STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	C 03/26/2018

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PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 3-27-18 The following information is related to the investigation of facility reported incident #73387-I and complaints #73956-C, #74443-C, #73165-C, #72561-C, #73784-C, #73720-C, #74591-C and 74741-C. Complaints #74443-C, #73165-C, #72561-C, #73784-C, #73720-C, #74591-C and #74741-C were substantiated. Facility reported incident #73887-I and complaint #73956-C were not substantiated.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candace Vanderlinden | TITLE: Administrator | (X6) DATE: 3-27-18

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

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to maintain a clean, homelike environment for residents. The facility reported a census of 42 residents. Findings include: 1. An interview with the Business Office Manager for the facility's Waste Management provider on 3/21/18 at 1:22 p.m. revealed the facility failed to pay garbage pick up fees for services at the end of 2017. She stated the facility did not receive garbage services for 2 weeks until they paid their bill for services provided. The facility piled bags of garbage on top of the dumpsters and on the ground. The Waste Management workers emptied the dumpsters after the bill was paid but did not pick up garbage off the ground. The facility is responsible to place the garbage inside	F 584		

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F 584	Continued From page 2 of the dumpster for removal. During an interview with the Maintenance Supervisor on 3/21/18 at 1:27 p.m. revealed when he started his employment at the end of December 2017 the facility had garbage piled up on top of the dumpsters and on the ground. He stated the garbage did not get picked up for several weeks and heard it was due to an issue of non-payment. During an interview with the facility Business Office Manager on 3/2/18 at 1:10 p.m. , she stated she receives a copy of the monthly bill and forwards the bills to corporate accounts payable for payment. BOM stated she is not aware of any payment issues but will obtain copies of the last 6 months garbage bill payments. During an interview with the Food Service Supervisor on 3/21/18 at 2:11 p.m. revealed there was a time at the end of December 2017 the garbage did not get picked up as scheduled. He stated it was piled up, some of the ground. 2. Review of the Minimum Data Set dated January 30, 2018 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicted the resident had intact cognitive ability. Review of the Care Plan dated 11/7/17 indicated Resident #1 had bladder incontinence and indicated the resident utilized incontinence products. Observations on 3/14/18 at 7:41 a.m., and 12:30 p.m. Resident's #1 had a strong urine odor. Observations revealed the resident's room is	F 584		

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F 584	Continued From page 3 carpeted and the bathroom floor is tile. Observations on 3/21/18 at 10:05 a.m. the resident's room smelled of urine. During an interview with Staff F on 3/22/18 at 9:12 a.m. the staff acknowledged the resident's room smelled of urine and would shampoo the carpet.	F 584		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		

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F 676	Continued From page 4 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, resident and staff interviews, and observations, the facility failed to consistently provide residents regular bathing opportunities for 3 of 4 residents reviewed (Residents #1, #4, #5) The facility reported a census of 42 residents. Findings include: 1. Review of the Minimum Data Set dated 1/24/18 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicted the resident had intact cognitive ability. Review of the Care Plan dated 7/18/17 revealed the resident requires extensive assistance from staff with showering twice weekly and as necessary. Review of the February 2018 bath records revealed Resident #1 had 5 baths in the month of February. Review of the March 2018 bath records revealed Resident #1 refused baths on 3/1 and 3/5. There was no documentation to indicate staff returned to the resident to offer again during the week.	F 676		

