

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2018
FORM APPROVED
OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165208		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/30/2018
NAME OF PROVIDER OR SUPPLIER GRANGER NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 KENNEDY STREET GRANGER, IA 50109	
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F 000 F 684 SS=G	<p>INITIAL COMMENTS <i>DOC 8/17/18</i></p> <p>Investigation of Complain # 75063-C was substantiated because it resulted in a deficiency not specific to the allegation.</p> <p>Complaint #75555-C was substantiated.</p> <p>Complaint #76863-C was substanitated.</p> <p>See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 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 clinical record review and physician and staff interviews, the facility failed to appropriately intervene after a resident exhibited physical signs/symptoms of a decline in status over a two week period (#3) and failed to assure another resident received physician ordered interventions to promote wound healing (#2) of 9 total residents reviewed. The facility reported a census of 61 residents. Findings include: 1. According to the 2/28/18 Minimum Data Set</p>	F 000 F 684	<p>This serves as the credible allegation of compliance for Granger Nursing and Rehabilitation Center. We assert that all correctives described on this plan of correction have been implemented, in regards to the specific deficiencies; we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Granger Nursing and Rehabilitation Center is committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Granger Nursing and Rehabilitation Center is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey.</p> <p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Granger Nursing and Rehabilitation Center has completed the following interventions as a result of complaint survey exiting 7/30/18. The facility will be in substantial compliance by 8/17/18.</p> <p>Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/10/2018

Janice P. Administrator 8/17/18
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 684	<p>Continued From page 1</p> <p>(MDS) assessment, Resident #3 had diagnoses that included Alzheimer's disease, high blood pressure, cognitive communication deficit, respiratory failure, atrial fibrillation (abnormal/irregular heart rhythm) and muscle weakness. The MDS documented the resident required the assistance of 2 staff for activities of daily living (ADLs).</p> <p>The 4/11/18 revised Care Plan identified return to the community as deemed not feasible as Resident #3 had a history of respiratory failure and has become more dependent upon staff.</p> <p>The facility's Change of Condition Process dated 9/15 instructed that assessment and intervention will vary depending on the extent of a change in resident's condition and the involvement of the interdisciplinary team when necessary. The nursing process of Assessment, Plan, Intervention and Evaluation will be used to ensure the optimal outcome for the resident. The process also noted that the physician's involvement is always required as is a follow-up assessment.</p> <p>Final test results dated 3/30/18 at 5:40 p.m. documented the lab notified the resident's doctor of elevated blood sodium results on 3/30/18 at 5:38 p.m. The physician then ordered Resident #3 to transfer to the ER (Emergency Room) for evaluation and treatment of a critical sodium level of 163. A nurse's note dated 3/30/18 at 6:23 p.m. documented Resident #3 transferred to the ER.</p> <p>A nurse's note dated 3/30/18 at 11:08 p.m. documented that Resident #3 admitted to the Critical Care Unit (CCU) with diagnoses of sepsis (a life threatening response to infection), low blood pressure, cystitis (bladder inflammation),</p>	F 684	<p>F 684 SS=G QUALITY OF CARE: Granger Nursing and Rehabilitation Center will ensure that each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices.</p> <p>The Director of Nursing re-educated licensed nurses on head to toe assessment, physician notification with changes in status, and wound care on 8/3/2018.</p> <p>Effectively immediately, the Director of Nursing and/or facility administrator will print the nurses notes daily on all residents from AHT (the electronic health record) and review at the morning meeting to determine if any additional intervention is needed.</p> <p>The Director of nursing re-educated all staff on 8/16/18 regarding use of the SBAR stop and Watch tools and interact program to improve</p> <p>overall communication and timely intervention with the physicians.</p> <p>The facility has completed 100% audit of MARS (Medication Administration Record) and TARS (Treatment Administration Records) to ensure accuracy. The facility will continue a monthly audit of all orders on an ongoing basis to ensure compliance.</p> <p>The Director of Nursing/Assistant Director of Nursing and/or designee will complete audits of the MAR's and TAR's at a minimum of 3X weekly to ensure treatments and medications are administered as ordered.</p>	

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F 684	<p>Continued From page 2 acute kidney failure and elevated sodium.</p> <p>A nurse's note dated 4/6/18 at 3:15 p.m. documented Resident #3 returned to the facility from the hospital. The nurse's assessment revealed Resident #3 had a regular heart rate with diminished lung sounds and audible wheezes in his lungs.</p> <p>A nurse's note dated 4/9/18 at 11:17 a.m. documented Resident #3 was weak with irregular lung sounds throughout and an irregular, thready (weak) pulse. The nurse also noted Resident #3's skin felt cool to the touch, his left grip as being stronger than his right and he leaned more towards his right side.</p> <p>A nurse's note dated 4/10/18 at 1:52 a.m. documented Resident #3 had an irregular, thready pulse, diminished lung sounds throughout, an inability to comply with instruction to grip his hands and a respiratory rate of 24 breaths per minute.</p> <p>A telephone order dated 4/11/18 instructed staff to obtain a basic metabolic panel (BMP; a lab test) at the next lab draw.</p> <p>A nurse's note dated 4/12/18 at 3:40 a.m. documented Resident #3 with a pulse of 141, diminished lungs sounds throughout with inspiratory and expiratory wheezes.</p> <p>Final test results dated 4/12/18 at 9:40 p.m. documented lab staff notified the facility on 4/12/18 at 9:35 p.m. of Resident #4's elevated potassium levels. A telephone order dated 4/12/18 at 10:30 p.m. instructed the facility to send Resident #3 to the ER due to a critical</p>	F 684	<p>The Director of Nursing and / or Assistant Director of Nursing will complete at a minimum of weekly documented rounds of wounds to ensure healing and that treatments are being completed per order. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing and facility administrator is responsible for ongoing compliance.</p>	

