resident's pant leg and noticed a geri sleeve in place with blood on the sleeve but she did not recall any tears or rip in the geri sleeve. The staff member then went to get the nurse while Staff J stayed with the resident. When the nurse arrived she left the resident's room and answered call lights.

On 12/5/17 at 12:27 p.m. Staff K, Registered Nurse (RN) was interviewed and stated that night 2 staff members assisted the resident with hour of sleep (HS) cares. After the staff positioned the resident in bed, they informed her [Staff K] the resident hit leg on the side rail. When she entered the room, the resident laid in bed and wore calf length socks and geri sleeves; however, one had a cut through it. When she assessed the area, she noted a fairly deep cut that drained serosanguinous drainage. She placed a gauze, applied pressure, placed 6 steric strips as the area became well approximated, covered the area with a non-adherent dressing, wrapped the area with Kerlix and put the geri sleeves back over the area for pressure and protection of the

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leg.

Review of an Emergency Room (ER) note dated 11/18/17 at 7:54 p.m., indicated the resident presented with a left posterior lower leg injury.

Review of an Emergency Doctor (ED) Provider Notes form dated 11/18/17 at 8:02 p.m., documented per a Sunny View Nurse; the resident was transferred between the beds the day prior when her left calf caught the bed rail which caused the laceration. The area had been anchor shaped and measured 6.5 cm on the hook area and 4 cm on the top of the hook with the subcutaneous tissue exposed. The Physician applied 4 loose sutures and added steri-strips.

A Quality Assurance Condition Report form dated 12/2/17 at 8:15 a.m. indicated the resident received a skin tear to her right shin. When the CNA's removed the resident's geri-sleeves on her legs, they noticed the area. The legs wept with 3 plus (+) pitting edema.

A Skin Condition Report form dated 12/2/17 indicated the resident received a skin tear to her right shin that measured 4.5 cm by 0.3 cm.

On 12/6/17 at 9:29 a.m. Staff F, LPN was interviewed and stated the skin tear on 12/2/17 resulted from removal of the geri sleeves.

Observation on 12/5/17 at 3:25 p.m. identified 20 of the 49 beds checked with 1 or 2 side rails had missing 1 to 4 plastic inserts (caps) on the end of the side rails with 3 of those areas without plastic inserts confirmed as rough and jagged by the maintenance man.

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F 689	Continued From page 17 A Skin Condition Report form dated 10/2/17 indicated the resident received a skin tear to her right outer calf. One measured 1.5 cm by 1.5 cm and the other 1.0 cm by 1.0 cm.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident and staff interviews, the facility failed to ensure resident bed rails were safe and in good repair. (Resident #2 and #3) The facility census was 88 residents. Findings include:	F 700	F700- Without foregoing the following statement, the Facility states that with respect to residents #2 and resident #3, and all other similarly situated residents, Maintance Director was aware as of 12-5-17 that if warranted end caps can be replaced on side rails. Side rail end caps on beds were replaced on or before 12-6-17. Maintenance Director or designee will monitor on per facility policy as well as random audits will be conducted through Quality Assurance.	

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1. Based on observation on 12/5/17 at 3:25 p.m., 20 of 49 beds checked with 1 or 2 side rails had 1-4 plastic inserts missing on the end of the side rails with 3 of those areas confirmed as rough and jagged by the maintenance man.

2. During interview on 12/4/17 at 12:55 p.m., Resident #2 indicated they received a skin tear when he/she scrapped their right leg on the bottom part of the side rail that did not have a plastic protector in the circle. Observation at the time revealed no plastic insert in the circular area on the bottom portion of the side rail closest to the door.

On 12/6/17 at 1:20 p.m., Staff A, Licensed Practical Nurse, LPN conducted an interview with the resident at which time the resident indicated he/she received the skin tear from the side rail closest to the door as he/she reached down and touched the side rail and said from this circle thing that does not have a cap on it.