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F 676	Continued From page 5 Review of the March Monthly Bath Documentation revealed the staff failed to document the resident refused their bath/shower and failed to have the nurse document interventions staff attempted to assist the resident. During an interview with Resident #1 on 3/14/18 at 12:30 p.m. , the resident stated she would take 2 baths a week if staff make the time to do them, she states she doesn't always get 2 baths a week. 2. According to the Admission Record dated 3/15/18 Resident #4 had diagnoses which included traumatic subdural hemorrhage, pressure ulcer, methicillin resistant staphylococcus aurous and non compliance with medical treatments. The assessment revealed the resident had intact cognitive ability and was totally dependent on staff for transfers, eating, and toilet use. The care plan revealed the resident experienced a self care deficit due to paraplegia and indicted the resident remained totally dependent on staff for bathing. The care plan failed to inform the staff the resident had a history of non-compliance with bathing and provide or suggest approaches to use when the resident refused their bath. Review of the January and February 2018 Monthly Bath documentation revealed the resident refused all bath in January and February and had 1 bath on March 6, 2018. 3. According to the Minimum Data Set (MDS) dated 2/20/18, Resident #5 had diagnoses which included heart failure, morbid obesity, dependent	F 676		

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F 676	Continued From page 6 personality disorder and chronic kidney disease. The MDS revealed the resident had total dependence on staff for bed mobility, transfers, dressing, toilet use and personal hygiene, the resident did not walk. The resident had a risk for pressure sores but the assessment failed to identify any current skin issues. The resident had a BIMS score of 14 which indicated they are alert and oriented and gave accurate information. Review of the resident's Care Plan last revised on 12/18/17 revealed the resident is dependent on staff for activities of daily living. The care plan directed staff to provide a bath twice weekly. Review of the January 2018 bath records revealed the resident had 3 baths the month of January. Review of the February 2018 Monthly Bath Documentation revealed the staff failed to bathe the resident from 2/23-2/29 and received 1 bath in March 2018 on 3/4/18 when the audit was completed on 3/14/18. During an interview with Resident #5 on 3/14/18 at 8:00 a.m. the resident shared most generally only gets 1 bath a week as there is not enough staff to get a bath twice weekly. She voiced her desire to have baths more frequently.	F 676		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		

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F 686	Continued From page 7 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff and resident interviews, the facility failed assess and provide treatments for residents for 4 of 4 residents with pressure sores (Resident #4, #5, #10, #11). The facility failed to have systems in place to ensure the residents' skin and wounds were being assessed properly and in a timely manner. The facility also failed to schedule adequate staff to ensure treatments for pressure ulcers were being consistently completed. This constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility reported a census of 42 residents. Findings include: 1. According to the Admission Record dated 3/15/18 Resident #4 had diagnoses of traumatic subdural hemorrhage, methicillin resistant staphylococcus aureus, pressure ulcer, osteomyelitis, noncompliance with medical treatment, chronic pain, right toe amputation, and thoracic vertebra fractures. The Minimum Data Set (MDS) assessment dated 2/6/18 revealed Resident #4 had no cognitive impairments. The MDS documented Resident #4 as totally	F 686		

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F 686	Continued From page 8	F 686		

dependent on staff for transfers, eating and toilet use and noted he had a catheter and a feeding tube. The MDS also documented Resident #4 as at risk for pressure ulcer development.

The Plan of Care revealed Resident #4 had skin integrity impairment to the lower extremities related to self-inflicted trauma. The Plan of Care directed the staff to use an alternating air mattress, gel cushion to the wheelchair, educate on causative factors and measures to prevent skin injury, encourage to continue care with the wound clinic until areas are healed, at times refuses to go to wound clinic, encourage him to lie down to avoid lying on his back, encourage protective shoes while in wheelchair, monitor location, size, and treatment of skin injury, report abnormalities, failure to heal, and signs/symptoms of infection. The Care Plan documented the resident, refuses dressing changes to right foot and refuses protective shoes.

The Plan of Care failed to address Resident #4's current pressure ulcers.

The Wound Report dated 2/8/18 revealed Resident #4 had a Stage II pressure ulcer to the right ischial tuberosity that measured 15.6 centimeters (cm) (length) by 9.5 (width) by 1.0 (depth). Resident #4 had a Stage II pressure ulcer to the left ischial tuberosity that measured 13.2 cm (length) by 7.0 cm (width) by 0.1cm (depth).