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F 684	<p>Continued From page 3</p> <p>potassium level. A nurse's note dated 4/13/18 at 3:55 a.m. documented that Resident #3 returned from ER. A recheck of his potassium level in ER and came back normal.</p> <p>A nurse's note dated 4/13/18 at 10:59 a.m. documented Resident #3 had diminished lung sounds throughout, an irregular and thready pulse, a pulse of 145, a blood pressure of 87/55, unequal grips and weak and skin cool to the touch.</p> <p>A nurse's note dated 4/15/18 at 3:03 a.m. documented Resident #3 had diminished lung sounds throughout with an irregular, thready pulse and weak, unequal grips. At 2:54 p.m. Resident #3 had diminished lung sounds throughout, an irregular, thready pulse with weak, unequal grips and skin cool to the touch.</p> <p>A nurse's note dated 4/16/18 at 3:38 a.m. documented Resident #3 had diminished lung sounds throughout, an irregular, thready pulse and weak, unequal grips.</p> <p>A telephone order dated 4/17/18 directed to check Resident #3's potassium in 1 week.</p> <p>A nurse's note dated 4/18/18 at 11:12 a.m. documented Resident #3 had diminished lung sounds throughout, an irregular, thready pulse with weak, unequal grips, skin cool to the touch and a blood pressure of 96/58.</p> <p>A nurse's note dated 4/19/18 at 4:31 a.m. documented Resident #3 had a blood pressure of 98/55, respirations of 24 breaths per minute, pulse of 112 beats per minute, cold hands with gray nail beds.</p>	F 684		

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F 684	<p>Continued From page 4</p> <p>A nurse's note dated 4/20/18 at 4:29 a.m. documented Resident #3 had a pulse of 117. On 4/21/18 at 3:44 a.m. Resident #3 had a pulse of 116, respirations of 26 and gray nail beds. On 4/22/18 at 3:40 a.m. Resident #3's blood pressure measured 98/80 and he had audible inspiratory and expiratory wheezes. A nurse's note dated 4/22/18 at 3:40 a.m. documented Resident #3 had continued audible inspiratory and expiratory wheezes.</p> <p>A nurse's note dated 4/26/18 at 10:55 a.m. recorded Resident #3's lungs sounded diminished throughout and he had dyspnea (difficulty breathing) with activity.</p> <p>Final test results dated 4/26/18 at 8:43 p.m. noted Resident #3's potassium measured at the upper limits of the normal range (5.1).</p> <p>A nurse's note dated 4/27/18 at 6:50 a.m. recorded Resident #3 had continued diminished lung sounds throughout, a fever with a temperature of 99.1 F (Fahrenheit), a pulse of 123 and respirations of 26. At 12:16 p.m. Resident #3 continued with diminished lung sounds throughout and now had a persistent non productive cough. The nurse wrote Resident #3 sometimes had labored breathing, an irregular and tachy (fast) pulse of 126 and tended to be sleepy, even at the table while eating.</p> <p>On 4/28/18 at 3:38 p.m., nurse's notes recorded continued diminished lung sounds throughout, a persistent non-productive cough, labored breathing and an irregular, tachy pulse. The nurse also wrote that Resident #3 tended to be sleepy at the table when eating and had a pulse</p>	F 684		

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F 684	<p>Continued From page 5 rate of 142.</p> <p>A nurse's note dated 4/29/18 1:32 p.m. documented Resident #3 as being sleepy, even at meals. The nurse also documented the resident's pulse rate measured 122.</p> <p>A telephone order dated 4/29/18 documented that Resident #3 should be sent to ER for further evaluation and treatment of respiratory distress.</p> <p>On 4/30/18 at 12:26 a.m. a nurse's note documented Resident #3 sounded awful with audible congestion heard from the doorway at about 9:00 p.m. that evening. The resident had labored breathing at rest at a rate of 38 breaths per minute. Resident #3's skin was pale, cool and diaphoretic (sweaty) to the touch. Staff contacted the on-call physician who ordered the resident to the ER for further evaluation and treatment.</p> <p>A Discharge summary noted that Resident #3 presented in ER on 4/29/18 at 11:01 p.m. with an altered mental status, severe sepsis (infection) with septic shock, pneumonia due to hemophilus influenza, acute kidney injury secondary to pneumonia and acute respiratory failure with hypoxia (lack of oxygen). ER notes on 4/29/18 at 11:10 p.m. recorded the doctor's assessment of pertinent positives including blood pressure 83/63, pulse 160, temperature 100.8 F, respirations 56 with severe respiratory distress, diffuse rhonchi (abnormal lung sounds) with upper airway noise, tachycardic with irregular rhythm and unresponsiveness to painful stimuli. According to an untitled document, the doctor noted he pronounced Resident #3 dead on 5/2/18 at 10:10 a.m. with dysrhythmia (abnormal heart</p>		F 684	

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F 684	<p>Continued From page 6</p> <p>rhythm) secondary to hyperkalemia (elevated potassium levels) which occurred as a result of septic shock with acute renal failure as the direct cause of death.</p> <p>An interview on 7/9/18 at 3:50 p.m. with Staff A, RN revealed that she wanted to cry when she looked back at Resident #3's situation. Staff A said she last saw Resident #3 on 4/25/18. Staff A said if you looked at his charting, you can see that he gradually got sicker and sicker. Staff A said nobody called the doctor about his signs and symptoms at any point before he got sent out and died from respiratory failure.</p> <p>On 7/16/18 at 12:42 p.m., when asked if staff notified the doctor of their assessment findings between 4/9/18 and 4/29/18, the Director of Nursing (DON) stated she submitted all the doctor's notifications that she could find. The DON said she thought someone should have called the doctor about the resident's change in status and/or notified him while at the facility.</p> <p>An interview on 7/26/18 at 11:25 a.m. with Resident #3's doctor revealed he expected the facility to notify him and keep him informed if their documentation included assessments of an elevated pulse of 140 and hand grips weaker on one side. The doctor said if their assessments included an elevated pulse and weak hand grips, the facility missed some opportunities to intervene sooner and should have been more vigilant in light of their findings and Resident #3's history.</p> <p>2. According to the 1/17/18 MDS assessment, Resident #2 had diagnoses that included heart failure, high blood pressure, peripheral</p>	F 684		