3. During interview on 12/5/17 at 1:40 p.m., Staff J, certified nurse aide, CNA indicated she and Staff I, CNA transferred Resident #3 from a wheel chair to bed while the resident wore leg protectors and pants. As staff sat the resident on the edge of the bed the resident yelled out in pain. Staff laid the resident down in bed and they noticed fluid on the resident's pants and bed. Staff J confirmed she knew the area came from the side rail because the skin tear was at the same height and the rail had a jagged edge on the circle part of the rail that had been pointed towards the foot of the resident's bed and the skin tear tore down

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F 700	Continued From page 19 like the exposed circle on the rail . Staff J confirmed she felt along the rail and felt the jagged edges. During an interview 12/5/17 at 4:34 p.m., Staff I confirmed she and Staff J pivot transferred the resident from wheel chair to bed and sat him/her on the edge of the bed. Staff J supported the resident's upper body while she swung the resident's legs onto the bed. The staff member indicated once the resident had been in bed he/she complained of pain however there had been no complaints while the resident had been positioned in the wheel chair. Staff lifted the resident's pant leg and noticed a geri sleeve in place with blood on the sleeve but she did not recall any tears or rip in the geri sleeve. During interview on 12/5/17 at 3:05 p.m., the maintenance man confirmed most beds in the facility failed to have plastic inserts on the side rails and that had been the case since he began to work at the facility approximately 1 year prior. The maintenance man indicated he checked the resident beds monthly which included having checked for the plastic inserts and there had been times he took plastic inserts from other resident beds when he found rough jagged areas and/or filed down the rough jagged areas. A Skin Condition Report form dated 11/17/17 indicated Resident #3 received a skin tear to his/her left lower extremity that measured 6.5 centimeters (cm) by 3.5 cm and 2.0 cm deep with serosanginous drainage and tissue exposure caused by a side rail.	F 700		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 20 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	F880- Without foregoing the following statement, the Facility states that with respect to resident #1 and resident #3, and all other similarly situated residents, Staff B was educated on 1-3-18 in regards to infection control policy and procedures furthermore all nurses were educated on 1-2-18 as a reminder of infection control policy and procedures. The Director of Nursing and/or designated representative will monitor for complaince through the facility's quality assurance program on a monthly basis. Unit Managers will conduct random audits to ensure ongoing compliance.	

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(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure staff maintained aseptic technique of supplies and resident care equipment to prevent cross contamination for two of five residents observed during cares. (Resident #1 & #2) The facility census was 88 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment

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dated 10/4/17, indicated Resident #1 had diagnosis that included diabetes mellitus, depression and a history of a transient ischmic attack (TIA) and required extensive assistance of staff with bed mobility, dressing and hygiene.

Observation on 12/5/17, revealed Staff B, Licensed Practical Nurse, LPN entered the resident's room with treatment supplies that included normal saline (NS) and a split gauze pad. Upon completion of the treatment Staff B took the NS bottle to the sink in the resident's room, placed the bottle directly on the counter without a barrier, wash her hands, picked up the NS bottle and placed it in the medication cart.

2. An Admission Record form dated 10/20/17 at 2:48 p.m., indicated Resident #2 had diagnosis that included anemia and peripheral vascular disease (PVD).

A MDS assessment dated 10/19/17, indicated Resident #2 required extensive assistance of staff with bed mobility, transfers, dressing, toilet use and hygiene and was non-ambulatory.

During observation on 12/5/17 at 9:30 a.m., Staff B removed the same bottle of NS from the medication cart as stated above, entered the resident's room with other treatment supplies, poured some NS into a small plastic medication cup, placed the NS bottle on the counter beside the resident's sink, performed the treatment, washed her hands, picked up the bottle of NS and placed it in the medication cart.

During interview on 12/5/17 at 10:46 a.m., Staff B confirmed she brought a new bottle of NS into the

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room of Resident #1 and upon completion placed the bottle back into the medication cart. Staff B used the same bottle of NS when she performed a treatment for Resident #2.

During interview on 12/5/17 at 5:37 p.m., Staff A, Unit Manager confirmed staff should have used a barrier when they brought treatment supplies into resident's rooms.

During interview on 12/5/17 at 10:49 a.m., the Director of Nursing (DON) confirmed staff should have used a barrier when they brought treatment supplies into resident's rooms.

Review of a Standard Precautions policy (not dated) included the following:

a. Patient care equipment - Handle used patient care equipment soiled with blood, body fluids, secretions or excretions in a manner that prevented skin and mucous membrane exposures, contamination of clothing and transfer of microorganisms to one's self, other patients and the environment.