The Nurse Practitioner Progress Note dated 3/13/18 revealed he saw the resident for multiple wounds. He documented many of the wounds were chronic, but the left ischial wound was much

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F 686	Continued From page 9 worse since last week. He documented the wounds' locations as back, buttocks, legs, and foot with the nature of the wounds as pressure related. He documented the left ischial wound measured 4.5 cm by 4.3 cm by 0.3 cm. The right ischial wound measured 6.0 cm by 8.0 cm by 1.1 cm and contained tan drainage and a foul odor. The wound beds of the two ischial wounds were the most concerning, with both documented as unstageable due to the gray/tan slough. The note revealed several wounds appeared improved, however the ischial wounds significantly worse. Resident #4 had two dressings in place on arrival, both placed by the Nurse Practitioner a week ago; one on the right foot and a duoderm on right thigh. The Nurse Practitioner noted Resident #4 also had a full thickness decubitus ulcer (pressure ulcer) of the coccygeal region that measured 3.2 cm by 4.3 cm by 0.3 cm and documented Resident #4 needed surgical debridement of the ischial wounds. The Nurse Practitioner talked to Resident #4 about the seriousness of the wounds and he agreed to admit to the hospital for further treatment. The March 2018 Treatment Administration Record (TAR) revealed a treatment ordered 3/6/18 for the coccyx wound (R buttock wound) to apply Santyl daily and cover. The Treatment Administration Record revealed omissions in the treatment on 3/10/18, 3/11/18 and 3/12/18. The copy of the TAR the facility provided on 3/17/18 revealed "R" documented on 3/10/18, 3/11/18 and 3/12/18 to indicate the resident refused the treatment. However, the entries were not labeled as late entries. The March 2018 TAR received on 3/15/18 revealed an order dated 2/1/18 for Santyl	F 686		

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F 686	Continued From page 10 ointment to lower back and hip daily. The record contained omissions in the treatment on 3/5/18, 3/6/18, 3/7/18, 3/9/18, 3/10/18, 3/11/18 and 3/12/18. The copy of the March 2018 TAR received on 3/16/18 revealed "R" documented for 3/10/17, 3/11/17 and 3/11/18. The TAR failed to designate the entries as "late." Review of the Progress Notes for March 2018 revealed no documentation that indicated the resident refused any of the treatments. In an interview on 3/16/18 at 9:50 a.m., the Director of Nursing reported she was not aware Resident #4 had an open area on his coccyx, because the last time she assessed his wounds was on 3/1/18. The DON also reported she noticed omissions on Resident #4's Treatment Administration Record on 3/15/18 and asked the staff to fix it. In an interview on 3/16/18 at 9:32 a.m., Staff A reported there is only one nurse and a medication aide in the building most of the time. Staff A worked 3/10/18 and 3/11/18. Staff A could not recall completing Resident #4's treatments. Staff A reported the Director of Nursing stated yesterday that the Treatment Record contained holes and needed to be fixed. Staff A reported he/she did not document any refusals on the Treatment Record in the last 24 hours. Staff A told the Administrator they were understaffed and not able to get everything done. Staff A reported the resident's needs are not being met. In an interview on 3/16/18 at 10:50 a.m., Staff B reported working 3/7/18, 3/8/18 and 3/9/18. Staff B did not recall completing Resident #4's treatments.	F 686		