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F 684	<p>Continued From page 7</p> <p>vascular/arterial disease, diabetes and difficulty walking. The resident required the assistance of 2 with transfers, the assistance of one with dressing, toilet use and personal hygiene and did not walk during the assessment period. The MDS recorded Resident #2 had 7 venous or arterial ulcers, diabetic foot ulcer/s and open lesion/s on his foot.</p> <p>The 1/22/18 Care Plan instructed Resident #2 needs would be anticipated and met by staff every day for 90 days due to the potential for impaired cognition. The Care Plan also instructed staff to administer medication as ordered, to promote adequate nutrition and hygiene due to Resident #2's risk for impaired skin integrity and documented a right leg amputation on 1/31/18.</p> <p>The Medication Discharge Report dated 1/31/18 at 7:33 a.m. documented that all necrotic wounds on Resident #2's right foot should be painted with Betadine, covered with gauze and woven around and between each toe every day (QD). The Patient Care Order Sheet dated 1/31/18 at 11:51 a.m. directed staff to place a dry dressing with Kerlix to the right lower extremity (RLE) QD.</p> <p>A nurse's note dated 1/31/18 at 1:54 p.m. recorded Resident #2 re-admitted to the facility following hospitalization for a right below the knee amputation (BKA).</p> <p>Physician orders on 2/1/18 authorized the facility's request to discontinue the wound dressing to Resident #2's right leg.</p> <p>A cardiology note dated 2/13/18 recorded Resident #2 had been seen by a physician that day who ordered the incision site of the below the</p>	F 684		

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F 684	<p>Continued From page 8</p> <p>knee amputation to be cleansed with Betadine and then wrapped BID (twice a day).</p> <p>A nurse's note dated 2/13/18 at 12:05 p.m. documented Resident #2 returned from a vascular appointment with a new order to paint Betadine to the right leg surgical incision, wrap it with Kerlix and change it QD.</p> <p>A Peripheral Vascular note dated 2/23/18 documented the resident with lower peripheral arterial disease and a right BKA. Resident #2 had a large eschar (dead tissue) medially (inside of the leg) and a smaller one laterally (the side of the leg). After removal of the gangrenous (dead) skin, the physician identified a small amount of purulence (fluid caused by infection) medially and an old hematoma (localized collection of blood) laterally. The doctor documented the resident's middle staples as intact, but his medial and lateral incision staples had been removed in the areas where there was a wound care issue. The doctor thought the wound should heal with daily packing with wet to moist dressings and debridement (removal of unhealthy tissue) in a couple of weeks. The plan included a subsequent visit for re-debridement in 2 weeks.</p> <p>The February 2018 TAR (Treatment Administration Record) documented staff cleansed the resident's RLE incision with an unspecified cleanser, covered it with clean 4x4s (gauze) and secured the guaze with Kerlix QD from 2/2/18 through 2/16/18, even though the 2/1/18 order discontinued the wound dressing to the right leg and another order had not been obtained for treatments until 2/13/18 with Betadine BID. The TAR also documented staff cleansed the RLE incision with an unspecified</p>	F 684		

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F 684	<p>Continued From page 9</p> <p>cleanser, covered it with clean 4x4s (gauze) and secured with Kerlix BID from 2/16/18 through 2/22/18, despite the 2/13/18 order specifying that the incision should be cleansed with Betadine and wrapped BID. The TAR also documented staff packed Resident #2's stump with gauze strips moistened in normal saline and wrapped with gauze BID from 2/24/18 through 2/28/18, despite the 2/23/18 order instructed a daily treatment instead.</p> <p>The Peripheral Vascular note dated 3/7/18 documented the 2 week follow up for peripheral arterial disease and lower right BKA. The physician recommended operative debridement to the right medial and lateral incision with necrotic tissue. The doctor also noted the need to "get a handle on the infection" to make sure Resident #2 did not lose his BKA stump and convert it to above the knee amputation. The doctor wrote that Resident #2 may be a candidate for a wound vac (vacuum device used to heal wounds) and at this point there is too much infection, but after a couple days of wound changes in the hospital it might be a possibility.</p> <p>The Vascular Discharge Summary noted that Resident #2 admitted to the hospital on 3/14/18 and discharged on 3/17/18. The resident's had diagnoses of a past right BKA with medial and lateral incision dehiscence (rupture along the incision) with infection. The resident had debridement of the right stump and placement of a wound vac to be utilized after being discharged. The discharge order also indicated the stump should continue to be packed with gauze strips moistened in normal saline and wrapped with roll gauze BID. The plan included a follow up appointment in 2 weeks for a wound check.</p>	F 684	