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F 686	Continued From page 11 During an interview 3/16/18 at 8:20 a.m., the Director of Nursing (DON) reported the weekly wound assessments were not completed the weeks of 2/1/18 and 3/8/18. The DON stated Resident #4 readmitted on 2/1/18. She clarified the week of 3/8/18, she was out of the building and nobody completed the assessments. In an interview on 3/16/18 at 9:55 a.m., the Nurse Practitioner reported he explained to Resident #4 that if he did not go to the hospital for treatment, he could die. The Nurse Practitioner had concerns the facility did not encourage Resident #4 to reposition off his bottom and comply with the treatment plan. The Wound Care Nurse reported concerns to the Nurse Practitioner that Resident #4's wounds contained dressings that the wound clinic had placed the week prior. During an interview with the local hospital wound care nurse on 3/22/18 at 8:00 a.m., the nurse stated Resident #4 would almost always comply with her requests while at the wound center. She stated she began seeing the resident in January 2018 when he stubbed his toe. He came to the clinic for wound treatment and in a skin audit completed that day, multiple pressure sores were found on his body. She spoke to the facility nurse about the issues and they commented the resident is very non-complaint and refuses to follow any of their suggestions. The wound nurse stated Resident #4 came to the wound clinic on March 13, 2018 with a new, open ischial pressure ulcer that had been only a reddened area the previous week. The wound nurse recommended a transfer to a local hospital for wound care, and the resident transferred on 3/13/18 to a local hospital.	F 686		

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F 686	Continued From page 12 According to hospital records that contained an Infectious Disease consult note dated 3/16/18, "Right buttock wound is so deep that wound nurse could feel bone. Clinically it is concerning for osteomyelitis (infection of the bone). I don't know how long he has had this condition, but most likely it is chronic osteomyelitis. He can not (sic) have MRI due to multiple metallic plates. WBC scan can confirm the presence of osteomyelitis. But even if it is not feasible, we may need to treat as chronic osteomyelitis. His wound culture is positive for E cloacae (bacteria) and C striatum (pathogen). We will add ertapenem (antibiotic) to cover E cloacae and anaerobes (organism that grows without air present)..." Plan (in part): -continue vancomycin -start Ertapenem 1g every 24 hours 2. According to the MDS dated 2/20/18, Resident #5 had diagnoses which included heart failure, morbid obesity, dependent personality disorder, and chronic kidney disease. The MDS revealed the resident was totally dependent on staff for bed mobility, transfers, dressing, toilet use and personal hygiene, and did not ambulate (walk). The MDS documented the resident as at risk for pressure sores but the assessment failed to identify any current skin issues. The resident had a BIMS score of 14 which meant the resident was alert and oriented and displayed intact cognition. Review of the resident's Care Plan last revised on 12/18/17 revealed the resident had actual skin impairments and directed the staff to assess the	F 686		

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	165453	A. BUILDING _____ B. WING _____	C 03/26/2018

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PEARL VALLEY REHABILITATION & HEALTHCARE CENTER O	601 E POLK ST WASHINGTON, IA 52353

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F 686	Continued From page 13 residents skin weekly, elevate lower extremities when in recliner or in bed, encourage good nutrition, use caution during transfers and bed mobility to prevent striking of the arms, legs and hands, and consult the wound clinic as needed. The care plan failed to document locations of actual skin impairments. Review of the March treatment records revealed the resident had an order for calmoseptine ointment to the coccyx area twice daily, but the order was discontinued on 3/14/18. The treatment record directed the staff to transport the resident to the wound clinic every other day to see the Wound Specialist at the local hospital, who completed the dressing changes to the resident's right lower leg. The local hospital ARNP visit notes dated 3/13/18 documented the resident had a pressure to the buttocks, unspecific stage. Review of the Pressure Sore list provided by the facility on 3/13/18 and 3/20/18 failed to include Resident #5 on the list of residents with pressure sores. Observations on 3/14/18 at 9:45 a.m. during perineal cares revealed the resident had a pinpoint open area to the left intergluteal crease. Staff C LPN noted the area and applied Calmoseptine cream per order. Staff C acknowledged the presence of the open area and said she would notify the physician/ARNP of the area. During an interview with the Director of Nurses (DON) on 3/16/18 at 8:20 a.m., review of the resident's clinical record with the DON at this time	F 686		

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F 686	Continued From page 14 revealed the record failed to contain documentation regarding the open area to the resident's buttocks, did not identify physician notification and failed to contain treatment orders. The DON stated she would contact Staff C to come to facility and document the new open area found. The DON stated the resident did not have a skin assessment the week of 3/8/18 because she was not in the facility that week due to illness, and no other staff completed the weekly skin assessments. During an interview with the resident's Advanced Registered Nurse Practitioner (ARNP) on 3/16/18 at 10:30 a.m., the ARNP stated he was not was not aware of the open area to the resident's bottom the staff discovered on 3/14/18. He verified the staff failed to contact him to obtain treatment orders for the area. The Progress Notes from 3/14-3/16/18 failed to contain documentation regarding the pinpoint open area discovered on 3/14/18. A note dated 3/16/18 at 9:00 a.m. completed by the DON documented the resident had an open area to the left intergluteal crease which measured 0.3 x 0.2 centimeters; staff will report issues to the wound nurse. During an interview with the resident during a skin assessment on 3/16/18 at 9:08 a.m., the resident reported her bottom hurt when she sat on it for an extended period of time. She commented she tried to lie in bed in the afternoon. 3. According to the MDS dated 2/10/18, Resident #10 had diagnoses which included Parkinson's disease, anxiety, depression, endocrine disorder	F 686		

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F 686	Continued From page 15 and mental disorder. The MDS documented the resident had a BIMS score of 4, which indicated the resident displayed severe cognitive ability and required extensive assistance of 2 staff for transfers and toilet use and extensive assistance of 1 staff for personal hygiene. The MDS revealed the resident experienced occasional urinary incontinence and was always continent of bowel. The assessment indicated the resident is at risk for pressure ulcers but didn't have any pressure ulcers at the time of the assessment. Review of the care plan dated 1/15/18 revealed the resident had impaired skin integrity related to incontinence. The care plan indicated the resident required a pressure reducing device to the chair and needed extensive assistance to turn and reposition. The care plan failed to identify actual skin impairment and the interventions to assist in healing. Review of a facility Progress Note dated 3/16/18 revealed the staff completed a skin assessment and noted the resident had an open area on the right side of the intergluteal crease measuring 1.0 x 0.8 centimeters; the staff contacted the primary care physician. A progress note dated 3/20/18 revealed an open area to the coccyx which measured 0.5 x 0.2 with depth of 0.1 cm. The staff contacted the primary care physician and obtained an order for a wound clinic consult. The notes dated 3/20/18 revealed the resident went to the wound clinic and returned with orders that directed: up only 1 hour only for meals, when in bed to turn side to side, leave incontinence garment open while in bed, encourage nutritional	F 686		

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F 686	Continued From page 16 shake, and apply stock barrier cream daily and as needed. Review of the January and February 2018 Treatment Record directed staff to apply Collagen/hydrogel to the left gluteal crease and cover with border gauze. The same Treatment Record directed staff to apply Zinc to the right gluteal crease and coccyx. Review of a Wound Clinic note dated 3/20/18 revealed the resident presented to the clinic with a wound to the coccyx; the Wound RN indicated the wound gradually occurred, described the wound as caused by pressure injury and assessed it at Stage 3 (a wound that penetrated the second layer of skin into the fat tissue). The area to the coccyx measured 0.5 x 0.4 x 0.2 centimeters. The treatments prescribed support surface in wheelchair, nutritional supplements, and apply a zinc oxide barrier. Wound Clinic staff documented the resident will have limited time out of bed until the wound heals. Review of the March 2018 Treatment Record failed to direct staff to apply Collagen/hydrogel to left gluteal crease and to apply Zinc to right gluteal crease and coccyx. The March Treatment Record directed staff to apply stock barrier daily, to move side to side with incontinence brief open and to be up only for 1 hour at meal time starting on 3/20/18. During an interview with the DON on 3/21/18 at 10:30 a.m., review of the March Treatment Administration Record did not contain treatments to the resident's left and right gluteal crease and coccyx area. The DON stated it was healed on 2/22/18 so the treatments were not needed in	F 686		