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F 684	<p>Continued From page 10</p> <p>A nurse's note dated 3/17/18 at 6:58 p.m. noted that Resident #2 re-admitted to the facility after hospital stay for debridement. New orders accompanied the resident for a wound vac on 3 areas of his stump.</p> <p>The Peripheral Vascular recheck note of 3/21/18 documented a post-hospital and 3/14/18 debridement follow up. Resident #2 presented with a mild low-grade infection and also clotted blood on the wound surface, rendering the wound vac ineffective. The doctor ordered to discontinue the wound vac and initiate wet to dry dressings BID, to wash the wound thoroughly in the shower with water QD to keep the bacterial count down and a 2 week follow up appointment.</p> <p>The Physician Progress Notes dated 3/21/18 ordered staff to apply wet to dry dressings 3 times a day (TID) and a follow up appointment scheduled on 4/6/18 at 10:10 a.m.</p> <p>A nurse's note dated 3/25/18 entered late for 3/21/18 recorded Resident #2 had been seen for a follow up to the wound debridement. Staff received new orders to discontinue the wound vac and begin wet to dry dressings TID. The nurse's late entry lacked documentation the doctor also ordered the wound to be washed thoroughly with water in the shower every day.</p> <p>The March 2018 TAR documented staff packed Resident #2's stump with gauze strips moistened in normal saline and wrapped with gauze BID from 3/1/18 through 3/13/18, despite the 2/23/18 order stipulating QD instead of BID. The TAR also documented the right stump had been treated with a wound vac on 3/19/18 and 3/21/18,</p>	F 684		

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F 684	<p>Continued From page 11 although the 3/17/18 hospital discharge ordered use of the wound vac and also said the stump should continue to be packed with gauze strips moistened in normal saline and wrapped with roll gauze BID. Facility staff failed to clarify the order. The TAR documented staff dressed the resident's right stump with wet to dry dressings moistened with normal saline TID from 3/21/18 through 3/31/18.</p> <p>The Peripheral Vascular Recheck dated 4/6/18 noted a 2 week follow up for a wound check as the reason for Resident #2's appointment. The doctor commented on the much improved BKA wound and ordered to continue wet to moist dressings BID (down from TID) and cleansing in the shower at least QD. The physician also ordered a 1 month follow up appointment.</p> <p>The Physician Progress Notes dated 4/6/18 ordered wet to moist dressing to be changed BID to the right below the knee amputation wounds and a follow up appointment in 1 month.</p> <p>The nurse's noted dated 4/6/18 at 3:48 p.m. recorded Resident #2 returned from an appointment with a new order for a wet to dry dressing to be changed BID using normal saline, despite the 4/6/18 order directing application of wet to moist dressings instead of wet to dry.</p> <p>The April 2018 TAR documented staff dressed Resident #2's right stump with a wet to dry dressing moistened with normal saline TID on 4/1/18 through 4/6/18. The TAR recorded staff dressed his right stump with a wet to dry dressing moistened with normal saline BID on 4/6/18 through 4/30/18, despite the 4/6/18 order for wet to moist dressing instead of wet to dry.</p>	F 684		

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F 684	<p>Continued From page 12</p> <p>Correspondence dated 5/4/18 notified Resident #2's primary care provider that Resident #2's right leg stump wound had slightly increased in size and they would continue with current wet to dry dressing and monitoring. The document also noted the next vascular appointment scheduled on 5/7/18.</p> <p>The Physician Progress Notes dated 5/7/18 indicated the wound/s looked good. The doctor ordered wet to moist dressing to be changed BID to the right BKA wounds and a follow up appointment in 3 months. The order also recommended a rehab consult.</p> <p>A nurse's note dated 5/7/18 at 1:47 p.m. noted that Resident #2 returned from an appointment for wet to moist dressings to the right BKA twice a day, his current treatment order. Tentatively, there will be a 3 month follow up appointment.</p> <p>The May 2018 TAR recorded staff dressed Resident #2's right stump with a wet to dry dressing moistened with normal saline BID on 5/1/18 through 5/30/18, despite the 4/6/18 and 5/7/18 orders for wet to moist dressing instead of wet to dry.</p> <p>During interview on 7/10/18 at 12:15 p.m., Staff C, LPN (Licensed Practical Nurse) recalled going into Resident #2's room one morning when he came in early as the wound nurse. Staff C noticed litter on the resident's floor that nobody cleaned up. The litter and a couple other things caused him to be irritable. He suspected Resident #2's right stump dressing had not been changed for the second time that day, so he checked on it. Staff C said his initials and date stamp were still</p>		F 684				

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F 684	<p>Continued From page 13</p> <p>on it from the day before, indicating it had not been done for the second time that day. Staff C said he approached the overnight nurse responsible for completing the dressing change and had her do the change before she left that morning. Staff C recalled a similar situation with another nurse. He found his own initials and date he last changed Resident #2's dressing, indicating the other nurse failed to change the dressing on his shift. Staff C said he wrote the staff member up the next morning.</p> <p>On 7/12/18 at 11:00 a.m., the DON stated the resident's February TAR as of 2/13/18 stipulated that staff should cleanse Resident #2's incision site with Betadine before wrapping the BKA BID. Due to a transcription error, the February TAR simply instructed staff to cleanse the incision site, but did not stipulate what to cleanse it with. Instead of correcting the TAR to reflect the order, the DON said she expected each person to go to the chart and refer to the order. When asked if she could see how by not correcting the TAR, the potential for error increased, the DON agreed that it seemed reckless and she expected someone to notice the mistake and correct it.</p> <p>A subsequent interview on 7/18/18 at 8:15 a.m. with Staff C revealed more details about the time he discovered that a nurse failed to complete a dressing change. When asked about the possibility the offgoing nurse still had time and the intention to change the dressing before the end of the shift, Staff C said he approached the nurse about 6:05 a.m. standing at the nurse's station with her coat on and about to leave the building. Staff C said he made her take off her coat and change the dressing before she left.</p>		F 684				