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F 686	Continued From page 17 March. Observation on 3/20/18 at 12:33 p.m. revealed Resident #10 lay on her back side. A skin assessment completed by the Director of Nursing documented the resident had an open area on the coccyx which measured 0.5 x 0.2 centimeters. The DON identified the area as a facility acquired pressure ulcer and identified it as a new area since she last assessed the resident on 3/16/18. Review of the list of pressure sores obtained on 3/13/18 revealed the list failed to identify Resident #10 as a resident with a pressure sore. Review of the list of pressure sores obtained on 3/20/18 revealed the resident had an open area to the coccyx measuring 0.5 x 0.4 x 0.1 centimeters and facility acquired. During an interview with the DON on 3/16/18 at 8:20 a.m., the DON stated the resident did not get a skin assessment the week of March 8, 2018 as she was not in the facility due to illness and nobody completed an assessment that week. 4. According to the Minimum Data Set (MDS) dated 2/12/18, Resident #11 had diagnoses which included dementia, seizure disorder and obstructive hydrocephalus. The assessment identified the resident with severe cognitive ability with short and long term memory problems and daily verbal behavioral symptoms. The resident demonstrated total dependence on staff for bed mobility, transfers, dressing, eating and toileting. The assessment failed to identify the resident had skin impairment.	F 686		

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F 686	Continued From page 18 Review of the Care Plan revised on 12/26/17 indicated the resident had a potential for impaired skin integrity related to fragile skin and directed the staff to keep fingernails short, complete Braden scale quarterly, keep body parts from excessive moisture, and follow protocols for treatment of injury and to keep skin clean and dry. The care plan identified the resident experienced both bowel and bladder incontinence, and directed staff to monitor skin for breakdowns and report concerns to the nurse. The care plan failed to identify any actual skin impairments. Review of a facility Progress Note dated 2/15/18 revealed a facility RN noted the resident's right heel appeared pink/purple, boggy (soft) and warm to the touch. The Nurse who noted the area put a nursing intervention in place to float the heels at all times with a pillow under the calves. During an interview with Staff A LPN 3/20/18 at 1:42 p.m., she stated she did not know Resident #11 had a pressure ulcer on her right heel. During an interview with Staff D on 3/20/18 at 3:18 p.m., Staff D stated the staff did not complete skin sheets for the pressure ulcer on Resident #11's right heel as she was not aware of the pressure sore. Staff D stated when the staff completed a skin assessment for Resident #11 on 3/16/18; they found a pressure ulcer on the resident's right heel. Review of an ARNP visit note dated 3/9/18 indicated the resident had bilateral (both sides) mushy heels and directed the staff to utilize heel protectors on both feet.	F 686		

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F 686	Continued From page 19 In an observation on 3/20/18 at 12:30 p.m., the DON noted the resident in bed with a blue foam boot on. The DON removed the boot and removed a protective dressing with Medi-honey on it. The DON measured the right heel wound. The right heel wound measured 5.7 x 3.9 centimeters, and was blackened and dry. The area was unable to be staged and described as facility acquired. An interview with the Hospice RN on 3/20/18 at 1:28 p.m. revealed the Hospice staff admitted the resident to Hospice services on 2/12/18. During a bath by the Hospice CNA on 2/14/18, the aide reported an area to the resident's right heel and the nurse came to the facility to assess the heel. The Hospice RN stated the wound was a facility acquired pressure ulcer and was unable to be staged. The RN requested the local hospital wound nurse assess the area and recommend treatment. Review of a Nursing Hospice Progress Note dated 2/14/18, the nurse documented she went to the facility and noted the resident had a dark red area to the right heel, a total of 6 centimeters. The left heel had a 2.5 centimeter red blotchy area without open areas. In progress notes dated 2/23/18, staff documented the resident's right heel as a boggy and fluid filled, with a purple area noted in the center and without drainage. The Hospice RN documented they spoke to a facility nurse who verified they were not aware the resident had any skin issues. The Hospice RN indicated they changed the resident's plan of care so the resident will no longer have shoes on or any other pressure causing devices on feet. Documentation revealed the area to the right heel measured 4 x 6 centimeters that day.	F 686		

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F 686	Continued From page 20 Review of a facility Progress Note dated 3/16/18 revealed a skin assessment completed and staff noted a dry black area on the resident's right heel which measured 5.3 x 4.6 centimeters. Staff documented the notified the physician and the resident had heel protectors on and heels were floated. Review of a fax to the primary care physician dated 3/16/18 directed the staff to apply Betadine to the resident's right heel daily and as needed. The February 2018 and March 2018 failed to document the resident had a right heel pressure ulcer and failed to direct staff regarding treatment of the pressure ulcer until 3/17/18. On 3/17/18, Resident #11 had their first treatment to the right heel. Review of a list of pressure sores obtained on 3/13/18 upon entrance to the facility failed to identity Resident #11 had a pressure sore. Review of a list of pressure sores obtained on 3/20/18 revealed Resident #11 had facility acquired pressure sore to the right heel which measured 5.3 x 4.6 cm. During an interview with the DON on 3/16/18 at 8:20 a.m., the DON stated the resident did not have a skin assessment the week of March 8, 2018 as she was out of the facility and nobody completed an assessment that week. An undated Wound Assessment Policy, directed staff to document the following at least weekly: location, size, dressings, drainage, undermining/tunneling, character of wound, appearance of surrounding tissue, stage, signs	F 686		

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F 686	Continued From page 21 and symptoms of infection, and pressure relieving devices. The facility abated the Immediate Jeopardy on March 16, 2018 by implementing the following actions: 1. Full head to toe assessment on all residents 2. Education of all Nursing staff 3. Completing new Braden Scales (Tool to identify residents at risk of skin impairment) on all residents 4. Developing a Wound Team to meet weekly on Fridays for Quality Assurance/Process Improvement 5. Communication with Dietician regarding all wounds 6. Educating all nurses regarding documentation 7. Audits of MARS/TARS 8. Audits of dressing changes and documentation 9. Audits with regard to repositioning residents 10. Perineal care audits 11. Forwarding all findings to the Quality Assurance Team These actions lowered the IJ from a "K" severity level to an "E" with ongoing monitoring required.	F 686		
F 689 SS=D	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.	F 689		

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F 689	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and observations the facility failed to maintain an environment free of hazards. The facility reported a census of 42 residents. Findings include: Observation on 3/14/18 at 7:46 a.m. revealed a 4 x 4 ft silver colored floor scale sitting on the floor in the short hall entrance to the low stimulation unit-Hall 400. The scale has a 3 inch raised bar running the length of the scale extending 4 foot into the hallway. The 400 Hall is approximately 8 foot wide so the scale is noted to take up 1/2 half of the hall way. The 400 Hall has double doors that open to allow resident and staff access to the rest of the building. During an interview with Staff C on 3/14/18 at 9:25 a.m., Staff C stated someone moved the scale from another area of the building to this location on Friday, March 9, 2018. She does not know the reason for moving the scale and states she doesn't know if any resident's have tripped over the scale on the floor but stated it looks like a tripping hazard. Observation on 3/14/18 at 10:00 a.m. revealed a female resident walking out of Hall 400 with the aide of her walker to speak to a nurse on Station 2. Observation on 3/14/18 at 12:35 p.m. revealed Staff C dragging the silver floor scale away from the entry of the 400 Hall and back against the wall by the therapy room located at the end of 500 Hall.	F 689		

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F 689	Continued From page 23 During an interview with the Administrator on 3/14/18 at 3:00 p.m. revealed the facility has 3 residents who independently wander outside of the 400 Hall into other parts of the facility.	F 689		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		