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F 686 F 686 SS=G	Continued From page 14 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 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 clinical record review and physician and staff interviews, the facility failed to administer treatments as prescribed to promote pressure ulcer healing for 1 of 3 residents sampled for wound treatments (Resident #1). The facility reported a census of 61 residents. Findings include: 1. According to the 3/9/18 Minimum Data Set (MDS) assessment, Resident #1 had diagnoses that included heart failure, diabetes, stroke, chronic kidney disease and cognitive communication deficit. The MDS documented the resident required extensive assistance of 1 to 2 staff for all activities of daily living (ADLs). The assessment also noted Resident #1 had the risk for developing pressure ulcers. The MDS indicated Resident #1 received pressure ulcer care for one existing ulcer, a Stage 4 ulcer		F 686 F 686	F 686 SS=G TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE ULCER: Granger Nursing and Rehabilitation Center will ensure that each resident receives care, with the consistent standards of practice, to prevent pressure ulcers and each resident does not develop pressure ulcers unless the individual's condition demonstrates that they were clinically unavoidable. Each resident with a pressure ulcer will receive necessary treatment and services, consistent with professional standards of practice, to promote healing, and to prevent infection and new ulcers from developing. Resident # 1 has been discharged from the facility. The Director of Nursing and facility administrator re-educated all staff on the importance of follow physician's orders, wound care, physician notification in treatment of wounds on 8/3/2018. Effective immediately, the facility administrator and/or Director of Nursing will print a medication and treatment report from AHT (the electronic health record) and bring to the morning meeting for review to ensure all medications and treatments are being administered per physician's orders. The charge nurse on the weekend will review all MARS/TARS to ensure treatments and medications are followed per physician's orders. The physician and nurse responsible for any discrepancy in orders noted will be contacted within the 24-hour period to follow up accordingly. The facility is in the process of			

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F 686	Continued From page 15 measuring 4.0 by 4.4 centimeters. The MDS identified the following descriptions 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. The 1/25/18 Care Plan recorded Resident #1 had a pressure ulcer to his right heel and treatment changes on 2/15/18, 3/8/18 and 3/29/18. The Care Plan instructed staff to promote adequate nutrition and hygiene and to report symptoms of infection to the doctor and responsible party as needed. The Care Plan also documented Resident #1 had the risk for infection related to poor nutrition and the pressure ulcer. The undated Wound Care Management policy documented the facility's standard as the promotion of healing of any wounds that are present on admission or acquired in the facility.		F 686	obtaining wound certification for the wound nurse and Director of Nursing to improve the overall professional standards of the wound care program through VOHRA which is a nationally recognized wound certification course for nurses. Copies of wound certification for these employees will be placed in their respective personnel file. The Director of Nursing and Assistant Director of Nursing will complete at a minimum of weekly documented wound rounds to ensure treatments are being administered per physician's orders and healing is present. The corporate nurse will review the wound module, and TAR's at a minimum of weekly remotely to ensure compliance with documentation and treatment administration until compliance is achieved. The facility administrator met with nursing staff on 8/3/2018 regarding documentation of treatments. Falsification of treatment administration will result in immediate termination of employment. Concerns identified will be reported and addressed in the facilities quality assurance compliance meeting for additional intervention as indicated. The facility administrator and Director of Nursing will be responsible for ongoing compliance.			

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F 686	<p>Continued From page 16</p> <p>Physician's Order dated 2/1/18 documented a new order for Betadine to be applied to Resident #1's right heel, covered with gauze and secured with roll gauze and tape twice a day (BID).</p> <p>A telephone order dated 2/6/18 indicated that Resident #1 should be sent to ER to be evaluated.</p> <p>A Nurse's Note dated 2/6/18 at 5:38 p.m. documented an order to transfer Resident #1 to Emergency Room (ER) for fluids and an evaluation for treatment. The resident left for ER via ambulance at 4:50 p.m.</p> <p>A Nurse's Note dated 2/10/18 at 1:49 p.m. documented that Resident #1 returned to the facility after being hospitalized for dehydration. The nurse noted the resident still had an ulcer to his right heel.</p> <p>The hospital Discharge Summary dated 2/10/18 at 4:35 p.m. recorded Resident #1 admitted on 2/6/18 and discharged on 2/10/18 with a principal problem of dehydration and a resolved acute kidney injury. The resident presented from the skilled nursing facility (SNF) with a chief complaint of dehydration. Resident #1 admitted to the hospital, received IV fluids with improvement and was cleared to go back to the SNF. The discharge orders did not include any treatments to Resident #1's wound/s. Admission Orders dated 2/10/18 lacked any orders to treat Resident #1's wound/s.</p> <p>The resident's clinical did not contain an order for Resident #1's right heel wound treatment after readmission to the facility on 2/10/18, nor did the Treatment Administration Record (TAR) reflect</p>		F 686				

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F 686	<p>Continued From page 17 that staff completed any treatments from 2/11/18 through 2/15/18. However, a Nurse's Note dated 2/11/18 at 2:31 a.m. documented staff completed a treatment to the right heel as ordered.</p> <p>A Physician's Order dated 2/15/18 at 2:00 p.m. instructed to apply Betadine to the resident's right heel, but changed to BID. The order also instructed the wound should be covered with gauze and secured with roll gauze and tape.</p> <p>The February 2018 TAR documented staff applied a Betadine 10% solution to the resident's right heel wound, covered it with gauze wrap and secured it with roll gauze and tape BID from 2/2/18 through 2/6/18. Beginning on 2/16/18, staff documented application of Betadine 10% solution to the right heel wound, covering it with gauze wrap and then secured with Kerlix and tape BID through 2/28/18.</p> <p>A Physician's Order dated 3/8/18 instructed staff to paint the resident's right heel wound with Betadine, apply skin prep to the wound margins, apply an ABD dressing over the wound and secure and tape the dressing with roll gauze BID.</p> <p>An Employee Counseling/Disciplinary Report dated 3/23/18 documented Staff C , LPN received a second written warning and final notice for documenting that he completed dressing changes he had not on 3/21 and 3/24/18.</p> <p>Physician's Order dated 3/29/18 instructed staff to cleanse Resident #1's right heel with 0.25% acetic acid and patted dry. Next, the wound surface should be painted with Betadine with a piece of gauze wet with Betadine the size of the wound, applied to it and changed daily (QD).</p>	F 686		

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F 686	<p>Continued From page 18</p> <p>The Wound Center Final Report dated 3/29/18 documented the progress notes of the Nurse Practitioner's (NP) assessment of Resident #1 and subsequent plan. The NP opened the resident's Stage 3 pressure ulcer on the right heel and obtained a culture. The NP documented her plan included applying Betadine to the wound, covering it with gauze and securing it with roll gauze and tape. Skin prep should be applied to the wound margins prior to applying the wound dressing; change BID.</p> <p>The March 2018 TAR documented staff applied Betadine 10% solution to Resident #1's right heel wound, covered it with gauze wrap and secured the wrap with Kerlix and tape BID that month with the exception of treatments only being administered once on 3/12/18, 3/13/18, 3/23/18 and 3/27/18 and neither of the treatments provided on 3/26/18 and 3/29/18. The TAR indicated the treatment order had been discontinued on 3/29/18. The TAR noted a new treatment order beginning on 3/29 to cleanse Resident #1's right heel with 0.25% acetic acid, pat dry, paint the site with Betadine, apply a soaked gauze dressing the size of the wound and secure it with Kerlix twice a day.</p> <p>The March 2018 Administration Record documented staff did not complete the treatments scheduled for 3/12/18 and 3/13/18 and 3/29/18 at 6:00 p.m. due to the resident being asleep. Staff did not apply the treatments on 3/26/18 and 3/27/18 at 6:00 p.m. because the resident refused. The record contained no documentation that staff re-approached the resident at a later time. The TAR documented no provision of the 6 a.m. treatment on either 3/29 or 3/31/18.</p>	F 686		

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F 686	<p>Continued From page 19</p> <p>Physician's Order dated 4/2/18 instructed staff to inject Rocephin (an antibiotic) with Lidocaine 1% (for pain) QD for 5 days. The resident's MAR documented staff administered the medication from 4/2 - 4/6/18.</p> <p>A nurse's note dated 4/2/18 at 1:55 p.m. noted a new order had been obtained for an antibiotic to be injected QD for 5 days for an infection to Resident #1's heel.</p> <p>An Employee Counseling/Disciplinary Report dated 4/17/18 recorded Staff D, RN received a written warning for not effectively doing treatments on 4/9/18 and 4/15/18. The warning documented Staff D signed for having completed treatments that he had not. The wound nurse took off the treatments from a previous day shift with the employee's initials on it when it was understood the treatments were to be done BID.</p> <p>A nurse's note dated 4/18/18 at 11:10 a.m. recorded Resident #1 continued to have a Stage 4 pressure wound to the bottom of his heel and the wound nurse stated it appeared to be deteriorating.</p> <p>A nurse's note dated 4/21/18 at 12:43 p.m. noted that Resident #1 had purulent drainage with a foul odor dripping onto the floor. Resident #1 complained of increased pain from deep inside. The nurse documented that the resident requested to go to ER and he wanted to get it cut off. Staff obtained orders to transport Resident #1 to ER via ambulance. The nurse later spoke with hospital staff and learned Resident #1 might have osteomyelitis (a bone infection) according to an X-ray. An entry at 3:30 p.m. documented</p>	F 686		

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F 686	<p>Continued From page 20</p> <p>Resident #1 admitted to the hospital with diabetic foot ulcer and probable osteomyelitis.</p> <p>The April 2018 TAR documented the administration of the resident's right heel treatment. The treatment orders instructed to cleanse Resident #1's right heel with 0.25% acetic acid, pat it dry, paint the site with Betadine, apply a soaked gauze dressing the size of the wound and secure it with Kerlix - Change daily. The TAR noted that staff administered the treatment every other day, instead of daily as ordered, from 4/1/18 and 4/21/18, at which time they discontinued the treatment.</p> <p>The Hospitalist's Discharge Summary dated 5/7/18 at 10:26 a.m. documented that Resident #1 admitted on 4/21/18 and discharged on 5/7/18. The summary noted the resident's principal problem as a diabetic ulcer of the ankle with the fat layer exposed. Resident #1's active problems included post above right knee amputation, heart failure, high blood pressure, diabetes, chronic kidney disease and peripheral artery disease. Resolved problems included osteomyelitis of the right foot. According to the summary, Resident #1 admitted from the facility for a non-healing right heel ulcer with increased drainage and a MRSA (bacteria) infection. An MRI (imaging test) showed heel osteomyelitis and a ruptured Achilles tendon; which ultimately resulted in an above the knee amputation on 4/30/18. The doctor noted that Resident #1 was stable and ready to be discharged to skilled care.</p> <p>During an interview on 7/9/18 at 3:50 p.m. with Staff A, RN stated she came to work one time and saw the dressing she put on the resident 3 days before her return to work. Staff A said her</p>	F 686		