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F 732	Continued From page 24 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post and have available daily nurse staffing information. Findings include: Observation upon entrance on 3/13/2018 at 11:30 a.m. failed to reveal nurse staffing information. Observation of the bulletin board revealed the schedule, but no hours or census. Observation on 3/14/2018 at 7:00 a.m. and 3/22/2018 at 4:00 p.m. revealed no nurse staffing information posted. During an interview on 3/13/2018 at 1 p.m., the DON (Director of Nursing) stated the facility failed to complete the forms and that they used to do so. Currently, the facility posted the schedule. The DON cold not say when the facility stopped completing the forms. During an interview on 3/22/2018 at 4:10 p.m., Staff E, Nurse Consultant verified the facility failed to complete the staffing sheets.	F 732		

Plan of Correction
Washington Complaint Survey 3/13/18 - 3/26/2018

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with STate and Federal regulations the facility has or will take the following actions set forth in the plan of correction.

F584 Safe/Clean/Comfortable/Homelike Environment

The facility does and will continue to ensure patients are provided with a safe, clean, comfortable, homelike environment.

The garbage was removed from the premises and the contract with Luke Waste was brought current. Resident #1's carpet was shampooed and deep cleaned. Resident #1 has since discharged from facility.

The administrator or designee will complete weekly audits to ensure all trash is removed from the premises x4 weeks, then monthly x 3 months.

All findings will be submitted to the facility QA&A committee.

F676 Activities Daily Living/Maintain Abilities

The facility does and will continue to ensure all residents are offered regularly scheduled baths per their bathing schedule and meet professional standards of quality for all patients including patient #1 and #4. All like residents were reviewed.

Bathing refusal documentation for resident #1 and #4 was not recorded. All nursing staff were re-educated on proper documentation requirements. The DON or designee will continue with ongoing education as needs are indicated to maintain compliance.

The Director of Nursing or designee will conduct random daily audits Monday through Friday for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. To ensure proper documentation requirements are being met.

All findings will be submitted to the QA&A committee.

F686 Treatment/SVCS to Prevent/Heal Pressure Ulcer

The facility does and will continue to ensure all patients, including patient #4, #5, #10, #11, receive care consistent with professional standards of practice, to prevent pressure ulcers and do not develop new pressure ulcers unless individual's clinical condition demonstrates that they were unavoidable.

All residents are at risk of pressure sores, if they are dependent on staff for ADL, or have comorbidities that increase risk for pressure sore development.

On 3/16/18 training was conducted by the Director of Nursing and MDS Coordinator on proper positioning of residents, floating of heels, prevention of pressure sores, proper documentation, refusals, and proper procedure for late entry documentation, and timely assessments. The facility will continue to ensure all residents receive care consistent with professional standards of practice, and that the residents receive necessary treatment and services to prevent pressure ulcers from developing.

The Director of Nursing or designee will conduct random audits of wound care and skin assessments weekly for 4 weeks, and then monthly for 3 months. Results will be shared in QA meetings. If results are favorable the audits will be reduced to quarterly for the remainder of the year.

F689 Free of Accident Hazards/Supervision/Devices

The facility does and will continue to ensure all patients that remain in a facility, that is free from accident hazards and that each resident receives adequate supervision.

The facility does and will continue to ensure all scale equipment is properly stored out of hallways and proper supervision is in place when scale is in use. All nursing staff were educated on proper scale storage and supervision.

The DON or designee will conduct weekly audits for 4 weeks, and then monthly for 3 months. To ensure proper storage of the scale.

All findings will be submitted to the QA&A committee.

F732 Posted Nurse Staffing Information

The facility does and will continue to ensure proper staffing hours be posted in an area available to residents and public. Staff educated regarding staffing expectations and the ability to provide quality care.

Residents at risk for poor quality of care if this standard is not met.

Daily schedules and census will be reviewed by Director of Nursing or designee. If there are staffing concerns they will be brought to the team's attention so that a solution can be identified. A scheduler is in place who is aware part of their job duties is to work the floor is staff is short.

All findings will be submitted to the QA&A committee.