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F 686	<p>Continued From page 21</p> <p>initials and the date she changed it were written on the dressing. Resident #1's right heel wound definitely got worse, it went from a stable wound to one you could smell down the hallway. Staff A stated the Director of Nursing (DON) makes lists of things that show on the computer as not completed and tells them to "clear the reds". When asked, Staff A said that means charting at a later time and/or date that a task was completed. Staff A stated she returned to work another time after having some days off and found 3 vials of Rocephin intended for Resident #1's use in the top drawer of the med cart, after the antibiotic should have been completed. Staff A told the DON about it and witnessed her throw the vials away in the trash container on the medication cart. Staff A thought it was possible that they pulled the antibiotic from the emergency medication kit, which could account for the 3 remaining vials, but she suspected the antibiotics were not given.</p> <p>An interview on 7/10/18 at 9:15 a.m. with the facility's Pharmacist revealed that Resident #1 had an order for Rocephin 1 gram (gm) to be given intramuscular injection (IM) QD for 5 days. The Pharmacist said they sent the medication on 4/2/18 and Rocephin had not been taken out of their emergency kit for administration.</p> <p>An interview on 7/10/18 at 12:15 p.m. with Staff C, LPN revealed that one of his duties as a wound nurse was to track the TAR and present a list of incomplete treatments and/or dressings to the appropriate staff person and instruct them to "clear the reds". Staff C said nobody ever told him they did not remember completing a task or refuse to chart a late entry. Staff C stated they just took the list and did it and he has had to</p>	F 686		

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F 686	<p>Continued From page 22</p> <p>reconcile things as long as 2 weeks old, but he has a good memory. Staff C mentioned seeing a dressing he put on Resident #1's foot one day, after it should have been changed again on the evening shift that followed him. Staff C could not remember the name of the person that failed to change the dressing, but recalled they charted they did it when they did not. When asked how he knew for sure that they did not do the dressing change, Staff C said his name and the date he changed it marked the dressing. Staff C believed it was one of two people because they frequently failed to change dressings.</p> <p>An interview on 7/11/18 at 8:00 a.m. with the DON revealed that Resident #1 went to the hospital on 2/6/18 and re-admitted on 2/10/18 without treatment orders. As a result, the record lacked documentation to verify that staff treated Resident #1's foot between 2/11/18 and 2/15/18. The DON checked to see if the wound nurse or re-admitting nurse called about orders, but she did not find any documentation to verify that. The DON said they should have at least called the hospital to see what they wanted to do after Resident #1 discharged on 2/10/18, but ideally they should have called the wound clinic. Resident #1 went to the Wound Clinic on the 2/15/18 or 2/16/18 and they faxed orders after the appointment. When asked about the times in March the TAR indicated Resident #1's treatments were not done, the DON said they write an explanation of why it was not done elsewhere. The DON said the resident refused 3 times. When asked about the lack of treatment because the resident was sleeping, the DON stated the nurse should have tried waking the resident, administered the treatment or contacted the doctor.</p>	F 686		

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F 686	<p>Continued From page 23</p> <p>An interview on 7/11/18 at 9:25 a.m. with the Administrator revealed that Staff C had previously been reprimanded and demoted to floor nurse because he charted he did some dressing changes, when in fact he had not. The Administrator said other staff reported the dressing they found on a resident did not have the LPN's initials and date as he documented, but another staff's initials from the dressing change they did before Staff C charted he completed it.</p> <p>On 7/11/18 at 9:35 a.m. the DON stated the wound clinic ordered the 3/29/18 Betadine dressing change daily and the nurse entered the order incorrectly. As a result, Resident #1 received treatments every other day instead of every day. The facility has a triple check system. The receiving nurse processes the order and has another nurse double check her. The DON did not know if the receiving nurse attempted to get the second check or if the second nurse didn't contact a nurse manager for the third check like they should have. The DON said that system fell apart.</p> <p>An interview on 7/17/18 at 11:57 a.m. with Staff B, RN revealed the facility always tells staff to make the 'reds go away'. They get a list of things like medications, treatments or tasks that are highlighted to indicate they have not been completed during their shift. Sometimes the list might be for something missed up to a week ago. There were times she didn't know if she completed some of the things on the list or just marked it completed to make the red go away. Staff B did not know what she should actually do and did not ask for an explanation; she does it to satisfy the facility because when they give each</p>	F 686		

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F 686	<p>Continued From page 24</p> <p>person the list, they want each employee to make it go away. Staff B did not think it's OK to sign off on something if staff are not sure whether they did it or not. Staff B believed everyone did it the same way she did, but it was not always possible to remember what you've done after having a few days off.</p> <p>An interview on 7/19/18 at 1:55 p.m. with the physician that discharged Resident #1 from the hospital on 5/7/18 after an above the knee amputation revealed the potential for the wound to get worse if dressings are not changed as frequently as they should be or if doctor's orders are not followed as prescribed. Depending on the circumstances, the doctor said "of course it could lead to amputation" if the wound was not properly cared for and the condition warranted amputation. The physician said he expected staff to follow doctor's orders. He said he expected them to notify him if his orders were not followed for any reason, even if another doctor thought a different treatment should be used.</p> <p>An interview on 7/19/18 at 2:20 p.m. with the Wound Center Triage RN revealed that if dressing changes are not done appropriately, as frequently as they are supposed to be, or if doctor's orders are not being followed then wounds can get worse. She also said depending on the amount of drainage and if the appropriate products are not being used, surrounding tissue can macerate and break down. The RN said wounds can also get contaminated and infected without proper hand hygiene.</p> <p>An interview on 7/19/18 at 4:20 p.m. with the Wound Center ARNP (Advanced RN Practitioner) revealed she saw Resident #1 once on 5/16/18.</p>		F 686		

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F 686	<p>Continued From page 25</p> <p>The ARNP said he had circulatory issues, renal disease and diabetes and that is why they treated him with an antimicrobial like Betadine; daily treatments can be very effective. The resident had osteomyelitis, but could not go through an MRI (magnetic resonance imaging) due to claustrophobia. If they were not doing treatments/dressing changes daily it could have caused his wounds to get worse and caused complications. Staff should have been following orders. The ARNP concluded if they invested the resources to have him sent to us, the facility would have had a vested interest in following our orders. The orders should have been followed to promote healing.</p> <p>An interview on 7/24/18 at 10:09 a.m. with Wound Center Medical Director revealed that if a dressing change does not get completed as often as it should, or if doctor's orders are not followed as prescribed, a chronic wound could get infected, develop osteomyelitis and ultimately require amputation if necessary.</p>	F 686		
F 755 SS=D	<p>Pharmacy Svcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,</p>	F 755	<p>F 755 SS=D PHARMACY SERVICES/PROCEDURES/PHARMACIST/RECORDS: Granger Nursing and Rehabilitation Center will ensure that pharmaceutical services are provided including procedures that assure accurate acquiring, receiving, and administering of all drugs and biologicals to meet the needs of each resident.</p>	

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F 755	<p>Continued From page 26</p> <p>dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical and facility record review and staff interviews, the facility's computer failed to interface with the pharmacy's computer, which interfered with prescription medication being available as prescribed for one out of three residents (Resident #4). The facility reported a census of 61 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated 2/5/18 documented Resident #4 had diagnoses that included obstructive uropathy and Non-Alzheimer's dementia.</p> <p>The Medication Discharge Report signed and dated 1/30/18 ordered Resident #4 to continue taking Tamsulosin (for prostate treatment) 0.4 mg</p>	F 755	<p>The Director of Nursing re-educated all nurses on the pharmacy interface system for accurate and timely delivery of medications on 8/16/18. All nursing staff have been re-educated to contact the pharmacy via phone and/or fax if a medication is not delivered to the facility as a follow up to the e-link computerized system. The physician will be contacted immediately should a medication be unavailable for possible substitute of medication if indicated. Effective immediately, the facility administrator and/or the Director of Nursing will print a medication report sheet each week day to review MARS (Medication Administration Report) and TARS (Treatment Administration Report) at the morning meeting for immediate intervention as needed. The charge nurse on the weekend will complete the same process.</p> <p>The Director of Nursing and/or designee will also review the 24 hour report with each tour of duty</p> <p>for follow up on any pharmacy concerns or issues. Concerns identified will be reported and addressed in the facilities quality assurance compliance meetings for additional intervention as indicated.</p> <p>The Director of Nursing and facility administrator will be responsible for ongoing compliance.</p>	

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F 755	<p>Continued From page 27 (milligrams) every night at bedtime.</p> <p>The February 2018 Medication Administration Record (MAR) recorded that Tamsulosin 0.4 mg staff administered the medication throughout the month except on 2/3/18, 2/4/18 and 2/24/18. The narratives at the end of the MAR documented staff did not administer the medication as it was not available on 2/3/18 and 2/4/18 and because the resident refused it on 2/24/18.</p> <p>The March 2018 MAR recorded that Tamsulosin 0.4 mg had not been administered to Resident #4 on 11 days, while staff charted it as administered on the other days throughout the month. The narratives at the end of the MAR documented staff did not administer the medication for various reasons ranging from 'ordered from pharmacy', 'med not available' or simply 'was not administered'.</p> <p>The April 2018 MAR recorded that Tamsulosin 0.4 mg had not been administered to Resident #4 on 12 days, while staff charted it as administered on the other days throughout the month. until the medication discontinued on 4/28/18. The narratives at the end of the MAR documented the medication was 'not administered'" and one time 'med not in cart'.</p> <p>The medication Shipping Manifests dated 2/2/18 through 4/17/18 documented all Resident #4's medication the pharmacy delivered to the facility during that time but the list did not include Tamsulosin.</p> <p>A letter authored by the facility's Medical Director dated 7/16/18 documented the facility brought it to his attention they failed to administer</p>	F 755		

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F 755	Continued From page 28 Tamsulosin 0.4 mg to Resident #4 as ordered. According to the Medical Director, staff believed a 'linkage' problem prevented the facility's computer from transmitting Resident #4's prescription information to the pharmacy. As a result, Resident #4 had not received Tamsulosin from approximately 1/31/18 through 4/28/18. An interview on 7/10/18 at 9:42 p.m. with Staff D, RN (Registered Nurse) revealed that he contacted the pharmacy almost every time he worked to get medication for Resident #4, which never arrived. Staff D said the resident did not have his Tamsulosin for March and April 2018. The RN said he cannot guarantee that he documented that he did not always give it, but he did sometimes. Staff D told the day nurses when they came in the morning and left notes to the Director of Nursing (DON) and said he got in trouble because he wrote that the medication 'unavailable. Once he contacted the on-call manager to get authorization to have the medication special-delivered. They denied the request because it would have been too expensive to have it delivered in the middle of the month. An interview on 7/16/18 at 1:45 p.m. with the DON revealed that as a result of this surveyor's inquiry, she realized they have a problem with their computer linking with the pharmacy's computer. The DON said they don't receive the order sometimes; it's pretty rare. Resident #4's Tamsulosin had never been delivered since he re-admitted on 1/31/18. The DON did not know why some people documented they gave it. The DON said she did not have any documentation from the pharmacy indicating they ever delivered Resident #4's Tamsulosin.		F 755				

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F 755	Continued From page 29 Additional interview on 7/17/18 at 3:00 p.m. with the DON revealed she did not find any documentation that staff took Tamsulosin from their E-kit (emergency reserve of medication) for Resident #4 between February and April 2018. On 7/24/18 at 10:00 a.m. the DON stated they did not have other orders for Resident #4's Tamsulosin between 1/30/18 and 5/1/18, just the hospital's discharge order dated 1/30/18.	F 755		